State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0196	A. BUILDING: _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-RI\	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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 State licensure inspection was conducted 2/7/17 through 2/9/17. Two complaints were investigated during the survey. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 138 certified bed facility was 124 at the time of the survey. The survey sample consisted of 26 resident reviews; 21 current residents (Residents #1 through #21) and 5 closed record reviews (Residents #22 through #26).	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 Facilities: 12 VAC5-371-300 Pharmaceutical Services A. Refer to F431 12 VAC 5-371-220 (C.1) Nursing Services; Cross Reference F-314 12 VAC 5-371-370 A, B, C & G. Maintenance and Housekeeping; Cross Reference F-253, F-323 and F-465 12 VAC 5-371-250 (B.2) Resident Assessment and Care Plans Please Cross Reference F 274 and F 280	F 001	RECEIVED MAR 0 6 2017 VDH/OLC Please see response to F 431 Please see response to F 314 Please see response to F 253, F 323 and F 465 Please see response to F 274 and F 280 Please see response to F 514 Please see response to F 164	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: EXECUTIVE DIRECTOR (X6) DATE: 3/6/17

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F 001	Continued From page 1 12 VAC 5-371-360 (E) Clinical Records Please Cross Reference F 514 12 VAC5-371-360 (B., C., D.) Please Cross Reference to F-164 COV 32.1-138.1 Article 2 (#9.) Please Cross-Reference to F-164	F 001		

PRINTED: 02/22/2017
FORM APPROVED
OMB NO. 0938-0391

[redacted]PARTMENT OF HEALTH AND HUMAN SERVICES
[redacted]NTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/7/17 through 2/9/17. Two complaints were investigated during the survey. Significant Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 138 certified bed facility was 124 at the time of the survey. The survey sample consisted of 26 resident reviews; 21 current residents (Residents #1 through #21) and 5 closed record reviews (Residents #22 through #26).	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (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. §483.70 (i) Medical records.	F 164	RECEIVED MAR 06 2017 VDH/OLC *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F164 1. Resident #4 privacy and protection of medical record is currently being maintained. 2. Residents residing in the facility have been identified as having the potential to affected.	

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

[redacted] EXECUTIVE DIRECTOR 3/6/17

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

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F 164	Continued From page 1 (2) The facility must keep confidential all information contained in the resident's records, 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review, and facility document review the facility staff failed to ensure the privacy and protection of a resident medical record for 1 of 26 residents in the survey sample, Resident #4. The facility staff failed to ensure the privacy and protection of Resident #4's medical record by allowing a facility Attending Physician to use his private cellular smart phone that was not secured by the facilities Information Technology (IT) Department and/or considered part of the clinical record, for taking and storing resident wound photos and texting resident medical information between the facility and physician.	F 164	3. Attending Physician's (for Resident #4) phone has been updated to contain security protection. Attending Physicians have been educated regarding the center's NCD (Nursing Center Division) Patient's Medical Records Policy, HIPAA (Health Information Insurance Portability and Accountability Act) At a Glance and Confidential and Information Security policy. Licensed Nurses have been in-serviced on the center's NCD (Nursing Center Division) Patient's Medical Records Policy, HIPAA (Health Information Insurance Portability and Accountability Act) At a Glance and Confidential and Information Security policy. 4. DNS, ADNS, Unit Managers will interview 3 attending physicians per week (for twelve weeks) to inquire how Licensed Nurses are communicating with them in order to determine if HIPAA is being maintained. DNS, ADNS, Unit Managers will follow up with any Licensed Nurses who are not complying with the HIPAA policies. Newly hired Licensed Nurses and newly attending physicians will be educated during their orientation period on the center's NCD (Nursing Center Division) Patient's Medical Records Policy, HIPAA (Health Information Insurance Portability and Accountability Act) At a Glance and Confidential and Information Security policy.	

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F 164	Continued From page 2 The findings included: Resident #4 was a 87 year old admitted to the facility 4/4/16 with diagnoses to include Unstageable Sacrum Decubitus (1), Dementia (2), and Depression (3). The most recent recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 11/24/16. The Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicated Resident #4 was cognitively intact and capable of daily decision making. Under Section M Skin Conditions the resident was coded as having 1 Unstageable Pressure Ulcer with slough (4) measuring 3.0 cm (centimeters) x 3.0 cm. On 2/9/17 at 1:00 p.m. in the facility conference room with five surveyors, the facility Wound Nurse LPN (Licensed Practical Nurse) #2, and the facility Attending Physician for Resident #4 present an interview was conducted regarding Resident #4's unstageable pressure ulcer. During the interview the Attending Physician pulled out his cellular smart phone and was scrolling and reading through text messages about Resident #4. This surveyor asked the Attending Physician, "Is that your personal cell phone and does the facility text you about your residents?" The Attending Physician stated, "Yes it is, and yes (Name) Director Of Nursing texts me the most about the residents and I text her back." The interview continued and the Attending Physician went into his cellular smart phone picture gallery and pulled up pictures he stated were of Resident #4's sacral pressure area that	F 164	The results of the audits will be presented to the Quality Assurance and Performance Improvement Meeting monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations in order to maintain compliance ongoing. 5, The corrective action will be completed on March 16,2017	

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he had taken to show the surveyor what the resident's wound looked like. After the Attending Physician pulled up Resident #4's sacral pressure area picture in his phone, he turned the picture to the Wound Nurse who acknowledged to the interviewing surveyor that is was indeed Resident #4's sacral area. This surveyor asked Resident #4's Attending Physician, "You have pictures of your resident's wounds on your personal phone?" Resident #4's Attending Physician stated, "Yes I do so I can monitor the wound progress. Is there something wrong with that, should I not be doing that? I always have the Wound Nurse in the room with me when I take the pictures and it doesn't show the face."

On 2/9/17 at 3:15 p.m. a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above information was shared. The Administrator was asked if Resident #4's Attending Physician's personal cellular smart phone was security protected through the facility's IT Department. The Administrator stated, "Yes, I think it is but let me check." The Director of Nursing was asked if she used her personal cellular phone when texting Resident #4's Attending Physician about residents and if her personal cellular phone was security protected through the facility's IT Department. The Director of Nursing stated, "I do text him but I don't use resident names, and no my phone is not security protected." The Administrator was asked by the surveyor, "Is Resident #4's Attending Physician's personal cellular smart phone considered a part of the Resident #4's facility medical record?" The Administrator stated, "No, it is not."

Resident #4's Admission Agreement signed 4/5/16 was reviewed and documented in part, as

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follows:

2. Care and Services:

a) Attending Physician. By execution of this Agreement, the Resident agrees to be admitted to the Center and while residing in the Center be under the care and treatment of an attending physician of the Resident's choosing who is licensed in the state in which the Center is located. The attending physician selected by the Resident must act in accordance with applicable state and federal rules and regulations, and the Center's rules and policies and procedures.

g) Notice of Privacy Practices. The information contained in the Resident's medical record is confidential and will not be disclosed without the written authorization of the Resident or as permitted or required by law. Specific information on how the Resident's medical information may be used and/or disclosed and the Center's responsibility to safeguard the Resident's private health information is provided in the attached Notice of Privacy Practices. By signing this agreement the Resident authorizes and acknowledges that the Center may take photographs of the Resident for health care purposes and identification of the Resident within the Center. See Attachment D, Notice of Privacy Practices.

The facility "NOTICE of PRIVACY PRACTICES ATTACHMENT D" effective date 7/19/13 is documented in part, as follows:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE

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REVIEW IT CAREFULLY.

Understanding Your Medical Record and Your Health Information:

(Facility Name) is committed to protecting the privacy and safeguarding the security of your protected health information. Each time you receive services from (Facility Name) or one of its affiliates, we record information that identifies you and relates to your medical condition, provision of health care, or payment for your treatment. Typically, this record consists of your medical history, symptoms, examination, observations, test results, diagnosis, care summaries, treatment, and future care plans. Understanding your health information and how it is used is important in maintaining its accuracy and confidentiality. This notice pertains to our workforce members and other health care providers we work with in a clinically integrated setting (e.g. members of our medical and clinical staff) and other participants in our organized health care arrangements, and pertains to uses and disclosures of your protected health information whether made verbally, on paper, or electronically, including through a health information exchange operated by (Facility Name) or a business associate.

Your Health Information Rights:

Although your medical record is the property of (Facility Name), the information belongs to you. You have legal rights regarding your health information.

Our Responsibilities:

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We are required by law to maintain the privacy of protected health information, provide you with this Notice of our legal duties and privacy practices with respect to protected health information, and to notify you if you are affected by a breach of unsecured protected health information.

The Facility policy titled "NCD (Nursing Care Division) Patient Medical Records" last release date 6/1/16 documented in part, as follows:

POLICY:
Medical records are maintained on each patient in accordance with accepted professional standards and practice, provide a basis for determining and managing the patient's progress including response to treatment, change in condition, and changes in treatment.

PROCEDURE:

1. The medical record is a legal document and its contents are confidential and should be accessed by authorized personal only. For requests to access a patient's medical record or for a copy of the patient's medical record, follow enterprise-wide privacy and security policy or State requirements.

2. The patient's medical record may be found in a hard copy paper format and in an electronic medical record system where the information is not printed.

10. Medical record information must be safeguarded against loss, destruction, or unauthorized use.
a. Information considered too confidential to place in the record used by staff may be retained

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F 164	Continued From page 7 in a secure place in the center. b. The record should show the location of this confidential information. d. If a medical record is needed outside of the unit/nursing station, the record may be signed out to maintain the medical records's accessibility and prevent loss. e. Medical records are to remain inside the Center in a secure area and upon completion of review are returned to the unit/nursing station. 11. The original medical record does not leave the center's property unless the patient has been discharged and the medical record has met the retention period. 12. Confidentiality of the medical record is maintained in accordance with the policy on Use & Disclosure of protected health information. The facility document titled "HIPAA (Health Insurance Portability and Accountability Act) AT A GLANCE" documented in part, as follows: *Use reasonable safeguards to protect the privacy of our patients and their protected health information. *Use reasonable precautions when opening email attachments. Email sent outside the (Facility Name) network containing protected health information must be encrypted. The facility policy titled "Confidentiality and Information Security" dated 4/28/10 is documented in part, as follows: POLICY; Residents, personal, and financial information are considered confidential. Confidential information, whether written, verbal	F 164		

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or electronic, is not revealed to anyone except in accordance with federal and state regulations.

Compliance Guidelines:

2. Employees must keep resident's medical, financial, and social information confidential except as permitted for continuity of care in accordance with policy.

On 2/9/17 at 4:30 p.m. while this surveyor was in his office, the Administrators stated, "I was wrong (Name) Attending Physician's or the Director of Nursing's personal phone is not secured or protected by our facility information technology department, I just checked with them. I will be immediately calling (Name) Attending Physician and make him aware that he can no longer take pictures of the residents or have resident information on his personal phone."

Prior to exit no further information was shared.

(1) Unstageable Pressure Ulcer: Suspected deep tissue injury in evolution.

(4) Slough: yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucous.

The above definitions are derived from the Minimum Data Set (MDS) Version 3.0 Resident Assessment and Care Screening.

(2) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement,

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F 164	Continued From page 9 and impulses. (3) Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 164	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility staff failed to maintain a sanitary, orderly, and comfortable interior environment which created a homelike environment for the Residents. The facility staff failed to ensure the sit to stand lift (a mechanical device used to assist residents from a sitting to a standing position for transfers), the dining room chairs and the dining room suction machine were maintained in a sanitary and safe condition. The finding included: On 2/8/17 at approximately 5:25 p.m., during environmental observations the sit to stand lift was observed outside of room 225. The foot	F 253	1. Sit to Stand Lift was cleaned on 2/8/17. Dining Room Chair arms were cleaned on 2/8/17. Suction machine was replaced and cleaned on 2/8/17. 2. Residents residing in the center have been identified as having the potential to be affected. 3. SDC (Staff Development Coordinator) will educate staff on cleaning equipment, as needed, after use. New dining chairs were ordered on 1/27/17. Monday – Friday during center rounds, Housekeeping Supervisor will audit lifts and dining facilities for cleanliness. Monday – Friday Unit Manager will observe suction machine in dining room for cleanliness and proper storage. 4. The results of the audits will be presented to the Quality Assurance and Performance Improvement Meeting monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations in order to maintain compliance ongoing.	

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F 253	Continued From page 10 board was with dust and a gritty debris. The Maintenance Director was interviewed at the sit to stand lift on 2/8/17 at approximately 5:25 p.m. The Maintenance Director was unsure of the cleaning schedule for the sit to stand but stated he would find out. An interview was conducted with Licensed Practical Nurse (LPN) #50 on 2/8/17 at approximately 5:30 p.m. LPN #50 was observed at the medication cart on the hallway. She stated the Certified Nursing Assistant (CNA) had just transferred the resident from the wheelchair to the bed using the sit to stand lift and the CNA put it outside the door while completing the resident's care. In the distant corner opposite the storage cabinet in the dining room was an uncovered suction machine with a large amount of dust on it. The maintenance label read; last inspection date March 2014, next inspection due March 2015. Also in the dining room all of the straight back chairs frames were severely scratched/battered and with multiple stains to the upholstered seats. The Maintenance Director stated this had previously been identified and the appropriate persons were aware limited seating was available the dining room. The above information was shared with the Executive Director and the Director of Nursing on 2/9/17 at approximately 3:10 p.m. The Director of Nursing stated the facility staff was unable to find a policy on cleaning resident care equipment but	F 253	5, The corrective action will be completed on March 16,2017	

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F 253	Continued From page 11 it is the responsibility of the nursing staff as well as the housekeeping staff to keep all mechanical lifts clean. She stated the nurses should clean the lifts in between resident use when debris is observed. The Director of Nursing also stated the suction machine in the dining room was there for emergencies but it was going to be removed and replaced with a clean ready to use unit. An invoice dated 1/27/17 provided by the Maintenance Director showed a request had been submitted and approved for 16 dining room chairs and resident room furniture to include dressers and nightstands.	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review the facility staff failed to conduct a Significant Change in Status Assessment (SCSA) MDS (Minimum Data Set) for 1 of 26 residents in the survey sample who elected hospice benefits, Resident #15.	F 274	1. Significant Change in Condition Assessment has been completed on Resident #15 to reflect the election of Hospice benefits. 2. During the Clinical Morning Meeting (Monday – Friday), the 24 Hour Change of Condition Report will be reviewed to identify residents who experience a significant change in status that will not normally resolve itself within without further intervention by staff or by implementing standard disease –related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both.	

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F 274	Continued From page 12 Resident #15 elected hospice benefits that began on 1/13/17. The facility staff failed to conduct a SCSA MDS. The findings included: Resident #15 was admitted to the facility from home on 12/20/16 with diagnoses to include peripheral vascular disease, chronic pain, adult failure to thrive and unspecified dementia. The current MDS was the admission MDS with an assessment reference date of 12/27/16. The resident was assessed as scoring a 6 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognition. Review of the clinical record evidenced a nurses note dated 1/11/17 that read, in part: "...spoke with physician and Hospice Director...both to review (resident) medical record history and current medical status and contact family..." A physician order dated 1/12/17 read. " Hospice Eval and treat". The resident was evaluated by Hospice on 1/13/17. Hospice benefits began that same day. The electronic record failed to evidence a significant change reassessment MDS was conducted after the election of Hospice benefits for Resident #15. On 2/9/17 at 1:30 p.m., both MDS Coordinators were interviewed. Both stated they were not aware that Resident #15 had elected Hospice services. MDS Coordinator #1 stated a	F 274	3. DNS will educate Interdisciplinary Care Team on completing a significant change in condition assessment for residents who experience a significant change in status that will not normally resolve itself within without further intervention by staff or by implementing standard disease –related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. MDS Coordinator (Minimum Data Set) will audit five medical records weekly for twelve weeks to validate significant change in condition assessments are completed as appropriate. 4. The results of the audits will be presented to the Quality Assurance and Performance Improvement Meeting monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations in order to maintain compliance ongoing. 5, The corrective action will be completed on March 16,2017	

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F 274	Continued From page 13 significant change MDS should have been completed. The MDS Coordinators provided a copy of the RAI that read, in part: CMS (Center for Medicaid/Medicare Services) RAI (Resident Assessment Instrument) January 2010 chapter 2: Assessments for the RAI page 2-20...If a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) but remains a resident at the nursing home, a SCSA (Significant Change in Status Assessment) should be performed regardless of whether an assessment was recently conducted on the resident. The above findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 2/9/17 at 3:50 p.m.	F 274	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280	1. Resident #14 care plan was updated to reflect use of the indwelling catheter. 2. Residents with indwelling catheters have been identified as having the potential to be affected. 3. SDC (Staff Development Coordinator) will educate Licensed Nurses to update the resident's care plan and contact the attending physician for an order to continue or discontinue the indwelling catheter. Unit Managers will conduct observation rounds, two times a week for twelve weeks, to determine any catheters in use, then review the medical record to validate there is a care plan and physician's order for the catheter.	

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F 280	Continued From page 14 plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280	4. The results of the audits will be presented to the Quality Assurance and Performance Improvement Meeting monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations in order to maintain compliance ongoing. 5, The corrective action will be completed on March 16,2017	

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(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 observation, staff interviews, and clinical record review the facility staff failed to revise a person-centered plan of care for 1 of 26 residents in the survey sample, Resident #14.

Resident #14 was observed with a Foley catheter (1) during the survey days. The clinical record failed to evidence the staff had revised the residents person-centered plan of care to include the Foley catheter.

The findings included:

Resident #14 was admitted to the facility on 6/21/16 with diagnoses to include urinary

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retention due to BPH-benign prostatic hypertrophy (2).

The current MDS (Minimum Data Set), a quarterly with an Assessment Reference Date of 12/29/16, coded the resident as scoring a 2 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was severely impaired. The resident was coded as having an indwelling catheter on this assessment and the Admission MDS with an assessment reference date of 6/28/16.

According to documentation provided by the facility a Foley catheter plan of care was initiated on 7/11/16 and canceled on 8/24/16.

During the survey dates of 2/8/17 and 2/9/17 the resident was observed with an indwelling Foley catheter.

The current comprehensive person-centered plan of care (not dated) in the electronic record failed to evidence it had been revised to include the Foley catheter.

A Health Status Change note dated 11/22/16 read, in part: "complained of pain and discomfort @ (at) lower abdomen. Assessment: bladder noted to be distended and hard, patient complained of pain when palpated Foley cath inserted, 900 cc (centimeter) of dark amber colored urine noted...urology consult and labs; will follow further instructions from MD".

The clinical record failed to evidence a physician order for the Foley.

On 2/9/17 at 1:30 p.m., both MDS Coordinators

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were interviewed. They indicated care plan revisions are the responsibility of the nurses on the units. When asked if a Foley catheter should be care planned both stated, "Yes".

The above findings was shared during the pre-exit meeting conducted on 2/9/17 at 3:50 p.m. with the Administrator and the Director of Nursing (DON). The DON stated, "Yes, it should be care planned, we are trying to train all nurses to update the care plans...MDS (Coordinators) try to update the care plans during morning meetings".

On 2/9/17 at 6:00 p.m., the DON stated the Foley catheter had been discontinued (no date provided) and then reinserted on 1/22/16 due to urinary retention, the nurse had followed the physicians order to keep the Foley in. The DON could not find the transcribed order. The DON further stated, "We made a mistake...we dropped the ball...".

A policy for revision of care plans was requested during the survey. None was provided prior to exit.

Definitions:

(1) Foley catheter: A urinary tract catheter with a balloon attachment at one end. After the catheter is inserted, the balloon is inflated. Thus, the catheter is prevented from leaving the bladder until the balloon is emptied. Taber's Cyclopedic Medical Dictionary, edition 20.

(2) Benign prostatic hyperplasia (BPH) is an enlarged prostate gland. The prostate gland

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F 280	Continued From page 18 surrounds the urethra, the tube that carries urine from the bladder out of the body. As the prostate gets bigger, it may squeeze or partly block the urethra. This often causes problems with urinating. Taber's Cyclopedic Medical Dictionary, edition 20.	F 280		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and review of the facility's policy, the facility staff failed to provide the necessary treatment, care and services, consistent with professional standards of practice, to prevent a new avoidable pressure ulcer (any lesion caused by unrelieved pressure that results in damage to the underlying tissue) from developing for 1 of 26 residents (Resident 6), in the survey sample.	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 314 1. Resident #6 is receiving care per physicians order for sacral ulcer. 2. Residents residing in the facility have had an updated Braden Assessment to determine their risk for developing pressure ulcers. Residents at high risk for pressure ulcers have been identified as having the potential to be affected. These identified residents have had a skin assessment performed to validate pressure areas have been identified and appropriate treatment orders in place as necessary. 3. Certified Nursing Assistance have been educated on identifying and reporting changes in skin. Licensed Nurses were educated on identification and treatment of pressure ulcers. During their orientation period, newly hired Certified Nursing Assistance will be educated on identifying and reporting changes in skin. During their orientation period, newly hired Licensed Nurses will be educated on identification and treatment of pressure ulcers.	

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F 314	Continued From page 19 The facility's staff did not identify Resident #6 had developed a sacral (the part of the spinal column which sits between the two hip bones) pressure ulcer until it had advanced to a stage three (3)* resulting in harm. The findings included; Resident #6 was originally admitted to the facility 07/13/16 and has never been discharged. The resident's current diagnoses include; stroke, left side weakness, difficulty swallowing, diabetes, high blood pressure, high cholesterol and heart disease. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/19/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were intact. The 1/19/17 MDS assessment also revealed the resident was without mood or behavior problems. The MDS assessment further revealed the resident required limited assistance one person with eating, extensive assistance of two or more persons with bed mobility, total care of one person with personal hygiene, bathing, dressing and toileting. The resident was coded as incontinent of bowels and bladder.	F 314	4. DNS, ADNS, Wound Care Nurse, SDC, Unit Manger, or designated Nurse Supervisor will perform a skin assessment on identified high risk residents to validate pressure areas have been identified and have appropriate treatment in place, if necessary, for ten residents weekly for a minimum of six months. Results of the skin assessments performed by the DNS, ADNS, Wound Care Nurse, SDC, Unit Manger, or designated Nurse Supervisor will be compared to the most recent skin assessment performed by the Charge Nurse. DNS, ADNS, Wound Care Nurse, SDC, Unit Manger, or designated Nurse Supervisor will follow up appropriately on any discrepancies noted. Results of audits will be presented in the center's QAPI Committee monthly for a minimum of six months for review and recommendations from the QAPI Committee to assure compliance is sustained ongoing. 5, The corrective action will be completed on March 16,2017	

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The clinical record revealed a Braden Scale for Predicting Pressure Sore Risk assessment dated 10/19/16. The score of 16 indicated the resident was at risk for pressure ulcer development. The Braden Scale for Predicting Pressure Sore Risk dated 1/17/17 score was 11 indicating the resident was at high risk for pressure ulcer development.

The Pressure Ulcer Weekly Log for 1/28/17 - 2/3/17 revealed Resident #6 acquired a stage 3 pressure ulcer to the sacrum on 1/17/17.

A pressure ulcer dressing change observation of Resident #6's sacrum was conducted on 2/8/17 at 10:50 a.m. The wound care nurse was assisted by a Certified Nursing Assistant (CNA) #8. The sacral wound was approximately 2.5 cm in length 1.5 cm wide 0.1 cm deep. The entire wound was pink and moist with no slough and drainage. The wound was cleaned with normal saline, Santyl ointment, and a foam dressing was applied. The resident had no complaint of pain or discomfort during the dressing change.

Resident #6's Weekly Skin Check dated 1/5/17, stated the resident had no skin conditions, changes, ulcers or injuries. On the body diagram the following sites were documented; at site 23, the coccyx (tailbone) was with a red area, at site 31, the right buttock was with old scratches, at site 37, the front of the right knee had edema and old scratch marks and at site 4, the face was with

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F 314	Continued From page 21 red areas around the mouth. There was a note in the comments/summary section of the Weekly Skin Check which read; "right hand peripheral intravenous therapy dressing. Peripherally inserted central catheter (PICC) line to right inner arm antecubital". Resident #6's Weekly Skin Check documentation dated 1/12/17 read at section "B1; Are there any skin conditions or changes, ulcers or injuries? The response was "NO". The note in the comments/summary section of the Weekly Skin Check read; "continue treatments". During the 2/9/17 interview at approximately 1:50 p.m., with the wound care nurse, she stated the treatment remained Triad cream as a preventative measure since the resident had previously been with a stage I pressure ulcer. Resident #6's Weekly Skin Check documentation dated 1/20/17 read at section "B1; Are there any skin conditions or changes, ulcers or injuries? The response was "yes". Section B2 asked if; is this new since the last documentation? The answer was "NO" The note in the comments/summary section of the Weekly Skin Check read; "no new open areas, treatment continue to sacrum and right heel". Resident #6's Weekly Skin Check documentation dated 1/26/17 read at section "B1: Are there any skin conditions or changes, ulcers or injuries? The response was "No". The note in the comments/summary section of the Weekly Skin Check read; "no new open areas, treatment continue to sacrum and right heel. Midline site left arm dry and intact".	F 314		

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The clinical record contained a Weekly Pressure Ulcer BWAT Report dated 1/17/17. The report stated Resident #6 was with a new onset pressure ulcer at site 53, the sacrum. The stage 3 pressure ulcer of the sacrum measured 5 centimeters by 4 centimeters by 0.1 centimeters. The report revealed the pressure ulcer was "irregular in shape, was initially observed on 1/17/17, was a full thickness skin loss involving damage or necrosis of subcutaneous tissue, may extend down to but not through underlying fascia; and/or tissue layers obscured by granulation tissue."

The Weekly Pressure Ulcer BWAT Report dated 1/17/17, also stated the stage 3 pressure ulcer of the sacrum had "distinct, outline edges, undermining less than 2 centimeters in any area and necrotic tissue type; white/grey non-viable tissue and/or non-adherent yellow". The report revealed there was 25 - 50 percent of necrotic tissue present. The wound produced a small amount of thin watery, pale red/pink drainage. The skin surrounding the wound was bright red and/or blanched to touch. The wound also contained granulation and epithelial tissue.

The treatment/evaluation section of the Weekly Pressure Ulcer BWAT (Bates-Jensen Wound Assessment Tool) Report dated 1/17/17 read; "area to sacrum noted. Area noted with yellow tissue to wound bed. Medical Doctor (MD) notified and new orders received for Santyl (an ointment to remove dead tissue from wounds) daily. Responsible Party notified of new area. Will re-evaluate in 1 week".

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F 314	Continued From page 23 An interview was conducted with the wound care nurse on 2/9/17 at approximately 1:50 p.m. The wound care nurse stated Resident #6 was "stable" prior to development of the stage 3 pressure ulcer and the only behavior exhibited was his resistance to meals in the dining room. She further stated the staff provided turning and repositioning, incontinence care and applied Triad cream (a zinc oxide based paste) to the resident's bottom every shift. During the 2/9/17 interview at approximately 1:50 p.m., with the wound care nurse, the Pressure Ulcer Investigation was reviewed. The Pressure Ulcer Investigation revealed Resident #6 was identified with a stage 3 pressure ulcer acquired in house on 1/17/17. The wound care nurse stated the investigation revealed the resident had the following risk factors; impaired transfer and bed mobility, chronic urinary incontinence, chronic bowel incontinence, diabetes, immobility, and inadequate nutrition/hydration therefore; the pressure ulcer was unavoidable. The wound care nurse stated it is not ideal for pressure ulcers to be discovered at a stage 3, "early on when there is only redness" is optimal. The wound care nurse also stated the Certified Nurse Assistants (CNA)s are the first line of defense for early detection as they provide routine bathing and incontinent care. The wound care nurse futher stated the facility interventions were consistently implemented and they included; preventative skin care (clean protect, moisture), consistently turn and reposition, utilization of appropriate reduction surface, evidence of consistently monitoring	F 314		

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F 314	Continued From page 24 skin/body, incontinence management program, Rehabilitation consult for positioning if indicated. Registered Dietitian consult to address nutrition needs, Preventions addressed on most recent MDS and prevention addressed on care plan to manage identified risk factors. Review of the care plan dated 7/25/16 and active at the time the stage 3 pressure ulcer was discovered on 1/17/17 read; Potential for skin/tissue integrity due to diagnoses of stroke with left side weakness requiring one person assistance with activities of daily living, bowel and bladder incontinence, diagnoses of diabetes. The goal read; (name of resident) will have skin intact through 4/29/17. The interventions were; assess (name of resident) skin weekly and as needed, provide dietary supplements as ordered, provide incontinence care as needed, When (name of resident) is out of bed, change position by shifting weight or return to bed for rest. The above findings were shared with the Executive Director and the Director of Nursing on 2/9/17 at approximately 3:10 p.m. The Staff Development Coordinator (SDC) was interviewed on 2/9/17 at approximately 4:45 p.m. The SDC presented a Quality Assurance Performance Improvement Action Plan (QAPIAP) dated previously dated 11/15/16 and updated to read 11/17/16. The SDC stated the facility staff recognized an increase in pressure ulcer at that time and developed a plan on 11/17/16 to identify trends and institute interventions to reduce the	F 314		

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opportunities for new pressure ulcer development. Review of the QAPIAP revealed the data was not accurate. The document stated there were 5 residents with acquired pressure ulcers the week of 9/5/16 - 9/11/16 , but the Pressure Ulcer weekly log revealed no pressure ulcers were in house acquired 9/5/16 - 9/11/16 and on 11/12/16 -11/18/16 the Pressure Ulcer weekly log revealed two pressure ulcers were in house acquired.

The SDC stated the measures/trends are not accurate but the interventions were instituted and continues to be implemented. They included Validate resident with acquired pressure ulcer have appropriate treatment, care plan interventions, pain assessment with new change in pressure ulcer, Braden scales, responsible party and registered dietitian notification, evaluation of treatment every 14 days. The Pressure Ulcer Investigation form was implemented for any new pressure ulcers, review of the weekly body checks for 1 month prior to pressure ulcer development to validate completion. Educate licensed nurses as needed, weekly skin assessments/body checks by licensed nurses. Re-implement turning schedule. Provide to nursing staff. In-service licensed nurses related to pressure prevention and treatment.

The SDC stated the during the interviewed on 2/9/17 at approximately 4:45 p.m., that all of interventions from the action plan developed 11/17/16 remained in effect. The SDC did not attach or provide copies of the staff which had been in-serviced on the QAPIAP dated 11/17/16.

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The facility's policy titled Prevention and Treatment of Pressure Ulcers and Other Skin Alterations with a release date of 5/2/16 read; the facility has a system in place to promote skin integrity, prevent pressure ulcer development/other skin alterations, promote healing of existing wounds and prevent further development of additional skin alterations. Under prevention steps the procedure reads; A at risk assessment is completed on admission and at designated intervals throughout the patient's stay. Patients at risk for developing pressure ulcers are identified by using the Braden Scale. Patients are identified as at risk for skin related issues such as moisture associated skin damage, skin tears, or other non-pressure skin related issues upon admission and at designated intervals throughout the patient's stay.

Another facility policy titled Pressure Ulcer dated 12/20/16 stated; "pressure ulcers prevention requires an interdisciplinary approach to care. Some parts of pressure ulcers prevention are highly routinized, but care must be tailored to the specific risk profile of each patient ... Risk assessment is a key component of clinical practice aimed at identifying individuals vulnerable to the development of pressure injuries. In order to target appropriate interventions and prevent pressure ulcer development, characteristic that increase probability of pressure injuries must be identified. Individuals who are at high risk are those portrayed by multiple risk factors affecting both the mechanical boundary conditions (i.e., the type shear, pressure, friction, magnitude, time and duration of the mechanical load and the

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F 314	Continued From page 27 susceptibility and tolerance of the individual)..." *A Stage 3 pressure ulcer is a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. A stage 3 pressure ulcer may include undermining or tunneling. (National Pressure Ulcer Advisory Panel)	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323	F 323 1. Each of the three dryers were cleaned on 2/8/17. 2. Each resident in the center has the potential to be affected. 3. The Laundry Personnel have been in-serviced on cleaning and documenting cleaning. The Laundry Personnel will maintain a cleaning log for each dryer. The dryer's lint trap will be cleaned after every hour, or as necessary. The Laundry Supervisor will review the dryer cleaning logs for completeness and accuracy three times per week. The Maintenance Director or Maintenance Assistant will inspect / clean / document the tops and backs of the dryers weekly, or as needed. Newly hired Laundry Staff will be educated during their orientation period on cleaning and documenting cleaning.	

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F 323	Continued From page 28 by: Based on observations and staff interviews the facility staff failed to maintain an environment as free of accident hazards as is possible. The facility staff failed to ensure large amounts of lint did not accumulate in 3 of 3 laundry dryers, creating a potential for a dryer fire. The findings included; Environmental Observations were conducted on 2/8/17 at approximately 4:50 p.m. of the facility's laundry with the Maintenance Director. A large amount of lint was observed throughout the washer/dryer room and in the one vent above the washers. There were 3 dryers in the washer/dryer room and neither was in the on position during the inspection. The first dryer, located beside the exit door which lead to the folding room was lukewarm, and without laundry inside. A large amount of a brownish material which had at some point melted was observed in the dryer. The Maintenance Director opened the lower compartment of dryer #1 to view the dryer filter. The filter was totally covered with thick lint and an additional large amount of lint was observed on the floor in the rear of the lint filter compartment. Items were observed in the second dryer but it was cold to touch. The Maintenance Director opened the lower compartment of dryer #2 to view the dryer filter and it too was completely covered with heavy lint. The floor of the lint compartment and the rear was much like dryer #1, filled with a large amount of lint. Dryer #3	F 323	4. Results of audits will be presented in the center's QAPI (Quality Assurance Performance Improvement Committee monthly for a minimum of three months for review and recommendations from the QAPI Committee to assure compliance is sustained ongoing. 5, The corrective action will be completed on March 16,2017	

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contained no items. The Maintenance Director opened the lower compartment to discover it was also covered with thick lint and the rear of the lint filter compartment and floor were covered with additional lint. The Maintenance Director was observed with an extremely large amount of lint on his clothing after climbing in the dryer filter compartments to remove excess lint.

A note was observed posted in the washer/dryer room which read; clean the lint filter after each load of laundry.

The Maintenance Director was interviewed as the environmental observation was conducted. The above problems were identified and he stated he would talk with the Housekeeping Director regarding the schedule for cleaning the laundry dyer's lint filters.

The Maintenance Director provided a document titled "HealthCare Services Group, INC. Laundry Inservice" dated 1/1/2000. It read on page 5 - 40 under the highlighted Dryer section that; "Lint screens must be cleaned every 2 - 3 loads. The bottom of the dryers must also be lint free. The drums of each dryer should be cleaned after each load to prevent any type of trash or lint from heating up and melting to the inside. Remember; the inside of each drum is coated with a non-stick that should not be scraped or scratched. The area between the drum and walls of the dryers should be blown clean of lint on a regular basis. The area at the top of the dryers by the control panel and around the pilot should be kept free of lint at all times. The area behind the dryers as

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well as the vent work coming from the dryers should be kept lint free. Always document the dryer cleaning."

The daily lint trap cleaning logs from 1/1/2017 to 2/8/17, was signed off every hour each day from 5:00 a.m. to 12:00 a.m. except there were no signatures from 12:00 p.m. through 1:00 p.m. and 11:00 p.m. -12:00 a.m.

The above findings were shared with the Executive Director and the Director of Nursing on 2/9/17 at approximately 3:10 p.m. The Executive Director stated the Maintenance Director had shared the information and staff was currently working on correcting the identified problems.

Dryer safety tips: Clothes dryers accounted for 92% of the fires; washing machines 4%, and washer and dryer combinations accounted for 4%. The leading cause of home clothes dryer and washer fires was failure to clean (32%), followed by unclassified mechanical failure or malfunction (22%). Eight percent were caused by some type of electrical failure or malfunction. The leading cause of home clothes dryer and washer fires is failure to clean them. Do not use the dryer without a lint filter. Make sure you clean the lint filter before or after each load of laundry. Remove lint that has collected around the drum. Rigid or flexible metal venting material should be used to sustain proper air flow and drying time. Make sure the air exhaust vent pipe is not restricted and the outdoor vent flap will open when the dryer is operating. Once a year, or more often if you notice that it is taking longer than normal for your clothes to dry, clean lint out of the vent pipe or

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F 323	Continued From page 31 have a dryer lint removal service do it for you. Follow the manufacturer's operating instructions and don't overload your dryer. Turn the dryer off if you leave home or when you go to bed. (http://www.nfpa.org/public-education/by-topic/safety-in-the-home/dryers-and-washing-machines)	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	F431 1. The vial of ppd in Homer Hall's medication room refrigerator was discarded on 2/7/17. 2. Residents residing in the center have been identified as having the potential to be affected. 3. The Staff Development Coordinator (SDC) will in-service License Nurses to date medication upon opening. Newly hired Licensed Nurses will be educated to date medication upon opening. 4. Unit Managers will audit medication refrigerators, medication rooms, and medication carts weekly for twelve weeks to validate medications are dated and labeled appropriately. Results of the audits will be presented to the Quality Assurance and Performance Improvement Committee monthly for three months for review and recommendations to assure compliance is sustained ongoing. 5, The corrective action will be completed on March 16,2017	

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professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on general observations of the nursing facility, the facility failed to ensure medications were labeled in accordance with currently accepted professional principles in 1 out of 3 facility medication refrigerators.

The Homer Unit's medication refrigerator possessed 1 unlabeled vial of (Purified Protein Derivative) PPD-Aplisol.

The findings include:

On 2/7/17 at 1:25 p.m., during inspection of the medication rooms, on the Homer Hall, 1 unlabeled vial of multidose (Purified Protein Derivative) PPD-Aplisol (for tuberculosis testing)

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was identified in the medication refrigerator. The vial was in use and half full. The Licensed Practical Nurse (LPN) #6 stated the vial should have been labeled and dated once it was opened. She stated the medication would have been good for 28-30 days. She stated an audit had been recently completed and the identified vial without a date was missed and would be thrown away.

On 2/7/17 at 1:35 p.m., the Unit Manager of Homer Hall came to the unit with a bag of PPD vials and stated, "When they open a vial, they have to date. If open with no date, they are to be discarded in the sharps container."

On 2/8/17 at 11:40 a.m., the Director of Nursing (DON) was asked what the facility's process was for labeling and dating opened vials. The DON responded vials were to be labeled and dated once opened and depending on the manufacturers recommendations, either refrigerated or place in the medication cart. She added if a vial is found without a date, it should have been thrown out because there would be no way to determine expiration of the drug.

The facility's policy and procedure titled "Medication Management" dated 8/31/14 indicated medications and treatment supplies are not used beyond their expiration dates and are to be discarded by the expiration date unless indicated by the pharmacy and/or manufacturer's instructions to discard sooner.

The professional standard from Drug Inserts.com indicated Aplisol vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.

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F 465 SS=F	Continued From page 34 483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility staff failed to maintain a safe, clean and sanitary environment. The findings included: During the Environmental Observations conducted on 2/8/17 at 4:00 p.m., the facility staff failed to maintain the facility in a safe, functional and sanitary condition. During observations on the grounds of the facility missing tiles were observed at the bottom of the front entrance ramp and one ramp tile on the right corner as one enters the facility was loose and elevated above the others. In the area outside the Fine Hall dining room at the end of the side walk was an inoperable heating unit, a Geri-chair, a big television, a card board box filled with discarded Christmas items, a five drawer file cabinet and 3 black rubber gripped rugs. The Maintenance Director stated the items were no longer usable and the site they were located in was considered	F 465 F 465	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 465 1. The tile on the front entry ramp was repaired on 2/8/17. The area outside the Fine Hall Dining Room was cleaned on 2/8/17. Environmental Room window was secured on 2/10/17. Outside the Rehab Gym, the landscape timbers were removed on 2/27/17, planter box was removed on 2/27/17, lattice fence was repaired on 3/1/17 Broken laundry cart was removed on 2/21/17. Broken fence gate was removed on3/2/17. Outside the Fine Hall End Exit, cigarette butts were cleaned up on 2/10/17. The electrical box was fixed on 2/8/17. Five pallets were removed outside the Fine Hall bathroom on 2/8/17. The concrete blocks were removed outside the Holmes Hall exit door on 2/27/17. The screen outside the SDC office was repaired on 2/8/17. The snow shovel was removed behind the generator on 2/9/17. Cigarette butts were cleaned up outside the Holmes Hall exit door on 2/21/17. The main dining room, behind the ice machine, was cleaned on 2/10/17 with the small	

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	495241	A. BUILDING _____ B. WING _____	C 02/09/2017

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F 465	Continued From page 35 "the junk pickup area". As one faced the outside exit door leading to Fine Hall and outside the dining area window was another area of unusable items, which included 5 pallets, discarded rubber rugs, many opened sugar substitute papers lying on the ground, a pile of leaves and plastic wrap. A bottle of (name of floor restorer) was observed sitting outside on the environmental room window sill and the environmental room window was able to be opened from the outside allowing anyone desiring to enter the building. Outside the rehabilitation gym was a garden and sitting area the Maintenance Director stated is utilized by rehab residents accompanied by the rehab staff. All of the landscape timbers were with rot as well as one planter box which was missing on-third of the sides, the lattice fence adjoining the neighbor's property was broken and falling down. A broken laundry cart was observed outside the physical therapy equipment storage and a broken fence gate was observed outside the Staff Development Coordinator's (SDC) office as well as the screen was off the window SDC office and leaning against the building. Outside the exit door at the back of Fine Hall was many cigarette butts discarded on the ground, an electrical box with a broken front cover. Five pallets were observed on the ground outside the Fine Hall staff bathroom. Continuing on the outside grounds, broken concrete blocks were observed outside the Holmes Hall exit door, a snow shovel and debris was observed against a window behind the generator and countless cigarette butts surrounded and expanded beyond the generator. The indoor Environmental Observations began on	F 465	wood blocks removed on 2/9/17. The suction machine in the dining room was cleaned and inspected on 2/8/17. The eight foot plastic table in the dining room was removed on 2/8/17. The areas that were chipped in the dining room were painted on 3/3/17. The stained and broken ceiling tiles on Fine Hall were replaced on 3/9/17/17. The Fine Hall ice machine room and ice machine were cleaned on 3/1/17. The ceiling tile next to the sky light on Fine Hall was replaced on 3/3/17. The Hopper Room on Fine Hall was cleaned on 2/28/17. The Fine Hall resident refrigerator was cleaned and defrosted on 2/10/17 with items discarded as needed. The wall cabinet in the Homer Hall Spa was removed on 3/3/17. The resident refrigerator on Holmes Hall was replaced on 2/9/17. The Homer Hall Soiled Utility Room and sink were cleaned on 2/9/17. The holes in the laundry room walls were repaired on 2/21/17. The refrigerator on Holmes Hall was cleaned and defrosted on 2/9/17 with items discarded as needed. The curtains in rooms 312, 313, 245, 237. 236, 231, 247, 251, 252, 256 will be replaced on 3/10/17. The dresser in 312 was replaced on 2/28/17. 2. Each resident in the center has been identified as having the potential to be affected.	

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F 465	Continued From page 36 2/8/17 at approximately 4:35 p.m., in the Main Dining room. Behind the soft drink machine was the ice machine drains. The drain pipe was supported by two small blocks of wood and a large amount of a black substance was observed hanging from the drainage pipe and splashed around on the floor with paper particles. Beneath the storage cabinet which held the ice machine was also dust, dirt and debris. In the distant corner opposite the storage cabinet was an uncovered suction machine with a large amount of dust on it and a label stating last inspection date. March 2014, next inspection due March 2015. Beside the suction machine was a large white portable table which could seat approximately 8 persons, the center was contorted and with sharp plastic two-thirds the length of the table. Throughout the dining room was chipped paint which the Maintenance Director felt was caused by placing the chairs too close to the walls. The Fine Hall ceiling between the environmental and television room was with stained and broken ceiling tiles. In the ice machine room dust and debris were observed on the ice machine. The ceiling beside the sky light next to the SDC office and the utility room was observed with strained and bulging ceiling tiles and the hopper was with stains and debris and dirty used gloves were observed on the floor. The Fine Hall resident refrigerator had a large amount of ice in the freezer and two boxes containing food items were frozen to the ice. There was a cup of (name of fast food restaurant) chili, a ketchup bottle without top, hot pockets sandwiches, and many other food items wrapped and without names or dates. There were 3 items	F 465	3. Staff was in-serviced to complete work orders when repairs are indicated. Staff was educated not to place trash, debris, broken equipment and cigarette butts on the exterior grounds. Maintenance Director and Maintenance Assistant were educated to check window screens to validate they are properly secured quarterly and after hurricanes or severe inclement weather. Maintenance Director and Maintenance Assistant educated to inspect landscaping materials quarterly and after hurricanes or severe inclement weather. Maintenance Director and Maintenance Assistant educated to inspect ice drains monthly. Maintenance Director and Maintenance Assistant educated to inspect equipment per preventative maintenance policies. Maintenance Director and Maintenance Assistant educated to conduct walk through of common areas including ice rooms, hopper rooms, shower rooms, laundry room, utility rooms and hallways monthly to identify chipped paint and walls in need of repair. Maintenance Director and Maintenance Assistant educated to conduct walk through of common areas and hallways monthly to identify ceiling tiles in need of replacing or repairing. Housekeeping Manager educated to conduct walk through of common areas, ice rooms, hopper rooms, shower rooms, laundry room, utility rooms and hallways weekly to	

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

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F 465	Continued From page 37 labeled with a resident's name but no date. On the Homer Unit was an unlocked spa shower room. In the wall cabinet with lock ability but without a lock was 1 opened container of shaving cream, 6 new containers of shaving cream, a 28 ounce bottle of moisturizing body lotion without a top, an opened barrier cream, 1 opened bottle of mouth wash and an emesis basin containing two disposable razors. The refrigerator on the Homer Unit designated for resident use contained thickened liquids, snacks from the facility's kitchen and many items without names or dates. On the bottom of the refrigerator was a brown spill, in the doorway of the refrigerator was an opened container of milk without a date and on the shelf of the refrigerator was an opened container of applesauce without a date. The molding around the refrigerator was with a brown and black substance and torn. The soiled utility room sink was with debris and brown discoloration and a large sticky yellow substance was on the floor next to the trash can. Multiple large holes were observed in the walls of the washer and dryer room above the thermostat, near the exit to leading into the area where laundry is folded and sorted. A very large area behind the washers was partially demolished down to the 2 by 4 studs. The Holmes Unit refrigerator was with a large amount of ice in the freezer and many undated/unnamed food items. The following rooms were observed with window drapery falling from the window; 312, 313, 245,	F 465	identify areas in need of additional cleaning. Unit Managers educated to check refrigerators for cleanliness and proper dating of food weekly. Unit Managers educated to check shower rooms / spas weekly to validate items are stored properly. Maintenance Director and Maintenance Assistant educated to observe window drapery weekly to validate drapery is properly hung. 4. Results of observation audits will be presented in the center's QAPI Committee monthly for a minimum of three months for review and recommendations from the QAPI Committee to assure compliance is sustained ongoing. 5, The corrective action will be completed on March 16,2017	

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F 465	Continued From page 38 237, 236, 231, 247, 251, 252, 252 and 256. The dresser in room 312 was falling apart and with many scrapes. The Maintenance Director stated it needed to be replaced. The Maintenance Director was interviewed as the environmental observation was conducted. The above problems were identified and he stated it was his responsibility as well as the Housekeeping Director's to maintain the facility's environment. Small repairs were completed during the week through or delegated to other employees as the observations continued. The above findings were shared with the Executive Director and the Director of Nursing on 2/9/17 at approximately 3:10 p.m. The Executive Director stated the Maintenance Director had shared the information and staff was currently working on correcting the identified problems.	F 465	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (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	F 514	F 514 1. Resident #16 physician's orders were clarified to discontinue inspecting the dialysis site to the right upper chest every shift for signs and symptoms of infection, bleeding, swelling, bruising, or warmth. 2. Residents with dialysis sites have been identified as having the potential to be affected and have had their care plans and physician's orders reviewed and updated as needed.	

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F 514	Continued From page 39 (iv) Systematically organized (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 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 staff interviews, observation and clinical record review the facility staff failed to ensure the medical record was accurate for 1 of 26 residents in the survey sample, Resident #16. The Treatment Administration Records (TARs) for January 2017 and February 2017 were inaccurate for Resident #16. An entry on the TARs with a start date of 3/3/16 instructed the staff to inspect dialysis site to right upper chest every shift for signs and symptoms of infection, bleeding, swelling, bruising, or warmth. The staff had been initialing each shift as inspecting the dialysis site. Further investigation evidenced there was no dialysis site to the resident's right chest. The findings included:	F 514	3. SDC (Staff Development Coordinator) will educate the Licensed Nurses on clarifying physician's orders as needed. Residents who receive dialysis will have their physician's orders audited for accuracy and completeness weekly for three months. During their orientation, newly hired Licensed Nurses will be educated on clarifying physician's orders as needed. 4. Results of audits will be presented in the center's QAPI Committee monthly for a minimum of three months for review and recommendations from the QAPI Committee to assure compliance is sustained ongoing. 5, The corrective action will be completed on March 16,2017	

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F 514	Continued From page 40	F 514		

Resident #16 was admitted to the facility on 1/26/15 with diagnosis to include end stage renal disease. The resident was receiving hemodialysis (1) treatments three times a week on Mondays, Wednesdays and Fridays.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 11/3/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status. The resident was coded as receiving dialysis treatments.

Physician orders read, in part: Inspect dialysis site to LUE (left upper extremity) every shift for signs and symptoms of infection, bleeding, swelling, bruising, or warmth every shift. Inspect LUE fistula for thrill and vibration every shift. Order date 3/1/16.

The TARs for January and February 2017 contained two entries for inspecting dialysis sites.
1. Start date 3/3/16- Inspect dialysis site to R (right) upper chest every shift for signs and symptoms of infection, bleeding, swelling, bruising, or warmth.
2. Start date 3/1/16-Inspect LUE fistula for thrill or vibration every shift.

The staff had been initialing each shift as inspecting both dialysis sites. Further investigation evidenced there was no dialysis site to the resident's right chest.

On 2/9/17 at 3:15 p.m., licensed practical nurse (LPN #1) accompanied this inspector into the resident's room. The resident was observed to have a dressing over the AV fistula site to the left

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F 514	Continued From page 41	F 514		

upper arm. The resident's chest wall did not have a dialysis (catheter) site. The nurse stated she used to be a dialysis nurse and the catheters on the chest (Udall) are for short term use, generally used for two weeks. The nurse stated she has taken care of the resident previously and did not recall him having a dialysis catheter to the chest wall.

On 2/9/17 at 5:45 p.m., the Homer unit manager was interviewed. The above findings was shared. The February TAR was reviewed for the dialysis site entries. She stated the nurses were checking both entries as having assessed both sites. She stated the nurse staff should have corrected the entry and discontinued the one for the right upper chest dialysis site as the resident did no longer have it. The unit manager could not locate in the electronic record when the dialysis chest catheter had been discontinued.

The above findings was shared during the pre-exit meeting conducted on 2/9/17 at 3:50 p.m. with the Administrator and the Director of Nursing (DON).

Definitions:

(1) Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.

The type of access a person has is important for getting the best dialysis possible. There are three types of access: catheter, arteriovenous (AV)

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F 514	Continued From page 42 graft and arteriovenous (AV) fistula. Catheter for hemodialysis: For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access. https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301	F 514		