STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495320	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/30/18 through 02/02/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenna Kennedy — TITLE: Administrator — (X6) DATE: 2-21-18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is delermined 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 t4 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/30/18 through 02/02/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 97at the time of the survey. The survey sample consisted of 21 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550	**F550** **Corrective Action(s):** Resident #14 has been assessed by nursing for his ADL needs to include incontinence care and toileting. Resident #14 has had his comprehensive plan of care reviewed and revised to reflect appropriate interventions and approaches to maintain dignity during his incontinent care and toileting. A facility Incident & Accident form has been completed for the incident involving resident #32. Resident #32 has had their comprehensive care plan reviewed and revised to reflect the proper procedure to be maintained during the meal pass and assisting residents during meal times. RECEIVED FEB 27 2018 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenna Kennedy — TITLE: Administrator — (X6) DATE: 2-21-18

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure the dignity of 2 of 21 residents was maintained (Resident #14 and Resident #32). The findings included: 1. The facility staff failed to ensure Resident #14's dignity was maintained. Staff walked the resident in front of the nursing station and down the side hall to the bathroom. Resident #14 was observed to be incontinent of urine. Resident #14 was admitted to the facility 5/17/17 with diagnoses that included but not limited to Huntington's Chorea, history of falling, dementia with behavioral disturbances and hypothyroidism. Resident #14's quarterly minimum data set (MDS) with an assessment reference date (ARD)	F 550	Identification of Deficient Practices & Corrective Actions(s): All other residents dependent for toileting /Incontinent care and eating may have the potentially been affected. The nursing staff will conduct a 100% audit of all residents dependent for toileting and eating will be completed to identify residents at risk. Residents identified at risk will be assessed by nursing for toileting/incontinent care needs and eating assistance to maintain dignity. Any/all comprehensive plans of care will be revised to address specific interventions and approaches to address resident care need to maintain dignity. Systemic Change(s): Facility policy and procedures were reviewed. No changes are warranted at this time. The DON and/or Social Services director will inservice the nursing staff on the facility policy & procedure regarding resident rights and dignity, to include maintaining dignity during toileting/incontinent care and while providing assistance during the meal pass.	

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F 550	Continued From page 2 of 11/9/17 assessed the resident with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making. Resident #14 required extensive assistance of two + persons for ambulation. Section H Bowel and Bladder assessed Resident #14 to always be incontinent of urine and bowel. Resident #14's person centered care plan dated 11/10/17 identified the problem of urinary incontinence related to loss of muscle tone. Approaches: Change soiled clothing after each incontinent episode. On 01/31/18 at 10:52 AM, Resident #14 was observed to be sitting at the nurses' station in a reclining Geri lounger with a locked table top. The restorative certified nursing assistant (C.N. A. #1) and licensed practical nurse #1 stated restorative wanted the surveyor to watch the resident ambulate. The director of nursing was observing Resident #14 ambulating as well. When the two staff members lifted Resident #14 from the reclining Geri lounger, the surveyor observed Resident #14 was incontinent of urine on the left side of her pants mainly. The DON was present and observed Resident #14 lifted from the chair to a standing position. The two staff members ambulated Resident #14 from the lounge at the nurse's station to the end of the nurse's station, around the nurse's station, and to the community bathroom in the hall. During the walk from the nurse's station to the bathroom, Resident #14 passed several residents and staff. The surveyor requested information on dignity during the end of the day meeting on 1/31/18 at 5:33 p.m.	F 550	Monitoring: The DON is responsible for compliance. The DON, ADON and/or designee will perform 3 random incontinent care and meal pass audits weekly to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of the weekly audits will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. Completion Date: March 19, 2018	

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F 550	Continued From page 3 The surveyor reviewed the facility policy titled "Quality of Life-Dignity" on 2/1/18. The policy read "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by a. Helping the resident keep urinary catheter bags covered; b. Promptly responding to the resident's request for toileting assistance; and c. Allowing residents unrestricted access to common areas open to the public, unless this poses a safety risk for the resident." During the end of the day meeting on 2/2/18 at 11:34 a.m., the surveyor asked both the director of nursing and the administrator if walking Resident #14 with soiled clothes was dignified. Both stated no. No further information was provided prior to the exit conference on 2/2/18. 2. The facility staff failed to maintain dignity while feeding Resident #32. Resident #32 was admitted to the facility on 10/31/17 with the following diagnoses of, but not limited to diabetes, dementia, Huntington's Disease, anxiety disorder and depression. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #32 was also coded as requiring extensive assistance of 1 staff	F 550		

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F 550	Continued From page 4 member for dressing and personal hygiene and totally dependent on 2 staff member for bathing. On 1/31/18 at 8:55 am, this surveyor observed Resident #32 in her room with a CNA (Certified Nursing Assistant) standing up beside the resident with her hand on her hip, feeding the resident with the other hand. The administrative team was notified on 01/31/18 at 05:16 pm of the above documented observation made by the surveyor. The surveyor asked the administrative team if they expected their staff to sit on the side of the resident's bed or stand while feeding them. The DON (director of nursing), ADON (assistant director of nursing) and ADM (administrator) stated they would expect their staff to get a chair and sit to feed the resident. No further information was provided to the surveyor prior to the exit conference on 2/2/18.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview clinical record review staff failed to keep necessary food and equipment within a blind resident's reach for one of 21 residents (Resident #43) in the survey sample.	F 558	F558 Corrective Action(s): Resident #43 has been reassessed by speech therapy for swallowing difficulties and for possible diet modifications. The dietary manager has reassessed resident #43 for her likes, dislikes and dietary preferences. C.N.A. #1 has been inserviced on the proper feeding assistance required for resident #43 at all melas. Resident #43's plan of care was updated to reflect her current dietary needs and assistance needed with meals.	

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F 558	Continued From page 5 Resident #43 was admitted to the facility on 8/20/13 and readmitted to the facility on 1/25/18. The resident's diagnoses include heart failure, chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy, hypertension, anxiety, depression, dependence on renal dialysis, dysphagia, and difficulty walking. On the 14 day MDS (minimum data assessment) with assessment reference date 12/13/17, the resident was assessed with severely impaired vision (no vision or sees only light, colors, or shapes). The resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, and was assessed as without behaviors affecting self or others. The resident was assessed as having no signs or symptoms of a swallowing disorder. On 1/31/18, the surveyor observed and interviewed the resident from approximately 8:20 AM until 9 AM. When the surveyor arrived, the resident's breakfast tray was on an overbed table, along with a small cooler and a clean brief, near the foot of the bed. The (blind) resident was unaware that the food was there and was unable to reach the tray. 01/31/18 08:49 AM The diet was pureed diet with thickened liquids. The resident stated she would like to liberalize the diet. She stated she had a regular texture diet in the hospital and would like the same here. The breakfast tray holds applesauce and gravy. The meal ticket does not say what is on the tray. There is a bowl of cream of wheat or grits (later learned it was oatmeal). The resident said she did not like either. A CNA (CNA#1) arrived at 8:49 AM to feed the resident. The resident asked twice for toast. The CNA #1	F 558		

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F 558	Continued From page 6 said she wasn't allowed toast the diet order was for a pureed diet. 01/31/18 09:09 AM CNA#1 finished feeding the gravy from the tray and left. The resident reported she was still hungry. LPN#1 answered the call bell and viewed the tray with less than 25% of food eaten. She called the kitchen and the dietary manager came and reviewed the tray and went to talk to the resident about preferences. She said she would bring the resident something more to eat. The dietary manager brought a chopped biscuit topped with gravy to the resident, who ate 100% of the additional food. 01/31/18 12:54 PM Found in AM with call button under the oxygen concentrator. Two different staff members spoke with the resident without noticing or putting the button where the resident could reach it. After surveyor pointed to the button, A CNA picked it up from the floor and laid it across the resident's chest without cleaning it. During a summary meeting on 1/31/18, the surveyor reported the concern that the resident's food and liquid, and call bell were not placed where she could reach them and the resident was not told that the tray was available.	F 558	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with vision impairment may have been potentially affected. The facility will conducted a 100% review of all residents with Vision impairment to identify residents at risk. Residents identified at risk will have their care plans reviewed and revised to indicate their level of feeding assistance required at all meals. **Systemic Change(s):** The current facility policy and procedure has been reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the DON or ADON on providing appropriate assistance at meals to include reviewing what is on the meal tray, alternate meal options and the location of food and beverages on and around the meal tray. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or unit managers will perform three random meal pass audits weekly during meal times on the floor to monitor for compliance. All negative findings will be corrected at the time of discovery and disciplinary action will be taken as warranted. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. Completion date: March 19, 2018	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		

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F 583	Continued From page 7 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide privacy for 1 of 21 residents during incontinent care and a dressing change (Resident #14). The findings included: The facility staff failed to ensure Resident #14's privacy was maintained. Two certified nursing assistants (C.N. A. #1 and C.N.A. #3) provided incontinent care and dressed the resident while	F 583	**F583** **Corrective Action:** C.N.A. #1 and C.N.A. #3 performing incontinence care and providing dressing assistance for resident #14 have been inserviced on the facility policy and procedure for providing privacy during incontinence care and ADL care. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents receiving incontinence care and ADL may have been potentially affected. A 100% observation audit of all residents receiving incontinence care and ADL care will be conducted to identify any residents at risk for the potential unnecessary exposure of their bodies during persooal care and services. Any residents identified as being exposed during the audit will be corrected at time of discovery and staff involved will receive immediate inservice training. An Incident & Accident Form will be completed for any/all incidents of exposure. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the DON, and/or Social Services director on Resident Rights, Confidentiality and Personal Privacy to include unnecessary exposure during personal care and services.	

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F 583	Continued From page 8 Resident #14's roommate observed. The two C.N.A.s failed to pull the privacy curtain separating Resident #14 from her roommate. Resident #14 was admitted to the facility 5/17/17 with diagnoses that included but not limited to Huntington's Chorea, history of falling, dementia with behavioral disturbances and hypothyroidism. Resident #14's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/9/17 assessed the resident with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making. Resident #14 was totally dependent on two + persons for dressing. Section H Bowel and Bladder assessed Resident #14 to always be incontinent of urine and bowel. Resident #14's person centered care plan dated 11/10/17 identified the problem of urinary incontinence related to loss of muscle tone. Approaches: Cleanse skin with soap and water after each incontinent episode. On 2/2/18 at 8:15 a.m., the surveyor observed Resident #14 in bed. The resident was attempting to get out of bed. The surveyor summoned certified nursing assistant #1. C.N.A. #1 and C.N.A. #3 both donned gloves and tried to provide incontinent care. C.N.A. #1 and C.N.A. #3 assisted Resident #14 to her back and then positioned Resident #14 on the right side. C.N.A. #1 then cleaned the resident's back side and then positioned the resident on the back and cleaned the resident's front. C.N.A. #1 then positioned Resident #14 on the side of the bed. C.N.A. #1 then put pants on the resident and then removed her gown. Resident #14 was naked from the	F 583	Monitoring: The DON is responsible for compliance. The DON, ADON and/or designee will perform two weekly incontinent care and ADL care audits on each unit in order to maintain compliance. Any/all negative findings will be corrected immediately and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date:** March 19, 2018	

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F 583	Continued From page 9 waist up. Both breasts were exposed. C.N.A. #1 then put a shirt on the resident. During the entire observation, the privacy curtain had not been pulled separating Resident #14 from her roommate. During the observation, Resident #14's roommate had her head turned toward her roommate, observing the care of Resident #14. The surveyor informed the assistant director of nursing of the above observation on 2/2/18 at 8:45 a.m. She stated she would expect the privacy curtain to be pulled between the two residents and stated she would take care of the issue. The surveyor informed the administrative staff of the above observation during the end of the day meeting on 2/2/18 at 11:34 a.m. The surveyor asked both the director of nursing and the administrator if they would expect their staff to pull the privacy curtain between the two residents. Both stated yes they would. The surveyor reviewed the facility policy titled "Quality of Life-Dignity" on 2/2/18. The policy read "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 10. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." No further information was provided prior to the exit conference on 2/2/18.	F 583		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604		

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F 604	Continued From page 10 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, guardian interview, staff interview, facility staff interview and clinical record review, the facility staff failed to ensure 2 of 21 residents were free of physical restraints (Resident #14 and Resident #35). The findings included:	F 604	**F604** **Corrective Action(s):** Resident #14 has been reassessed by nursing, therapy, and the attending physician for the need and use of a Geri Lounger with a table top while up in the chair. Resident #14's responsible party was notified and explained the risks and benefits of using a table while in the Geri-chair and consent was obtained. Resident #35 has been reassessed by nursing, therapy, and the attending physician for the need and use of a self-releasing seat belt while up in the wheelchair. Resident #35's responsible party was notified and explained the risks and benefits of using a self-releasing belt while in the chair and consent was obtained. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents utilizing restraints may have been potentially affected. The facility conducted a 100% review of all residents currently utilizing restraints to identify other residents at risk and that appropriate Responsible party notification has been made. All residents identified at risk will be corrected at time of discovery. The results of this audit were reviewed by the Risk Management Committee to ensure proper diagnosis, medical necessity, consent for use and that the least restrictive appliance is being used.	

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	495320	A. BUILDING _____ B. WING _____	02/02/2018

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F 604	Continued From page 11 1. The facility staff failed to assess and monitor Resident #14's Geri lounger with table top that the resident was unable to remove. From the State Operations Manual, a "Physical restraint" is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: o Is attached or adjacent to the resident's body; o Cannot be removed easily by the resident; and o Restricts the resident's freedom of movement or normal access to his/her body. As described under Definitions, a physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. The resident's physical condition and his/her cognitive status may be contributing factors in determining whether the resident has the ability to remove it. For example, a bed rail is considered to be a restraint if the resident is not able to put the side rail down in the same manner as the staff. Similarly, a lap belt is considered to be a restraint if the resident cannot intentionally release the belt buckle. Examples of facility practices that meet the definition of a physical restraint include, but are not limited to: o Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising; The clinical record of Resident #14 was reviewed	F 604	Systemic Change(s): The facility Policy and Procedure for Restraints has been reviewed and no changes are warranted at this time. Nursing staff will be inserviced on obtaining consent for use of a restraint, the proper use of restraints and the need for supporting medical diagnosis /medical symptoms to justify the use of the restraints. The Risk Management Committee will review all restraints weekly to verify they have an appropriate medical diagnosis /symptom that warrant the use of the restraint and that consent has been obtained. The committee will also make recommendations to staff for restraint reductions and the least restrictive alternatives. Monitoring: The DON is responsible for compliance. Residents utilizing restraints will be reviewed weekly in risk management to monitor compliance. The audit findings at the Risk Management meeting will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 604	Continued From page 12 1/30/18 through 2/2/18. Resident #14 was admitted to the facility 5/17/17 with diagnoses that included but not limited to Huntington's Chorea, history of falling, dementia with behavioral disturbances, hypothyroidism, and neurocognitive disorder. Resident #14's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/9/17 assessed the resident with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making. Resident ##14 was totally dependent on two + persons for bed mobility, transfers, walking in corridor, dressing, toilet use, and bathing. Section J 1700 (fall history) did not identify any falls in the previous 6 months. Section P Restraints did not code any type of restraint or any alarms for Resident #14. Resident #14's person centered care plan dated 11/10/17 identified the problem of impaired thought processes related to (r/t) Dx. (diagnosis) Huntington's Chorea. Approaches: Evaluate the need for physical restraint use. Identified as a problem/need also was falls potential due to resident's impaire(sic) independently mobility. Has HX (history of) falls Transfered (sic) at this time Dx. (diagnosis) Huntington's Chorea. Approaches: Geri-lounge with table top and activity apron for table top. The surveyor observed Resident #14 during the initial tour on 1/30/18 at 2:55 p.m. Resident #14 was sitting in a Geri-chair with a table top. On the table top, the surveyor observed a book and flat, water filled, round objects that contained various pictures. The certified nursing assistant #5 sitting with the resident stated the resident couldn't	F 604		

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F 604	Continued From page 13 remove the table top. "It's locked." The surveyor observed Resident #14 again on 1/31/18 08:01 AM. Resident #14 was seen in the rehab department. Resident #14 was again in the Geri-lounge chair with the table top secured. The restorative certified nursing assistant (RCNA #6) stated she was doing one on one with the resident. On the table was a sensory book that the resident attempted to flip through that made sounds. Also, the RCNA #6 was playing with different types of balls. The RCNA #6 would hand the ball to Resident #14 to throw. Sometimes the resident would throw the ball and sometimes she would just lunge at the RCNA #6. Resident #14 was observed to not attempt to remove the table top. On 1/31/18 at 10:52 AM, Resident #14 was observed to be sitting at the nurses' station in a reclining Geri lounger with a locked table top. The surveyor observed Resident #14 on 2/1/18 at 8:00 a.m. Resident #14 was sitting in the lounge at the nurse's station with certified nursing assistant #7. Resident #14 was sitting in the Geri-lounge chair but the table top had been removed. The surveyor observed the resident focused on the television program. C.N.A. #7 had an over the bed table in front of the C.N.A. that held modeling clay, sensory items, and a sensory book. C.N.A. #7 stated she was sitting with the resident for the day. The surveyor observed Resident #14 numerous times throughout the day on 2/1/18 without the table top attached to the Geri-lounge chair. During one of the observations, the surveyor observed resident with a blanket covering her lap	F 604		

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F 604	Continued From page 14 and an activity apron on top of the blanket. The resident's eyes were closed. The clinical record was reviewed for the physician order for the Geri-lounge chair with table top. The order dated 12/11/17 read "Geri Lounge with table top and activity apron for table top pm (whenever needed)." The surveyor interviewed Resident #14's guardian on 2/1/18 at 1:00 p.m. The guardian was asked if the facility had informed her of the Geri-lounge chair with table top. The guardian stated she didn't remember getting a call directly but stated the facility may have called and talked to her supervisor. The surveyor interviewed registered nurse #2 on 1/31/18 at 5:00 p.m. The surveyor reviewed the progress note written on 12/11/17 at 10:19 a.m. by R.N. #2 and asked if she had notified the guardian of the physician order. R.N. #2 stated "I didn't call the guardian. I should have." The surveyor reviewed the restraint need assessments for Resident #14. There was one "Resident Need Assessment Form" completed on 11/9/17. The form completed by R.N. #2 read under "Medical Factors for Consideration Not Applicable". "Not Applicable" was the only entry marked on the 2-page form. The "Not Applicable" answer was in response to the question "1. Would restraints be used to prevent resident from removing tubes?" There was not a restraint needs assessment form completed prior to the use of the Geri-lounge chair with table top ordered on 12/11/17. The surveyor discussed the concern with the	F 604		

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F 604	Continued From page 15 Geri-Lounge with the table top with the director of nursing on 1/31/18 at 11:00 a.m. The director of nursing stated the table top was used as an "activity" table to keep the resident occupied. The surveyor asked after the resident had been at the facility since May 2017 and had only one fall what was the reason for the "activity" table starting in December 2017. The DON stated the table was not a "restraint" but an activity table. The surveyor requested the facility policy for restraint use on 2/2/18 at 9:00 a.m. The policy titled "Restraint Utilization and Reduction" was reviewed 2/2/18. The policy read in part "Our restraint policy will be discussed with each resident and his/her responsible party during the admission process. PURPOSE: A restraint is defined as any manual method or device attached or adjacent to an individual that cannot be easily removed by the resident and restricts freedom of movement or normal access to one's body. PROCEDURE: 1. Complete the Restraint Need Assessment Form with the participation of the interdisciplinary team upon admission. 2. The resident and/or responsible party will be informed of the risks and benefits for restraint use as outlined on the Safety Device Consent Form. 4. Prior to implementation the team must ensure that consent is obtained from Resident/responsible party and documented accordingly. 5. Consultation of the Rehabilitation department should be completed to determine the least restrictive intervention. 9. All restraints/safety devices will be reviewed minimally quarterly for possible elimination and/or reduction in use. The surveyor interviewed the rehab director on 2/2/18 at 10:00 a.m. The rehab director stated	F 604		

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F 604	Continued From page 16 Resident #14 had never been on caseload since admitted 5/17/17. The surveyor informed the administrative staff of the concerns with the Geri-lounge chair with the locked table top used as an activity device during the end of the day meeting on 1/31/18 at 5:33 p.m. and again on 2/2/18 at 11:34 a.m. No further information was provided prior to the exit conference on 2/2/18. 2. The facility staff failed to ensure Resident #35 could release the "self-releasing" seat belt. The clinical record of Resident #35 was reviewed 2/1/18 and 2/2/18. Resident #35 was admitted to the facility 6/14/06 and readmitted 3/14/13 with diagnoses that included but not limited to vertebro-basilar artery syndrome, lack of coordination, urinary tract infection, muscle weakness, atherosclerotic heart disease, hemiplegia affecting left dominant side, conduct disorder, and cerebral infarction due to occlusion or stenosis of cerebral artery. Resident #35's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/30/17 assessed the resident with long term memory problems, short term memory problems and severely impaired cognitive skills for daily decision making. Section G Functional Status assessed the resident to require extensive assistance of two + persons for transfers and locomotion off the unit and locomotion on the unit required extensive assistance of one person. Section J did not identify any recent falls in the past 6 months. Section P Physical Restraints was reviewed. There was no restraint coded.	F 604		

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F 604	Continued From page 17 Alarms were coded that a bed alarm, chair alarm, and a motion sensor alarm all were used daily. The clinical record reviewed 2/1/18 and 2/2/18 revealed an order for an alarming self-release belt to wheelchair ordered 12/13/17. Resident #35's person centered care plan dated 12/1/17 identified falls/injuries as a problem with one approach to use alarming self-release seat belt to chair. On 2/1/18 at 2:03 p.m., the surveyor asked Resident #35 to release the seat-belt. The resident was unable to do so. The surveyor observed Resident #35 in the dining room on 2/01/18 at 2:05 PM Resident #35 was observed sitting in a wheelchair. Resident #35 was observed with a self-releasing seat belt. Resident #35 was asked by the surveyor to release the seat-belt. Resident #35 was unable to release the seat belt. The resident was asked by the restorative certified nursing assistant #6 and by registered nurse #3. Resident #35 would not release the seat belt. On 2/01/18 3:37 PM, the director of nursing (DON) asked the resident to release the self-releasing seat belt. Resident unable to release after multiple requests. The DON stated she would call the daughter and inform her of the restraint issue. The surveyor informed the administrative team of the inability of Resident #35 to release the self-releasing seat belt when asked during an end of the day meeting on 2/2/18 at 11:34 a.m.	F 604		

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F 604	Continued From page 18 No further information was provided prior to the exit conference on 2/2/18.	F 604		
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- (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	F 655	**F655** **Corrective Action(s):** Resident #43's medical record and Comprehensive care plan has been reviewed and revised to reflect her hemodialysis schedule needs and her Vision impairment needs at meal times. Resident #83 and Resident #92's attending physician and RP were notified that the facility failed to provide a written summary of their base line comprehensive care plan. Resident #83 and their RP and Resident #92 and their RP have received and reviewed their base line comprehensive Care Plan. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON, RCC and/or designee to identify residents who did not receive a written summary of their baseline comprehensive care plan All residents and RP's identified who did not received a written summary of their baseline comprehensive care plan will have their care plan reviewed and updated and a written summary of their resident centered care plan will be reviewed and given to the Residents and RP's identified. A Facility Incident & Accident Form will be completed for each incident identified.	

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F 655	Continued From page 19 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: 2. For Resident #83 the facility staff failed to provide the resident or his representative a written summary of his baseline comprehensive care plan. The clinical record of Resident #83, reviewed 2/1/18. Resident #83, admitted to the facility on 12/15/17 with diagnoses that included, but were not limited to: high blood pressure, diabetes mellitus, anxiety, depression, urinary retention, and psychosis. A review of Resident #83's clinical record revealed on the 14 day minimum data set (MDS), with an assessment reference date of 1/1/18: Section C (cognitive patterns) of this assessment scored the resident as a 13 indicating the resident was cognitively intact; Section B coded Resident #83 to understand and to be understood. Resident #83's care plan was reviewed. The resident was asked if he had been given a written summary of his care plan. Resident #83 said, "I was asked to go to a care plan meeting, but nothing was given to me." On 2/1/18 at 2:55pm, the MDS nurse was asked if she had provided Resident #83 and his responsible party with a copy of his baseline care	F 655	Systemic Changes: The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise base line care plans within 48 hours of admission to the facility and a written summary will be given to the Resident and RP. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, implementation of the baseline as well as the process for reviewing the base line care plan with residents and RP's. Monitoring: The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits on all new admissions 48 hours after admission to ensure a base line care plan has been completed timely and that a written summary has been completed and reviewed with the resident and/or RP. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 655	Continued From page 20 plan, she said, "No." On 2/2/18 at 11:39 am, the administration staff were informed of the aforementioned. The facility staff prior to exit on 2/2/17 provided no further information. 3. For Resident #92, the facility staff failed to provide a written copy of the baseline care plan. Resident #92 was admitted to the facility on 01/12/18. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, hyperlipidemia, thyroid disorder, depression, psychotic disorder, schizophrenia, bipolar disorder and dementia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/18/18 coded the Resident as 7 out of 15 in section C, cognitive patterns. This is an admission MDS. The surveyor spoke with the Resident on 01/31/18 at approximately 0900. Surveyor asked Resident if she had received a copy of her care plan and Resident stated that she had not. Surveyor spoke with DON on 02/01/18 regarding providing Resident with copy of care plan and DON stated "To be honest, we are not doing it". The concern of not providing Residents with copy of care plans was discussed with the administrative team during a meeting on 02/02/18 at approximately . No further information was provided prior to exit. Based on resident interview, staff interview,	F 655		

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F 655	Continued From page 21 clinical record review, and facility document review, facility staff failed for 3 out of a sample of 21 records: 1) to develop a person centered comprehensive care plan that addressed the resident's needs concerning dialysis and vision for Resident #43; 2) to provide Resident #83 or his representative a written summary of his baseline comprehensive care plan; 3) to provide Resident #92 a written copy of the baseline care plan. 1. Resident #43 was admitted to the facility on 8/20/13 and readmitted to the facility on 1/25/18. The resident's diagnoses include heart failure, chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy, hypertension, anxiety, depression, dependence on renal dialysis, dysphagia, and difficulty walking. On the 14 day MDS (minimum data assessment) with assessment reference date 12/13/17, the resident was assessed with severely impaired vision (no vision or sees only light, colors, or shapes). The resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, and was assessed as without behaviors affecting self or others. The resident was assessed as having no signs or symptoms of a swallowing disorder. Review of the resident's care plan revealed that the resident's care plan did not address actions necessary to accommodate the resident's severely impaired vision or the need to schedule meals and medications to accommodate the hemodialysis schedule. As a result, the resident missed morning medications while out of the	F 655		

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	495320	A. BUILDING _____ B. WING _____	02/02/2018

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F 655	Continued From page 22 facility for hemodialysis on 1/11, 1/16, and 1/18/18. The surveyor observed the resident in bed, with the breakfast tray and out of reach of the resident on 1/31/18 from 8:20 AM when the surveyor arrived until 8:49 when CNA #1 started to feed the resident. The resident stated she could feed herself if she could reach the food. Care plan review revealed that the care plan did not address the resident's inability to see objects in the room and the resulting need to place items within reach and tell the resident what was nearby and where she could reach it. The concern was reported the the administrator and director of nursing during a summary meeting on 2/1/18.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (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	F 656	**F 656** **Corrective Action(s):** Resident #43's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include approaches to address her vision impairment. A Facility Incident & Accident Form was completed for this incident.	

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F 656	Continued From page 23 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview facility staff failed to develop care plans vision needs for 1 of 21 residents in the survey sample (Resident #43). Resident #43 was admitted to the facility on 8/20/13 and readmitted to the facility on 1/25/18. The resident's diagnoses include heart failure, chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy, hypertension, anxiety, depression, dependence on renal dialysis, dysphagia, and difficulty walking. On the 14 day MDS (minimum data assessment) with assessment reference date	F 656	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, ADON, RCC and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified. Systemic Changes: The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.	

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F 656	Continued From page 24 12/13/17, the resident was assessed with severely impaired vision (no vision or sees only light, colors, or shapes). The resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, and was assessed as without behaviors affecting self or others. The resident was assessed as having no signs or symptoms of a swallowing disorder. 01/31/18 09:26 AM Resident reports that she is nearly blind and cannot see to do anything. After the dietary manager brought pureed bread with gravy, the resident scooped some into the upturned dome lid and pulled the dome on to her chest and ate the food from the dome with her fingers. At 9:31, a CNA arrived to feed her. Limited vision was not on the diagnosis list. The care plan did not address the vision limitation. During the end of day meeting on 1/31/18 with the administrator, director of nursing, and a corporate clinical representative, the surveyor reported the concerns with the failure to address the needs of the visually impaired in the resident's care plan. The surveyor discussed the concerns with care planning with the administrator and director of nursing during a summary meeting on 1/31/18.	F 656	Monitoring: The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for complaince. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 657	F-657 Corrective Action(s): Resident #32's comprehensive cares plan has been reviewed and revised to reflect interventions and approaches to prevent falls. A Facility Incident & Accident Form was completed for this incident.	

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F 657	Continued From page 25 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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review facility staff failed to review and revise the person centered comprehensive care plan for 4 of 21 residents (Resident's #32, #91, #43 and #15). The findings included: 1. The facility staff failed to review and revise the person centered care plan after a fall for Resident #32. Resident #32 was admitted to the facility on 10/31/17 with the following diagnoses of, but not limited to diabetes, dementia, Huntington's disease, anxiety disorder and depression. On the MDS (Minimum Data Set) with an ARD	F 657	Resident #91's comprehensive cares plan have been reviewed and revised to reflect his preference to be in his room with privacy curtains pulled and the light out. Social Services and Activities have met with him to review his current activity and psychosocial needs to make sure we are meeting his needs. A Risk Management Incident & Accident Form was completed for this incident. Resident #43's medication regime has been reviewed by the attending physician and nursing staff to determine an administration schedule that can be met on the days that Resident #43 has dialysis. Resident #43's comprehensive care plan has been reviewed and revised to reflect the current medication schedule to be followed on dialysis days to ensure medications are administered before or after dialysis. Interventions and approaches were also added for the residents impaired vision status and her need to be alerted to where food items were located on her tray and that they are in reach for her to feed herself. A Risk Management Incident & Accident Form was completed for this incident. Resident #15's comprehensive cares plan has been reviewed and revised and the self-releasing seat belt has been removed from resident #15's comprehensive care plan. A Risk Management Incident & Accident Form was completed for this incident.	

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F 657	Continued From page 26 (Assessment Reference Date) of 11/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #32 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and totally dependent on 2 staff member for bathing. The surveyor conducted a clinical record review on 1/31/18 at 9:29 am. The surveyor noted that the resident had documentation on her care plan of several falls but no new interventions had been documented on the care plan after these falls. The surveyor noted, on 2/01/18 at 7:37 am, a fall was documented on 1/4/18. It was noted that the following documentation was on the care plan regarding this fall: "Notify MD/RP V/S". There were no new interventions documented by the staff. The surveyor interviewed the ADON (assistant director of nursing) about the above care plan documentation. The ADON stated, "We put Dycem to the resident's wheelchair, but it was not documented on the care plan." The surveyor asked the ADON if she would expect her staff to add interventions to the care plan as they were implemented. The ADON stated, "Yes, it should be care planned when we do the intervention. No further information was provided to the surveyor prior to the exit conference on 2/2/18. 2. The facility staff failed to review and revise the person centered care plan for Resident # 91. Resident #91 was admitted to the facility on 2/4/17 with the following diagnoses of, but not limited to anemia, heart failure, depression, muscle weakness, adult failure to thrive and	F 657	Identification of Deficient Practices & Corrective Action(s): Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified. Systemic Changes: The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition.	

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F 657	Continued From page 27 cirrhosis of the liver. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/17/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #91 was also coded as requiring limited assistance of 1 staff person for dressing and personal hygiene and physical assistance of 1 staff member for bathing. The surveyor conducted a clinical record review of both of the electronic and paper clinical record on 1/31/18 and 2/1/18. During this review, the surveyor reviewed the person centered comprehensive care plan with a revision date of 10/26/17. Under the problem of "Mood" it stated," ... _____ (name of the resident) is noted to have sad facial expressions which usually can be altered with interaction He had DX (diagnosis) Depression, no behaviors noted at this time ..." The interventions that were noted were as follows: " ..."SW (social worker) to visit as needed " Meds/Labs (medications/labs) as ordered Inform MD (medical director) of any changes, AIMS scale as needed, Pharmacy reviews for possible drug reductions, ... " Explain procedures prior to giving care, approach in a calm manner, reorient with care and pm (as needed) ...provide a calm environment." The surveyor also reviewed the person centered comprehensive care plan with a revision date of 1/18/18. The same problem and interventions remained in place from the last revision date of 10/26/17. The surveyor reviewed the nursing documentation from October 2017 through January 2018. The nursing revealed that the	F 657	Monitoring: The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 657	Continued From page 28 resident was noted to like to be in his room with the privacy blinds pulled completely around the bed and the room dark with no lights on. The surveyor observed this on 1/30/18 and 1/31/18. The surveyor on notified the administrative team of the above documented findings on 1/31/18 at 5:16 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 2/2/18. 3. For Resident #43, facility staff failed to address the resident's need to receive medications prior to scheduled absences for hemodialysis. Resident #43 was admitted to the facility on 8/20/13 and readmitted to the facility on 1/25/18. The resident's diagnoses include heart failure, chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy, hypertension, anxiety, depression, dependence on renal dialysis, dysphagia, and difficulty walking. On the 14 day MDS (minimum data assessment) with assessment reference date 12/13/17, the resident was assessed with severely impaired vision (no vision or sees only light, colors, or shapes). The resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, and was assessed as without behaviors affecting self or others. The resident was assessed as having no signs or symptoms of a swallowing disorder. Review of the resident's care plan revealed that the resident's care plan did not address actions necessary to accommodate the resident's severely impaired vision or the need to schedule meals and medications to accommodate the	F 657		

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F 657	Continued From page 29	F 657		

hemodialysis schedule. As a result, the resident missed morning medications while out of the facility for hemodialysis on 1/11, 1/16, and 1/18/18.

The surveyor observed the resident in bed, with the breakfast tray and out of reach of the resident on 1/31/18 from 8:20 AM when the surveyor arrived until 8:49 when CNA #1 started to feed the resident. The resident stated she could feed herself if she could reach the food. Care plan review revealed that the care plan did not address the resident's inability to see objects in the room and the resulting need to place items within reach and tell the resident what was nearby and where she could reach it.

The concern was reported the the administrator and director of nursing during a summary meeting on 2/1/18.

4. The facility staff failed to review and revise the person centered care plan when Resident #15 no longer had a self-releasing seatbelt.

The surveyor reviewed Resident #15's clinical record 1/30/18 through 2/2/18. Resident #15 was admitted to the facility 11/12/07 and readmitted 6/26/12 with diagnoses that included but not limited to cerebral palsy, urinary tract infections, abnormal involuntary movements, and lack of coordination.

Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/10/17 assessed the resident with a BIMS of 15 out of 15. Section P0200 Alarms was not coded for any type of alarms (chair, bed, floor mat alarm, motion sensor alarm, wander/elopement alarm, or other

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F 657	Continued From page 30 alarm). The surveyor reviewed Resident #15's person centered care plan on 1/31/18. One problem/need listed read "Falls-- Approaches Self release belt as ordered." The December 2017 physicians' orders read in part "12/1/14 Self-release seatbelt to chair." The surveyor interviewed Resident #15 on 1/30/18 beginning at 3:01 p.m. Resident #15 was observed in bed with her wheelchair by her bed. The surveyor did not observe a seat belt in the wheelchair. The surveyor observed Resident #15 again on 1/31/18 during the breakfast meal. Resident #15 was in bed. The surveyor did not observe a self-releasing seat belt in the wheelchair. The surveyor observed Resident #15 on 2/1/18 at breakfast time (8:30 a.m.) in her room sitting in her wheelchair. The surveyor did not observe a self-releasing seat belt on the wheelchair. The surveyor asked the director of nursing about the self-releasing seatbelt for Resident #15. The DON and the surveyor checked Resident #15's wheelchair on 2/1/18 at 8:58 a.m. The DON stated stated she did not have a seatbelt and the care plan needed to be changed. The surveyor informed the administrative staff of the above concern in the end of the day meeting on 2/2/18 at 11:34 a.m. No further information was provided prior to the exit conference on 2/2/18.	F 657		
F 658	Services Provided Meet Professional Standards	F 658		

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F 658 SS=D	Continued From page 31 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to follow professional standards of nursing practice for administering medications. The findings included: The facility staff failed to following professional standards of nursing practice during a medication pass and pour observation, resulting in a medication error for Resident #83. Resident #83 was admitted to the facility on 12/15/17. Diagnoses included but not limited to hypertension, diabetes mellitus, hyperlipidemia, anxiety disorder, depression, and psychotic disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/22/17 coded the Resident as 13 of 15 in section C, cognitive patterns. This is an admission MDS. Surveyor observed Resident #83 receiving his medications during a medication pass and pour completed by LPN (licensed practical nurse) #2 on 01/31/18 at approximately 0800. One of the medications observed being administered was Calcium plus D. Surveyor did not observe the medication Vitamin D being administered.	F 658	F658 **Corrective Action(s):** Resident #83's attending physician has been notified that the facility staff did not administer Vitamin D per physician order and had administered the wrong Vitamin to resident #83. Resident #83's physician orders have been reviewed to ensure all medication orders are accurate. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident's medication orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding.	

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F 658	Continued From page 32 Resident #83's medications were reconciled with the clinical record on 01/31/18 at approximately 0815. The clinical record contained a signed POS (physician's order summary) for January 2018 which read in part "Vitamin D 2000 unit tablet, one tablet po (by mouth) QD (every day)". Surveyor could not locate an order for Calcium plus D. The Resident's eMAR (electronic medication administration record) was reviewed and contained an entry, which read in part "Vitamin D 2000 unit tablet, one tablet po QD". This entry was scheduled for 8am and had been initialed by LPN #2 as having been administered. Surveyor could not locate an entry for Calcium plus D. Surveyor spoke with LPN #2 on 01/31/18 at approximately 0830. Surveyor asked LPN #2 to show her the medication Vitamin D that she had administered to Resident #83, and LPN #2 removed the bottle labeled Calcium plus D from the medication cart. Surveyor pointed out to LPN #2 that this was not Vitamin D, and LPN #2 stated, "It has the D in it". Surveyor asked LPN #2 to confirm the physician's order. After confirming the physician's order, LPN #2 stated, "I gave the wrong thing". Surveyor spoke with the DON (director of nursing) on 01/31/18 at approximately 0945 regarding the medication error. Surveyor requested and was provided with a policy entitled "Administering Medications" which read in part "7. The individual administering the medication must check the label THREE (3) times to verify the right Resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication".	F 658	Systemic Change(s): The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include giving at ordered time and physician notification if a medication is held or refused. Monitoring: The DON is responsible for maintaining compliance. The DON and/or ADON will review medication orders weekly coinciding with the care plan calendar in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 658	Continued From page 33 The concern of not following standards of practice was discussed with the administrative staff during a meeting on 01/31/18 at approximately 1705. No further information was provided prior to exit.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident representative interview and clinical record review, the facility staff failed to ensure activities of daily living were maintained for good oral hygiene for one of 21 residents in the survey sample (Resident #64). The findings included: Resident #62 was admitted to the facility on 2/19/13 with the following diagnoses of, but not limited to diabetes, anxiety disorder, psychotic disorder and tube feeding. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/28/17, the resident was coded as having short term memory problem with having some difficulty in new situations. Resident #62 was also coded as being totally dependent on full staff members for dressing, personal hygiene and bathing. On 1/30/18 at approximately 2:30 pm, the	F 677	F 677 Corrective Action(s): Resident #64's oral hygiene status has been reassessed by the nursing department and her comprehensive care plan has been revised to reflect her current oral hygiene needs to maintain good grooming and oral hygiene. Identification of Deficient Practices/Corrective Action(s): All other residents may have potentially been affected. The DON, ADON, and or designee will reassess each resident's current oral hygiene status to include appropriate interventions to meet their resident specific needs. Any/all negative findings discovered during the assessment will be corrected at time of discovery. The residents comprehensive care plans will be revised to reflect their current oral hygiene needs and services for maintaining good grooming and hygiene.	

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F 677	Continued From page 34 surveyor interviewed the resident representative. The resident representative stated to the surveyor "They do a good job except for keeping her lips and mouth moist. They always look so dry." The surveyor observed the resident's lips dry and cracked with her mucous membranes in the resident's mouth observed to be dry also at this time. The surveyor conducted a brief clinical record review and it was noted that the resident was "NPO" (nothing by mouth) and was receiving tube feeding continuous per pump. The surveyor observed Resident #64 on 1/31/18 at approximately 8:30 am, and the surveyor observed two CNAs coming out of the resident's room as the surveyor was entering the resident's room. The resident was lying in bed with her lips dry and cracked and mouth observed to be dry. On 1/31/18 at 1:30 pm, the surveyor went into the resident's room and observed the lips of Resident #64 continued to be dry as well as her mouth. The surveyor notified the administrative team on 1/31/18 at 5:16 pm of the above documented observations and of the resident representative interview conducted on 1/30/18 at approximately 2:30 pm. The surveyor requested to see CNA documentation of mouth care and the facility's policy on mouth care. On 2/1/18 at 9:45am, the DON (director of nursing) stated, "We don't have a policy for mouth care but it should be considered as ADL's." The surveyor requested copies of documentation of ADL's being performed on this resident. At 11 am, the surveyor received copies of the ADL's in	F 677	Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or designee will provide ongoing inservice training to the CNA's to address the importance of providing good grooming and hygiene to include oral care to all residents. The DON and ADON's will conduct daily resident care rounds at differing times throughout the day to observe the grooming and hygiene status of all residents. Residents found with improper ADL or hygiene care will be corrected at time of discovery and the CNA staff assigned to the resident will receive additional training and/or disciplinary action as appropriate. Monitoring: The DON is responsible for maintaining compliance. The DON and/or ADON will perform ADL/grooming audits weekly coinciding with the care plan calendar to insure that their current ADL/grooming and oral hygiene needs are addressed. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detail findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 677	Continued From page 35 the electronic record. The surveyor reviewed this documentation and could not find documentation of mouth care being performed on Resident #64. No further information was provided information prior to the exit conference on 2/2/18.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to obtain a physician order for restorative nursing and documented care that was not given for 1 of 21 residents (Resident #15). The findings included:	F 688	F688 Corrective Action(s): Resident #15 has been screened by the therapy department and had their Restorative Nursing program reviewed and clarified with the attending physician. Resident #15 has had their comprehensive care plan revised to reflect their current Restorative Nursing programs and appropriate interventions and approaches to meet the resident's AROM and STP transfer needs. Identification of Deficient Practice(s) and Corrective Action(s): All other residents with Restorative nursing orders may have been potentially affected. The DON and/or ADON will conduct a 100% review of all resident's restorative nursing orders to identify residents at risk. Residents identified will be assessed for the development of individualized restorative nursing programs, active rehab interventions, and/or modifications to the current Restorative Nursing Programs prevent a decline in function.	

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F 688	Continued From page 36 The facility staff failed to ensure a current physician order for restorative nursing care was obtained and the restorative C.N.A. documented restorative care that was not given for Resident #15. The clinical record of Resident #15 was reviewed 1/30/18 through 2/2/18. Resident #15 was admitted to the facility 11/12/07 and readmitted 6/26/12 with diagnoses that included but not limited to cerebral palsy, urinary tract infections, abnormal involuntary movements, and lack of coordination. Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/10/17 assessed the resident with a BIMS of 15 out of 15. Section G Functional Status assessed that the resident required extensive assistance of two + persons for bed mobility and dressing, total assistance of two + persons for transfers and toileting, extensive assistance of one person for locomotion on and off the unit and personal hygiene, and total dependence on 1 person for eating. Section O. Special Treatments, Procedures, and Programs coded that the resident received 5 days of active range of motion in the 7-day look back period (11/4/17 -11/10/17). Resident #15's person centered care plan dated 11/13/17 identified ADL (activities of daily living)/rehab potential/requires assist with ADLs, dx (diagnosis) cerebral palsy, unspecified abnormal involuntary movements, and lack of coordination as a problem/need. Approaches: Restorative nursing as ordered. The December 2017 physician's orders were	F 688	Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The therapy department will inservice the nursing staff on the importance of consistently implementing restorative nursing programs to include timeliness of initiating the program. The interdisciplinary team will review each care plan for appropriateness and accurate interventions. Monitoring: The DON is responsible for maintaining compliance. The DON or ADON will perform weekly audits of all restorative nursing orders and restorative documentation coinciding with the Care plan calendar. All negative findings will be corrected at time of discovery and appropriate disciplinary action taken for staff members involved. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 688	Continued From page 37	F 688		

reviewed. The physician order for restorative nursing read "8/01/17 Restorative nursing as ordered."

There were no specific orders for the type of restorative nursing Resident #15 was to receive.

Resident #15 had physician orders dated 12/12/17 for physical therapy and then discharge orders dated 1/2/18. The surveyor reviewed the physical therapist "restorative program" for nursing dated 1/2/18. Marked were Active range of motion (AROM) for both lower extremities, sit to stand min (minimal) assistance needed and Transfers (SPT-Stand Pivot Transfer) minimal assistance needed. 6-7/wk (6-7 times per week) to maintain current level of function.

The surveyor interviewed the assistant director of nursing on 2/1/18 at 8:45 a.m. The ADON stated she would expect the restorative recommendations to be reviewed with the physician and orders written.

The surveyor interviewed Resident #15 on 2/1/18. The surveyor had observed Resident #15 in bed on both 1/30/18 and 1/31/18. The surveyor asked the resident if she had gotten up on Wednesday 1/31/18. Resident #15 stated she had not.

The surveyor reviewed the January 2018 restorative care flow record. The restorative care flow sheet indicated there was documentation on 1/31/18 that the resident had AROM and transfers. The surveyor interviewed the restorative C.N.A. #6 on 2/1/18 at 8:05 a.m. The restorative C.N.A. #6 stated she had documented in error on 1/31/18 and stated Resident #15 did

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F 688	Continued From page 38 not have restorative that day. The surveyor informed the administrative staff of the above concern in the end of the day meeting on 2/2/18 at 11:34 a.m. No further information was provided prior to the exit conference on 2/2/18.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690	F690 Corrective Action(s): C.N.A. #1 & #3 who provided incontinent care to Resident #14 have received one-on-one inservice training on providing proper incontinence care to male and female residents with return demonstration to confirm competency. A facility Incident & Accident form has been completed for this incident. Resident #90 has been reassessed by nursing and therapy for Bowel and Bladder retraining and a new Bowel and Bladder assessment has been completed. Resident #90 has been placed on a Bowel and Bladder retraining trial. A facility Incident & Accident form has been completed for this incident.	

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F 690	Continued From page 39 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure 2 of 21 residents (Resident #14 and Resident #90) received appropriate treatment and services to prevent urinary tract infections and failed to identify, assess and provide appropriate treatment and services to achieve or maintain as much normal bladder function as possible. The findings included: 1. The facility staff failed to provide incontinence care correctly for Resident #14. The clinical record of Resident #14 was reviewed 1/30/18 through 2/2/18. Resident #14 was admitted to the facility 5/17/17 with diagnoses that included but not limited to Huntington's Chorea, history of falling, dementia with behavioral disturbances, hypothyroidism, and neurocognitive disorder. Resident #14's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/9/17 assessed the resident with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making. Resident ##14 was totally dependent on two + persons for bed mobility,	F 690	Identification of Deficient Practice(s) and Corrective Action(s): All other residents incontinent of bowel and bladder may have been potentially affected. The facility conducted a 100% review of all clinical records to identify residents who are incontinent of Bowel and Bladder and require assistance with Incontinence Care. A new Bowel and Bladder assessment was completed for all residents to determine if any were in need of a bowel and Bladder retraining trial. Residents identified as requiring assistance with incontinent care and/or in need a bowel and bladder retraining trial will then have their comprehensive care plans reviewed and revised to include appropriate interventions and approaches to include proper incontinent care and Bowel& Bladder retraining trial. Systemic Change(s): The facility policy and procedure has been reviewed. No revisions are warranted at this time. All CNA staff will be inserviced on the policy and procedure for providing incontinence care for male and female residents to prevent/reduce urinary tract infections/complications and promote dignity. All Licensed nurses will be inserviced on proper assessment and completion of the Bowel and Bladder assessment on admission and quarterly to monitor bowel and bladder changes and determine if a bowel & Bladder training program is needed.	

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F 690	Continued From page 40 transfers, walking in corridor, dressing, toilet use, and bathing. Section H Bowel and Bladder assessed the resident to always be incontinent of both bowel and bladder. On 2/2/18 at 8:15 a.m., the surveyor observed Resident #14 in bed. The resident was attempting to get out of bed. The surveyor summoned certified nursing assistant #1. C.N.A. #1 and C.N.A. #3 both donned gloves and tried to provide incontinent care. C.N.A. #1 and C.N.A. #3 assisted Resident #14 to her back and then positioned Resident #14 on the right side. C.N.A. #1 then cleaned the resident's back side and then positioned the resident on the back and cleaned the resident's front. C.N.A. #1 then positioned Resident #14 on the side of the bed. C.N.A. #1 then put pants and a top on the resident. The surveyor informed the assistant director of nursing of the above observation on 2/2/18 at 8:45 a.m. She stated she would take care of the issue. The surveyor informed the administrative staff of the above observation during the end of the day meeting on 2/2/18 at 11:34 a.m. and requested the facility policy on perineal care. The surveyor reviewed the policy titled "Perineal Care" on 2/2/18. The policy read in part "Steps in the Procedure 9. For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. B. Wash perineal area, wiping from front to back (1). Separate labia and wash area downward from front to back. (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse	F 690	Monitoring: The DON will be responsible for monitoring compliance. The DON, ADON, and/or designee will perform 4 random weekly Incontinence care audits to maintain compliance. All Residents on Bowel and Bladder retraining programs will be reviewed weekly in the Risk Management meeting to monitor for program compliance. Any/all negative findings will be corrected at time of discovery and one-on-one inservice training will be completed with staff members. Detailed findings of the audits will be reported to the Quality Assurance Committee for review, analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 690	Continued From page 41 the same washcloth or water to clean the urethra or labia. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (4) Gently dry perineum. E. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not use the same washcloth or water to clean the labia. Rinse thoroughly and dry thoroughly. No further information was provided prior to the exit conference on 2/2/18. 2. The facility staff failed to implement a bladder training program for Resident #90. The clinical record of Resident #90 was reviewed 1/30/18 through 2/2/18. Resident #90 was admitted to the facility 7/29/17 with diagnoses that included but not limited to hemiplegia following cerebral infarct affecting left non-dominant side, muscle weakness, dysphagia, difficulty in walking, cognitive communication deficit, dysarthria, and lack of coordination. Resident #90's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/18/18 assessed the resident with a BIMS of 8/15. Section D Mood assessed the resident with a total severity score of 01. Section G Functional Status assessed the resident to require extensive assistance of 2 + persons for bed mobility, transfers, walk in room, walk in corridor, and toileting. Resident #90 required limited assistance of one person for locomotion on unit and locomotion off unit as well as eating. Resident #90 required extensive assistance of one person for dressing. Section H Bowel and Bladder Resident #90 was coded to be	F 690		

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F 690	Continued From page 42 incontinent of urine and bowel occasionally (1/1). Resident #90's person centered care plan was reviewed. One problem with onset date of 1/19/18 read "Occasional episodes of urinary incontinence related to loss of bladder muscle tone. Approaches: Encourage resident to call for assistance with toileting. Change clothing after each incontinent episode." The surveyor reviewed the Bowel and Bladder Assessment dated 7/29/17. The recommendation read "Able to participate in B/B Training Plan." The Bowel and Bladder Assessment completed 10/20/17 had the following recommendation: Able to participate in B/B Training Plan. The Bowel and Bladder Assessment completed 1/18/18 had the following recommendation: Able to participate in B/B Training Plan. Resident #90's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/4/17 assessed the resident with occasionally incontinent (less than 7 episodes of incontinence) of urine. H0200 Urinary Training Program Has a trial of a toileting program been attempted on admission/reentry or since urinary incontinence was noted in the facility? The answer was marked no. The same response was found on the quarterly MDS with ARD of 10/26/17 and the quarterly MDS with ARD of 1/18/18. The surveyor interviewed the director of nursing on 2/2/18 at 9:45 a.m. The surveyor showed the DON the B/B assessments and she stated she depended on the staff who do the assessments to inform her of the resident's need. The	F 690		

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	495320	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

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F 690	Continued From page 43 surveyor requested the facility policy on bowel and bladder training. The surveyor reviewed the facility policy titled "Bowel and Bladder Retraining (TAKE program) on 2/2/18. The policy read "Procedure Bladder Retraining: 1. Assess the resident if he/she is a viable candidate for bladder training." Resident #90 was assessed to be able to participate in a bladder training program but the facility staff failed to implement the program. No further information was provided prior to the exit conference on 2/2/18.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §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 resident interview, staff interview, facility document review and clinical record review, the facility staff failed to offer non-pharmacological interventions for pain management for 1 of 21 residents (Resident #90). The findings included: The facility staff failed to offer non-pharmacological pain interventions for pain prior to the use of pain medication for Resident	F 697	**F697** **Corrective Action(s):** Resident #90's attending physicians was notified that the facility failed to attempt non-pharmacological interventions prior to the administration of PRN Tylenol and PRN Norco 5-325mg for pain. A facility Incident and Accident form was completed for this incident.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 697	Continued From page 44 #90. The clinical record of Resident #90 was reviewed 1/30/18 through 2/2/18. Resident #90 was admitted to the facility 7/29/17 with diagnoses that included but not limited to hemiplegia following cerebral infarct affecting left non-dominant side, muscle weakness, dysphagia, difficulty in walking, cognitive communication deficit, dysarthria, and lack of coordination. Resident #90's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/18/18 assessed the resident with a BIMS of 8/15. Section D Mood assessed the resident with a total severity score of 01. Section G Functional Status assessed the resident to require extensive assistance of 2 + persons for bed mobility, transfers, walk in room, walk in corridor, and toileting. Resident #90 required limited assistance of one person for locomotion on unit and locomotion off unit as well as eating. Resident #90 required extensive assistance of one person for dressing. Section J Health Conditions was reviewed for pain management. Resident #90 was assessed a 2 out of 10 for pain and no non-intervention for pain management had been used. Resident #90's person centered care plan dated 1/19/18 identified the problem that read "occasional pain r/t (related to) neuropathy" and approaches included attempt non-pharmacological pain relief measures such as repositioning, back rubs. Document effectiveness. Administer pain medication as requested. Document effectiveness. Pain Initial Rating Tool completed 7/29/17 and	F 697	**Identification of Deficient Practices/Corrective Action(s):** All other residents receiving pain medications may have been potentially affected. The DON, ADON, and/or Unit Managers will conduct a 100% audit of all resident's receiving PRN pain medications to identify resident at risk for not having non-pharmacological interventions attempted prior to administration of PRN pain medication. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication orders & treatment orders. This includes assessing the location of a resident's pain and attempting non-pharmacological interventions prior t0 (PRN) pain medication administration. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as performing physician ordered monitoring and follow up per physician orders.	

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F 697	Continued From page 45 10/20/17 did not identify any complaint or evidence of pain. The Pain Initial Rating Tool completed 1/18/18 identified the resident complaints of pain or had evidence of pain that was intermittent, rated as a 2 for intensity on a scale of 0-10, worse pain was 2 and best pain was 2, described as an ache, pain relieved by medication. The signed January 2018 physician orders were reviewed. Physician orders for pain medications included: Tylenol 325 mg (milligrams) tablet Give 2 tablets=650 mg po (by mouth) q (every) 4 hours prn (as needed) for breakthrough pain and Norco 5-325 tablet 1 tablet by mouth every 6 hours as needed for pain. The surveyor reviewed the January 2018 electronic medication administration record (eMAR). Resident #90 received Tylenol on 1/3/18 at 10:41 a.m. for a pain level of 4. Resident #90 received Norco 5-325 on the following days/times and with the pain level listed: 1/1/18 at 9:23 a.m. with a pain level of 4 1/4/18 at 8:29 a.m. with a pain level of 9 1/5/18 at 9:19 a.m. with a pain level of 4 1/7/18 at 7:37 a.m. with a pain level of 4 1/8/18 at 8:10 a.m. with a pain level of 4 1/9/18 at 7:44 a.m. with a pain level of 4 1/13/18 at 7:48 a.m. with a pain level of 6 1/19/18 at 7:58 a.m. with a pain level of 4 1/23/18 at 7:58 a.m. with a pain level of 4 1/24/18 at 7:54 a.m. with a pain level of 4 1/25/18 at 7:49 a.m. with a pain level of 4 1/27/18 at 7:42 a.m. with a pain level of 4 1/28/18 at 7:45 a.m. with a pain level of 4 1/31/18 at 7:49 a.m. with a pain level of 9	F 697	Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 697	Continued From page 46 The surveyor reviewed the notes for January 2018. There was no evidence non-pharmacological interventions were used prior to the administration of pain medications in January 2018. The surveyor discussed the use of non-pharmacological interventions with the director of nursing on 2/02/18 at 9:55 AM and requested the policy on pain management. The DON stated the rehab department will offer heat wraps, positioning measures, etc. The DON was informed that there were no non-pharm interventions prior to pain medications for Resident #90. The surveyor reviewed the facility policy titled "Pain-Clinical Protocol" on 2/2/18. The policy read in part under "Treatment Management 2. The physician will order appropriate non-pharmacologic and medication interventions to address the resident's pain. 3. The staff will evaluate and report how much and how often the individual asks for PRN (whenever needed) pain medication. B. If there are more than occasional analgesic requests, and depending on the success of non-pharmacological interventions, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, or switching to another analgesic." The surveyor informed the administrative staff of the above concern during the end of the day meeting on 2/2/18 at 11:34 a.m. No further information was provided to the surveyor prior to the exit conference on 2/2/18.	F 697		

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F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide the necessary behavioral health care and services to attain or maintain the highest practical well-being for 1 of 21 residents in the survey sample (Resident #91). The findings included: 1. The facility failed to provide behavioral health care and services to Resident #91. Resident #91 was admitted to the facility on 2/4/17 with the following diagnoses of, but not limited to anemia, heart failure, depression, muscle weakness, adult failure to thrive and cirrhosis of the liver. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/17/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #91 was also coded as requiring limited assistance of 1 staff person for dressing and personal hygiene and physical assistance of	F 740	**F740** **Corrective Action(s):** Resident #91 has been assessed by their attending physician and a referral to Brighter Day Behavioral Health Services has been made to assess their current psychological and behavioral needs to establish an appropriate plan of treatment to meet his behavioral and psychosocial needs. The comprehensive care plan has been revised to reflect the current approaches and interventions in place. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who display psychosocial and/or behavioral needs/difficulties may have been potentially affected. The DON, ADON and/or Social Service director will conduct 100% review of all resident's records for the last 30 days to check residents displaying any behavioral health needs or difficulties. Residents identified at risk will have their current needs and behaviors assessed by their attending physician and/or Behavioral Health services to establish appropriate treatment interventions.	

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F 740	Continued From page 48 1 staff member for bathing. The surveyor conducted a clinical record review of both of the electronic and paper clinical record on 1/31/18 and 2/1/18. During this review, the surveyor reviewed the person centered comprehensive care plan with a revision date of 10/26/17. Under the problem of "Mood" it stated," ... _____ (name of the resident) is noted to have sad facial expressions which usually can be altered with interaction He had DX (diagnosis) Depression, no behaviors noted at this time ..." The interventions that were noted were as follows: o ..."SW (social worker) to visit as needed o Meds/Labs (medications/labs) as ordered Inform MD (medical director) of any changes, AIMS scale as needed, Pharmacy reviews for possible drug reductions, ... o Explain procedures prior to giving care, approach in a calm manner, reorient with care and prn (as needed) ...provide a calm environment." The surveyor also reviewed the person centered comprehensive care plan with a revision date of 1/18/18. The same problem and interventions remained in place from the last revision date of 10/26/17. The surveyor reviewed the nursing documentation from October 2017 through January 2018. The nursing revealed that the resident was noted to like to be in his room with the privacy blinds pulled completely around the bed and the room dark with no lights on. The surveyor observed this on 1/30/18 and 1/31/18. The surveyor on notified the administrative team of the above documented findings on 1/31/18 at 5:16 pm in the conference room. The director of	F 740	Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON, Unit Managers and/or RCC will review the 24-hour report daily to insure that each resident's current medical needs including their behavioral health and psychosocial needs are being addressed in a timely manner to ensure that appropriate medical and psychological interventions are being obtained as ordered. All negative findings will be reported to administrator for immediate corrective action. Monitoring: The Director of Nursing is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform chart audits weekly coinciding with the Care Plan calendar to monitor for compliance. Detailed findings of the audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 740	Continued From page 49 nursing stated to the surveyor that she would look into this and get back with the surveyor regarding the findings. On 2/2/18 at approximately 10 am, the director of nursing stated to the surveyor, "We just started the paperwork necessary to make the referral due to the resident's depression. We didn't start this process until after you brought it to our attention on 1/31/18." No further information was provided to the surveyor prior to the exit conference on 2/2/18.	F 740		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758	F 758 Corrective Action(s): Resident 15's attending physician and consulting pharmacist was notified that resident 15 did not receive appropriate psychotropic drug monitoring for the physician ordered Celexa and Remeron. Resident 15's physician and consulting pharmacist has reviewed resident 15's medication regime and made adjustments to the medication regime. A facility Incident & Accident form was completed for this incident. Resident 90's attending physician and consulting pharmacist was notified that resident 90 did not receive appropriate psychotropic drug monitoring for the physician ordered Lexapro. Resident 90's physician and consulting pharmacist has reviewed resident 90's medication regime and made adjustments to the medication regime. A facility Incident & Accident form was completed for this incident.	

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F 758	Continued From page 50 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide monitoring for psychotropic medications for 4 of 21 residents (Resident #15, Resident #90, Resident #86, and Resident #84). The findings included: 1. The facility staff failed to assess and monitor the use of Celexa (an antidepressant used for depression) and Mirtazapine (an antidepressant) and failed to do gradual dose reductions for both the Celexa and the Mirtazapine (Remeron) for	F 758	Resident 86's attending physician and consultant pharmacist was notified that resident 86 did not receive appropriate psychotropic drug monitoring for the physician ordered Lithium Carbonate and Ativan, and that the PRN Ativan order did not have a stop date for it. Resident 86's physician and consulting pharmacist has reviewed resident 86's medication regime and made adjustments to the medication regime. A facility Incident & Accident form was completed for this incident. Resident 84's attending physician and consulting pharmacist was notified that resident 84 did not receive appropriate psychotropic drug monitoring for the physician ordered Lexapro. Resident 84's physician and consulting pharmacist has reviewed resident 84's medication regime and made adjustments to the medication regime. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving psychotropic medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic medication to identify residents without appropriate psychotropic medication monitoring. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding.	

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F 758	Continued From page 51 Resident #15. Celexa (citalopram) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Accessed at https://www.drugs.com. Mirtazapine is an antidepressant. Mirtazapine is used to treat major depressive disorder. Accessed at https://www.drugs.com. The clinical record of Resident #15 was reviewed 1/30/18 through 2/2/18. Resident #15 was admitted to the facility 11/12/07 and readmitted 6/26/12 with diagnoses that included but not limited to cerebral palsy, urinary tract infections, abnormal involuntary movements, and lack of coordination. Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/10/17 assessed the resident with a BIMS of 15 out of 15. Section D Mood scored the resident with a total severity score of 00. Section G Functional Status assessed that the resident required extensive assistance of two + persons for bed mobility and dressing, total assistance of two + persons for transfers and toileting, extensive assistance of one person for locomotion on and off the unit and personal hygiene, and total dependence on 1 person for eating. Resident #15's person centered care plan identified a problem/need for psychological well-being/mood behavior dated 11/13/17. Approaches included meds (medications) as ordered.	F 758	Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of psychotropic medication to include antidepressants medications. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will complete weekly physician orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 758	Continued From page 52 The surveyor reviewed Resident #15's December 2017 signed physician orders. Resident #15 had orders for Celexa 10 mg (milligram) tablet po (by mouth) qhs (at bedtime) for depression (start date 5/2/16) and Mirtazapine 15 mg po qhs for sleep (start date 8/2/13). The surveyor reviewed the January 2018 electronic medication administration record (eMAR). Both the Celexa and Mirtazapine were listed on the January eMAR and both had been administered every night at 8:00 p.m. indicated by a check mark in the box along with the nurse's initials that administered the medication. The surveyor reviewed the monthly medication regimen review forms. Neither Celexa nor the Mirtazapine had had a GDR since the medications were started-2013 for the Mirtazapine and 2016 for the Celexa. The surveyor also was unable to locate where the staff monitored Resident #15 for the use of both Celexa and Mirtazapine. The surveyor was unable to locate monitoring for effects and side effects of both of the drugs. The surveyor discussed the issue with the director of nursing on 2/1/18 at 9:29 a.m. She stated they might be on the notes. The surveyor reviewed the January 2018 progress notes and the January eMAR notes and found no evidence of staff monitoring Resident #15 for effects and side effects of the Celexa and Mirtazapine. On 2/01/18 09:59 AM, the DON stated the facility does not do monitoring on antidepressants. The surveyor requested the facility policy on behavior monitoring for psychotropic medications.	F 758		

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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 758	Continued From page 53 The surveyor reviewed the facility policy titled "Depression-Clinical Protocol" on 2/2/18. The policy read in part "Monitoring and Follow-Up 1. The staff and physician will monitor the resident's response to treatment for depression and will document approaches, timetables, and goals of treatment in the interdisciplinary care plan and progress notes. a. Possible monitoring criteria might include resolution of signs and symptoms of depression, improvement in scores on depression screening tests, improved attendance at usual activities, and improved sleep patterns. 2. The staff and physician will monitor the resident carefully for side effects specific to each class of medication as well as interactions between antidepressants and other classes of medications. 3. If antidepressant medications have been used, the physician will identify situations for tapering or stopping the medications, for example, after 6 months to 1 year of treatment for a first episode of major depression." The surveyor informed the administrative staff of the above concern in the end of the day meeting on 2/2/18 at 11:34 a.m. No further information was provided prior to the exit conference on 2/2/18. 2. The facility staff failed to assess and monitor the use of escitalopram oxalate (Lexapro) for Resident #90. The clinical record of Resident #90 was reviewed 1/30/18 through 2/2/18. Resident #90 was admitted to the facility 7/29/17 with diagnoses that included but not limited to hemiplegia following cerebral infarct affecting left non-dominant side,	F 758		

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	495320	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

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F 758	Continued From page 54 muscle weakness, dysphagia, difficulty in walking, cognitive communication deficit, dysarthria, and lack of coordination. Resident #90's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/18/18 assessed the resident with a BIMS of 8/15. Section D Mood assessed the resident with a total severity score of 01. Section G Functional Status assessed the resident to require extensive assistance of 2 + persons for bed mobility, transfers, walk in room, walk in corridor, and toileting. Resident #90 required limited assistance of one person for locomotion on unit and locomotion off unit as well as eating. Resident #90 required extensive assistance of one person for dressing. Section H Bowel and Bladder Resident #90 was coded to be incontinent of urine and bowel occasionally (1/1). Resident #90's person centered care plan updated 1/19/18 identified potential for falls due to residents impaire (sic) independent mobility. Approaches: Observe resident for adverse side effects/toxicity of medications in current drug regime. Potential for injury was also listed as a problem. Approaches: Discuss side effects of drugs (Xanax) with resident and family member/responsible party, administer medications as ordered by physician, and monitor behavior and document pm (whenever necessary). Report any negative behavior observations to physician. The January 2018 signed physician's orders were reviewed. Resident #90 had physician orders that read "Escitalopram 10 mg (milligrams) tablet administer one tablet daily (no reason given) start date 8/22/17."	F 758		

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F 758	Continued From page 55 Escitalopram is used to treat depression and anxiety. Accessed at https://drugs.com. The surveyor reviewed the January 2018 electronic medication administration records (eMARS). Escitalopram 10 mg was entered on the eMAR and administered each morning at 8:00 a.m. The eMAR did not reveal evidence that staff were assessing and monitoring the use of the medication. The surveyor discussed the concern with the director of nursing on 2/01/18 at 3:12 PM that there was no monitoring for the effects or side effects of Escitalopram (Lexapro). She stated staff are not monitoring the use of antidepressants. The surveyor requested the facility policy on monitoring psychotropic medications. The surveyor reviewed the facility policy titled "Depression-Clinical Protocol" on 2/2/18. The policy read in part "Monitoring and Follow-Up 1. The staff and physician will monitor the resident's response to treatment for depression and will document approaches, timetables, and goals of treatment in the interdisciplinary care plan and progress notes. a. Possible monitoring criteria might include resolution of signs and symptoms of depression, improvement in scores on depression screening tests, improved attendance at usual activities, and improved sleep patterns. 2. The staff and physician will monitor the resident carefully for side effects specific to each class of medication as well as interactions between antidepressants and other classes of medications. 3. If antidepressant medications have been used, the physician will identify	F 758		

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F 758	Continued From page 56	F 758		

situations for tapering or stopping the medications, for example, after 6 months to 1 year of treatment for a first episode of major depression."

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 2/2/18 at 11:34 a.m.

No further information was provided prior to the exit conference on 2/2/18.

3. For Resident #86 the facility staff failed to provide behavior monitoring for the psychotropic medications Lithium carbonate and Ativan, and failed to discontinue a prn (as needed) order for Ativan after 14 days.

According to the Physician's Desk Reference, Lithium carbonate is a mood stabilizer used for the treatment of bipolar disorder.

According to the Physician's Desk Reference, Ativan is a sedative/hypnotic medication used for the treatment of anxiety.

Resident #86 was admitted to the facility on 07/19/17. Diagnoses included but not limited to hypertension, hyperlipidemia, cerebrovascular accident, dementia, hemiplegia, Parkinson's disease, seizure disorder, anxiety, depression, psychotic disorder and schizophrenia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/15/18 coded the Resident as 11 out of 15 in section C, cognitive status. This is a quarterly MDS.

Resident #86's clinical record was reviewed on

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F 758	Continued From page 57 02/01/18. It contained a physician's order summary for the month of January which read in part "Lithium carbonate 150mg cap-take on cap BID (twice daily) Q (every) daily", "Lithium carbonate 300mg cap-take one cap po (by mouth) QHS (at bedtime) Qdaily (every day)", Ativan 0.5mg tablet 1 po q 8 hours" and "Ativan 20mg/10ml vial. Inject 1mg/0.5ml intramuscularly Q 12h (every 12 hours) prn". Resident #86's eMAR (electronic medication administration record) was reviewed and contained entries which read in part "Lithium carbonate 150mg cap-take on cap BID (twice daily) Q (every) daily", "Lithium carbonate 300mg cap-take one cap po (by mouth) QHS (at bedtime) Qdaily (every day)", Ativan 0.5mg tablet 1 po q 8 hours" and indicated the Resident was receiving medications as ordered by the physician. The surveyor could find no evidence of behavior monitoring for these medications The eMAR also contained an entry, which read in part "Ativan 20mg/10ml vial. Inject 1mg/0.5ml intramuscularly Q 12h (every 12 hours) prn". There was not stop date listed for this order. The surveyor spoke with the DON (director of nursing) on 02/01/18 at approximately 1600 regarding the behavior monitoring and the prn Ativan. She could offer no explanation as to why the behavior monitoring was not being done. She also stated that the facility had reviewed the prn orders, but must have missed this one. The concern of not monitoring behaviors and not having a stop date for a prn psychotropic medication was discussed with the administrative team during a meeting on 02/02/18 at	F 758		

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F 758	Continued From page 58 approximately 1130. No further information was provided prior to exit. 4. For Resident #84 the facility staff failed to provide behavior monitoring for the psychotropic medication escitalopram. According to the Physician's Desk Reference, escitalopram is an antidepressant used for the treatment of depression. Resident #84 was admitted to the facility on 09/30/14 and readmitted on 12/30/14. Diagnoses included but not limited to anemia, heart failure, hypertension, hyperlipidemia, dementia, anxiety depression, psychotic disorder, asthma, and benign prostatic hyperplasia. The most recent MDS with an ARD of 01/11/18 coded the Resident as 12 out of 15 in section C, cognitive status. This is a quarterly MDS. Resident #84's clinical record was reviewed on 02/01/18 and contained a physician's order summary for the month of January 2018, which read in part "escitalopram 5mg tablet-take 1 tablet by mouth daily". The Resident's eMAR was reviewed and contained an entry, which read in part "escitalopram 5mg tablet-take 1 tablet by mouth daily" and indicated that the Resident was receiving medication as ordered by the physician. The surveyor could not locate any evidence that behavior monitoring was being done. The concern of the behavior monitoring not being done was discussed with the administrative team during a meeting on 02/02/18 at approximately 1130.	F 758		

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F 758	Continued From page 59 ND further information was provided prior to exit.	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview facility staff failed to address the Residents stated preference of a resident, capable of making needs known, for a liberalized diet, for 1 of 21 Residents, #43. Resident #43 was admitted to the facility on 8/20/13 and readmitted to the facility on 1/25/18. The resident's diagnoses include heart failure, chronic obstructive pulmonary disease, diabetes mellitus with diabetic polyneuropathy, hypertension, anxiety, depression, dependence on renal dialysis, dysphagia, and difficulty walking. On the 14 day MDS (minimum data assessment) with assessment reference date 12/13/17, the resident was assessed with severely impaired vision (no vision or sees only light, colors, or shapes). The resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, and was assessed as without behaviors affecting self or others. The resident was assessed as	F 804	**F 804** **Corrective Action(s):** Resident #43's dietary orders have been reviewed by the physician and the resident's dietary preferences were reviewed. Changes to resident 43's diet orders have been added to her comprehensive care plan to reflect approaches and interventions to meet her dietary specific needs. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. The Dietary Manager will conduct a 100% review of all resident diet orders and food preferences with all residents in the facility. Any diet changes or diet texture changes requested by the residents will be reviewed with the attending physician for possible modification to the diet orders. Any changes with resident likes, dislikes or preferences will be corrected at time of discovery and their comprehensive care plans revised to reflect the resident specific needs.	

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F 804	Continued From page 60 having no signs or symptoms of a swallowing disorder. On 1/31/18, the surveyor observed and interviewed the resident from approximately 8:20 AM until 9 AM. When the surveyor arrived, the resident's breakfast tray was on an overbed table, along with a small cooler and a clean brief, near the foot of the bed. The (blind) resident was unaware that the food was there and was unable to reach the tray. 01/31/18 08:49 AM The diet was pureed diet with thickened liquids. The resident stated she would like to liberalize the diet. She stated she had a regular texture diet in the hospital and would like the same here. The breakfast tray holds applesauce and gravy. There is a bowl of cream of wheat or grits (later learned it was oatmeal). The meal ticket does not say what is on the tray. The resident said she did not like either. A CNA (CNA#1) arrived at 8:49 AM to feed the resident. The resident asked twice for toast. The CNA #1 said she wasn't allowed toast the diet order was for a pureed diet. 01/31/18 09:09 AM CNA#1 finished feeding the gravy from the tray and left. The resident reported she was still hungry. LPN#1 answered the call bell and viewed the tray with less than 25% of food eaten. She called the kitchen and the dietary manager came and reviewed the tray and went to talk to the resident about preferences. She said she would bring the resident something more to eat. The dietary manager brought a chopped biscuit topped with gravy to the resident, who ate 100% of the additional food. The surveyor asked the director of nursing about the resident's request to advance the texture of	F 804	Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The dietary manager and dietary staff will be inserviced by regional nurse consultant on the policy and procedure regarding resident preferences and residents right to choose regarding diet, food preferences and likes and dislikes. Monitoring: The CDM is responsible for maintaining compliance. The CDM will review resident diet orders, supplement orders, preferences, likes and dislikes weekly with residents coinciding with the Care plan calendar to monitor for compliance. All negative findings will be corrected at time of discovery. Disciplinary action will be taken for each negative finding noted. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. Completion Date: March 19, 2018	

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F 804	Continued From page 61 her food. The director of the therapy department explained that the resident's swallow study indicated the resident had a dysphagia evaluation on 11//27/17 which indicated the resident required maximum cueing and pharyngeal strengthening exercises. The resident was discharged from speech therapy on 12/18/17 after refusing to participate in further pharyngeal strengthening exercises. The surveyor asked if the care plan had been updated to include the resident's food texture presence and need for cueing with swallowing. The therapy director did not know what the comprehensive care plan said about swallowing. During a summary meeting on 1/31/18, the surveyor reported the concern that the resident's food and liquid, and call bell were not placed where she could reach them and the resident was not told that the tray was available. 01/31/18 11:00 AM The resident stated she wanted regular texture food. Staff told her her order was for pureed and left. The concern was reported to the administrator, director of nursing, and a corporate representative during a summary meeting on 1/31/18.	F 804		
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	F 812	**F 812** **Corrective Action(s):** All undated, unlabeled, out of date food items identified in the Dry-storage area, walk-in freezer, reach in freezer and the refrigerators identified during the initial kitchen tour that were not properly labeled or out of date were immediately removed and disposed of. A facility Incident and Accident form was completed for this incident.	

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F 812	Continued From page 62 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, staff interview and facility document review, the facility staff failed to label and date opened food items in the kitchen. The findings included: The facility staff failed to ensure food items in the kitchen that were opened included a date when opened and a label of the package contents. The surveyor toured the kitchen on 1/30/18 at 1:28 p.m. with the food services director (FSD). The surveyor observed in the walk-in freezer a pan of brownies dated 12/27/17. The FSD stated we are only to keep food for 30 days and then get rid of it. A bag of French toast was opened but without a date. A bag of personal pan pizzas was opened but no date. A second pan of brownies was dated 12/9/17. A bag of rolls did not have a date when opened. The FSD stated they were taken out of their bag yesterday 1/29/18. 4 bags of shredded zucchini did not have a date or label on them. A bag of garlic bread was not dated when opened. The FSD stated she expected the dietary staff to label and	F 812	Identification of Deficient Practices & Corrective Action(s): All other food items in may have been potentially affected. The Food Service Manager, and/or Registered Dietician will inspect the kitchen dry storage areas, the walk-in freezer, reach in freezers and refrigerators to identify any negative findings. All negative findings will be corrected at time of discovery and appropriate disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding identified. Systemic Change(s): Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician and/or Dietary manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy for proper food storage to include proper labeling and dating. The inservice will also include all aspects of infection & sanitation control measures. Monitoring: The CDM is responsible for maintaining compliance. The Administrator and/or Food service manager will complete the Dietary audit tool weekly for monitoring and maintaining compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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F 812	Continued From page 63 date food items when opened. The surveyor and FSD entered the dry storage area. The surveyor observed an opened bag of tricolor pasta with use by date of 11/30/17. The FSD stated she would remove it. The surveyor and FSD checked the cook's refrigerator. In the cook's refrigerator, the surveyor observed a jar of Smucker's caramel sauce 19.5 oz. with a use by date of 1/7/17. The FSD removed the jar of caramel sauce and discarded it. The surveyor and the FSD checked the chest type of deep freezer. The surveyor noticed a build-up of ice in the deep freezer. In the freezer, there were two packages of bologna wrapped in aluminum foil-one with a use by date of 1/11/18 and the second one with a use by date of 1/2/18. Both packages of bologna were removed by the FSD. The surveyor and the FSD observed the chest style ice cream cooler. The surveyor noticed an accumulation of ice more on the right side of the freezer than the left side. The FSD stated the freezer was defrosted two times a year. The surveyor requested the facility policy for labeling, dating and storage of food and asked for the policy for obtaining outside food from a food vendor from the administrator on 1/30/18 at 2:30 p.m. The surveyor informed the administrative staff of the kitchen concerns during the end of the day meeting on 1/31/18 at 5:33 p.m. and again on 2/2/18 at 11:34 a.m.	F 812		

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F 812	Continued From page 64 The surveyor reviewed the facility policy titled "Food Storage" on 2/1/18. The policy read in part "Good storage guidelines include date labeling food correctly to determine when a food is no longer safe to consume and should be discarded. Food labeling is also a component of proper food storage to easily identify foods, especially when the food has been removed from the original packaging." No further information was provided prior to the exit conference on 2/2/18.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842	F842 Corrective Action(s): Resident #95's Pharmacy Consultation has been reviewed and signed by the DON and the attending physician and is now filed in Resident 95's medical record. A facility Incident & Accident form has been completed for this incident. Resident #34's attending physician has been notified that the facility staff failed to accurately document that Restorative nursing care was provided for 6 days in January, 2018. A facility Incident & Accident form has been completed for this incident.	

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	495320	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

(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 SHDULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 65 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 842	Identification of Deficient Practices & Corrective Action(s): All other residents may have potentially been affected. A 100% review of all resident Medical Records will be conducted by the DON, ADON, and or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff, Social Services director, Activity Director and dietary manager will be inserviced by the Regional Nurse Consultant or DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's and departmental notes according to the acceptable professional standards and practices.	

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F 842	Continued From page 66 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility staff failed to ensure a complete and accurate clinical record for 2 of 21 Residents, #95 and #34. The findings included: 1. For Resident #95 the facility staff failed to ensure a pharmacy consultation was available for review in the clinical record. Resident #95 was admitted to the facility on 06/09/15 and readmitted on 01/07/18. Diagnoses included but not limited to hypertension, anxiety, transient ischemic attack, depression hemiplegia, anemia, peripheral vascular disease, gastroesophageal reflux disease, dementia, dysphagia and delusional disorders. The most recent MDS (minimum data set) with an ARD (assessment reference date) of coded the Resident as 13 of 15 in section C, cognitive patterns. This is an admission MDS. Resident #95's clinical record was reviewed on 02/01/18. It included a pharmacist consultation form for the month of July 2017. The form in the clinical record had not been signed as having been reviewed by the physician or the DON. The surveyor spoke with the DON regarding the consultation form on. DON provided the surveyor with a consultation form for the month of July 2017 with physician signature and DON	F 842	Monitoring: The DON and Medical Records director are responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

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HER(TAGE HALL CLINTWOOD	1225 CLINTWOOD MA(N STREET, ROUTE 607 PO BOX 909 CL(NTWOOD, VA 24228

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F 842	Continued From page 67 signature. DON stated that the form was located in the Resident's thinned file. Surveyor then requested to see the original form that was in the Resident's clinical record, and the DON stated that she had misplaced it. The concern of the unsigned pharmacy consult form was discussed with the administrative team during a meeting on 02/02/18 at approximately 1130. No further information was provided prior to exit. 2. The facility staff failed to ensure a complete and accurate documentation to indicate the facility staff provided range of motion, transfers, and ambulation for Resident #34. Resident #34 was admitted to the facility on 1/9/10 with diagnoses including, but not limited to: hypertension, anxiety, psychosis, schizophrenia, heart failure, and pain. On the MDS assessment dated 11/30/17, the resident scored 10 on the brief interview for cognitive status; he was coded to understand and to be understood. Review of Resident #34's clinical record revealed his January 2018 Restorative care flow record. There was no documentation of his range of motion, transfers, or ambulation for the 3rd, 4th, 5th, 6th, 7th, or the 8th. The assistant director of nurses was asked if the restorative nursing was done for the days in question. She stated, "I don't know; the restorative CNA is off on medical leave." The incomplete documentation was shared with	F 842		

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F 842	Continued From page 68 the facility administration staff on 2/2/18 at 11:39am. Prior to exit on 2/2/18, no further information was provided to the surveyor related to the incomplete documentation.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880	F880 Corrective Action(s): C.N.A.'s #1 & #3 involved in providing incontinent care to resident #14 have received one-on-one inservice training on proper incontinent care and infection control practices when providing incontinent care include proper hand-washing. A Facility Incident & Accident form was completed for this incident. C.N.A.'s #2 & #4 involved in providing incontinent care to resident #67 have received one-on-one inservice training on proper incontinent care and infection control practices when providing incontinent care include proper hand-washing. A Facility Incident & Accident form was completed for this incident. C.N.A. #6 that was assisting resident #15 with eating has been inserviced on proper feeding techniques and infection control practices to be followed during meal times, to include not feeding residents while sitting on the bed.	

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F 880	Continued From page 69 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control	F 880	Identification of Deficient Practice(s) & Corrective Action(s): All residents may have the potential to be affected by improper infection control techniques related to improper incontinent care and feeding practices. The DON, ADON or designee will perform personal care audits on all C.N.A. staff to observe for proper infection control practices during incontinent care and feeding residents while in bed. Any negative findings will be addressed immediately and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedures have been reviewed and no changes are warranted at this time. All facility staff will be inserviced on the facility policy and procedure for maintaining proper infection control practices. The inservice training will include proper incontinent care, hand washing and feeding procedures by the DON and/or Regional Nurse Consultant.	

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F 880	Continued From page 70 guidelines for 3 of 21 residents (Resident #14, Resident #67, and Resident #15). The findings included: 1. The facility staff failed to provide correct incontinent care and failed to wash hands after removing gloves for Resident #14. The clinical record of Resident #14 was reviewed 1/30/18 through 2/2/18. Resident #14 was admitted to the facility 5/17/17 with diagnoses that included but not limited to Huntington's Chorea, history of falling, dementia with behavioral disturbances, hypothyroidism, and neurocognitive disorder. Resident #14's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/9/17 assessed the resident with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making. Resident ##14 was totally dependent on two + persons for bed mobility, transfers, walking in corridor, dressing, toilet use, and bathing. Section H Bowel and Bladder assessed the resident to always be incontinent of both bowel and bladder. On 2/2/18 at 8:15 a.m., the surveyor observed Resident #14 in bed. The resident was attempting to get out of bed. The surveyor summoned certified nursing assistant #1. C.N.A. #1 and C.N.A. #3 both donned gloves and tried to provide incontinent care. C.N.A. #1 and C.N.A. #3 assisted Resident #14 to her back and then positioned Resident #14 on the right side. C.N.A. #1 cleaned the resident's anal area and then positioned the resident on the back and cleaned	F 880	Monitoring: The DON will be responsible for monitoring compliance. The DON, ADON, and/or designee will perform 4 random weekly personal care audits to monitor for proper infection control practices during incontinent care and resident feeding to maintain compliance. Any/all negative findings will be corrected at time of discovery and one-on-one inservice training will be completed with staff member. Detailed findings of the audits will be reported to the Quality Assurance Committee for review, analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: March 19, 2018	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

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F 880	Continued From page 71 the resident's front. Gloves had been donned initially but C.N.A.#1 failed to remove them after cleaning the anal area, failed to wash her hands or donn a clean pair of gloves after going from a dirty area of the body to a cleaner area of the body. The surveyor informed the assistant director of nursing of the above observation on 2/2/18 at 8:45 a.m. She stated she would take care of the issue. The surveyor informed the administrative staff of the above observation during the end of the day meeting on 2/2/18 at 11:34 a.m. and requested the facility policy on perineal care. The surveyor reviewed the policy titled "Perineal Care" on 2/2/18. The policy read in part "Steps in the Procedure 2. Wash and dry your hands thoroughly. 7. Put on gloves. 9. For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. B. Wash perineal area, wiping from front to back (1). Separate labia and wash area downward from front to back. (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (4) Gently dry perineum. E. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not use the same washcloth or water to clean the labia. Rinse thoroughly and dry thoroughly. 12. Remove gloves and discard into designated container. Wash and dry your	F 880		

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F 880	Continued From page 72 hands thoroughly. No further information was provided prior to the exit conference on 2/2/18. 2. The facility staff failed to wash hands after removing gloves and then re-applying gloves a second time during incontinence care for Resident #67. Resident #67 was admitted to the facility 12/4/12 and readmitted 5/12/14 with diagnoses that included but not limited to schizophrenia, major depressive disorder, anxiety, and unspecified psychosis. The surveyor observed Resident #67 transferred from a Geri-chair to the bed using the stand-up lift on 01/31/18 01:17 PM. The surveyor observed C.N.A. #2 and C.N.A. #4. Both C.N.A.s applied gloves. Geri chair positioned at foot of the bed. Door closed. Instructed to lean forward by C.N.A. #2. Resident #67 positioned in lift and transferred to the bed. The surveyor then observed peri care done by C.N.A. #2 and C.N.A. #4. After C.N.A. #2 completed peri care to the front area, C.N.A. #4 then rolled the resident to the right side and provided care to the rectal/anal area. Brief applied. Both C.N.A.s removed gloves then both reapplied gloves. The surveyor observed no handwashing between glove use. Both C.N.A.s took gloves off after positioning the resident in the bed and washed their hands. The surveyor informed the administrative staff of the above concern during the end of the day meeting on 1/31/18 at 5:33 p.m. The administrator, the director of nursing and the assistant director of nursing stated they would	F 880		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 880	Continued From page 73 expect staff to wash hands between glove use. The surveyor requested the infection control policy and procedure for handwashing/glove use during the end of the day meeting on 1/31/18. The surveyor reviewed the facility policy titled "Personal Protective Equipment-Gloves" on 2/2/18. The policy read in part "1. All employees must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin. 8. Wash your hands after removing gloves." No further information was provided prior to the exit conference on 2/2/18. 3. The facility staff failed to follow established infection control guidelines by sitting on Resident #15's bed while assisting the resident with eating. The surveyor reviewed Resident #15's clinical record 1/30/18 through 2/2/18. Resident #15 was admitted to the facility 11/12/07 and readmitted 6/26/12 with diagnoses that included but not limited to cerebral palsy, urinary tract infections, abnormal involuntary movements, and lack of coordination. Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/10/17 assessed the resident with a BIMS of 15 out of 15. Section G Functional Status assessed Resident #15 to be totally dependent on 1 person for eating. Resident #15's person centered care plan dated 11/13/17 read "Nutritional Status mechanically altered, therapeutic diet dx (diagnosis) dysphagia,	F 880		

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F 880	Continued From page 74 dx of GERD (gastroesophageal reflux disease) and anemia. She refuses to let certain staff feed her." The surveyor observed Resident #15 eating breakfast on 1/31/18 at 9:15 AM. Certified nursing assistant (C.N.A.#6) was assisting Resident #15 with eating. Resident #15 was in bed and CNA #6 was seated on the left side of Resident #15's bed. There was not a chair in Resident #15's room. Resident #15's wheelchair was positioned on the right side of the bed. The surveyor interviewed CNA #6 on 2/1/18 at 9:14 a.m. regarding sitting on Resident #15's bed. During the interview, C.N.A. #6 was asked what she normally does when feeding a resident in bed. C.N.A. #6 stated "usually she would sit in a chair but Resident #15 asked me to sit on the side of the bed and I did." The surveyor informed the administrative staff of the above concern during the end of the day meeting on 1/31/18 at 5:33 p.m. Both the administrator and the director of nursing stated they would expect the C.N.A. to get a chair and sit in the chair. The surveyor requested the facility policy on feeding residents. The surveyor reviewed the facility policy titled "Assisting the Impaired Resident with In-Room Meals" on 2/2/18. The policy read in part "Steps in the Procedure 3. If you are going to be seated during the feeding, position a chair where it will be convenient for you and the resident." No further information was provided prior to the exit conference on 2/2/18.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495320	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/2/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495320	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/2/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility staff failed to ensure that a written discharge notice was provided to Resident #98, his representative, or the Ombudsman for I of 3 closed record reviews.

The findings include:

For Resident #98, the facility staff failed to provide Resident #98, resident's representative (RP), or the Ombudsman a written notice of discharge.

The clinical record of Resident #98 was reviewed on 2/2/18. Resident #98 was admitted to the facility on 11/24/17, with diagnoses that included, but were not limited to: high blood pressure, diabetes mellitus, anxiety, heart failure, and left femur fracture. Resident #98 was discharged to the hospital on 11/28/17.

The clinical record did not contain written information of a discharge notice provided to the resident, his representative, or the ombudsman. On 2/2/18 at 9:51a.m, the director of nurses (DON) was asked if a written notice had been provided to the resident, RP, and the ombudsman. The DON said, "I will check." At 10:50 am, she informed the surveyor, "Resident #98, his RP, nor the ombudsman was given written notice discharge."

During a meeting with the administrator, DON, ADON, and regional nurse consultant, the issue of the written discharge notice was discussed.

Prior to exit, no further information was provided by the facility to surveyor related to the above concern.

State of Virginia

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0109	A. BUILOING: _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 01/30/18 through 02/02/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 97at the time of the survey. The survey sample consisted of 21 current Resident reviews and 3 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Homes Resident Rights 12 VAC 5-371-150- cross reference to F550 and F623 Infection Control 12 VAC 5-371-180- cross reference to F812 and F880 Nursing Services 12 VAC 5-371-220- cross reference to F550, F558, F658, F677, F688, F690, F697 and F758 Resident Assessment and Care Planning 12 VAC 5-371-250- cross reference to F558, F655, F656 and F657	F 001	**F001** **Resident Rights** **12VAC 5-371-150 Cross reference to F550 & F623** Cross Reference to POC for F550 and F623 **Infection Control** **12 VAC 5-371-180 Cross reference to F812 & F880** Cross Reference to POC for F812 & F880 **Nursing Services** **12 VAC 5-371-220 Cross reference to F550, F558, F658, F677, F688, F690, F697 and F758** Cross Reference to POC for F550, F558, F685, F677, F688, F690, F697 and F758 **Resident Assessment & Care Planning** **12 VAC 5-371 -250 Cross reference to F558, F655, F656 and F657**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenna Kennedy — TITLE: Administrator — (X6) DATE: 2-21-18

State of Virginia

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	VA0109	A. BUILOING: _____ B. WING _____	02/02/2018

NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 1 Dietary and Food Service 12 VAC 5-371-340- cross reference to F804 Administration 12 VAC 5-371-360- cross reference to F842	F 001	Cross Reference to POC for F558, F655, F656 and F657 **Dietary and Food Service** **12 VAC 5-371-340 Cross reference to F804** Cross Reference to POC for F804 **Administration** **12 VAC 5-371-340 Cross reference to F842** Cross Reference to POC for F842 **Completion Date:** March 19, 2018	