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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 02/26/18 through 03/1/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.**	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/26/18 through 03/01/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 137 certified bed facility was 121 at the time of the survey. The survey sample consisted of 24 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	F 550	F 550 Resident Rights/Exercise of Rights 1. For Resident #17, the Foley catheter bag was covered during the survey. 2. Residents that currently reside in the center with Foley catheters have the potential to be affected. Observations have been conducted by the Director of Nursing (DON)/ Designee to ensure that residents residing in the facility with Foley catheters have their drainage bags covered. 3. In-Servicing has been conducted with current nursing employees by the DON/ Designee regarding ensuring that Foley catheter bags are covered for residents with Foley catheters. Observations will be conducted by the DON/Designee (5) five times/week for (3) three months for residents with Foley catheters to ensure that Foley catheter bags are covered.	04/04/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	03/26/18

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

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F 550	Continued From page 1 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. §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 and facility document review the facility staff failed to ensure catheter bag was covered for 1 of 27 Residents, #17. The findings included: For Resident #17 the facility staff failed to ensure Foley catheter bag was covered. Resident #17 was admitted to the facility on 02/28/15 and readmitted on 08/21/16. Diagnoses included but not limited to anemia, hypertension, neurogenic bladder, urinary tract infection, diabetes mellitus, Alzheimer's disease, dementia, anxiety, depression and chronic kidney disease.	F 550	4. The results of the observations will be discussed by the Administrator/Designee at the Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for three months. The Interdisciplinary team (IDT) will recommend revisions to the plan as indicated to sustain substantial compliance. 5. 04/04/2018	

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F 550	Continued From page 2 The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/13/18 coded the Resident as 8 of 15 in section C, cognitive patterns. This is a significant change MDS. Surveyor observed Resident #17 on 02/27/18 at approximately 1005. Resident was up in wheelchair, seated in the dining room. The Resident's Foley catheter drainage bag was attached to the side of wheelchair and was not covered with a privacy cover. Surveyor observed Resident #17 again on 02/27/18 at approximately 1530. Resident was seated in day room, in wheelchair. Foley catheter drainage bag was attached to side of wheelchair and was not covered with a privacy cover. The surveyor spoke with the DON (director of nursing) on 02/28/18 at approximately 0815 regarding Resident #17. DON stated that the Resident's catheter bag should have been covered. The concern of the Foley catheter bag not being covered with a privacy cover was discussed with the administrative team during a meeting on 02/28/18 at approximately . No further information was provided prior to exit.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of	F 565	F 565 Resident/Family Group and Response 1. A resident council meeting has been conducted on or before 04/04/2018 in which follow-up was communicated to the resident council regarding grievances. The change to the process for resident council was also communicated to the council by the Administrator/Designee.	04/04/18

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F 565	Continued From page 3 upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This Requirement is not met as evidenced by: Based on resident council group interview, staff interview and resident council group minutes review it was determined the facility staff failed to follow up and communicate a response to resident council grievances during subsequent meetings of the council. The Findings Included: On February 28, 2018, at 1:50 p.m. the surveyor reviewed the Resident Group Council minutes.	F 565	2. Residents that reside in the facility have the potential to be affected. A resident council meeting has been conducted on or before 04/04/2018 in which follow-up was communicated to the resident council regarding grievances. The change to the process for resident council was also communicated to the council by the Administrator/Designee. 3. In-servicing has been provided to the IDT by the Administrator/Designee on or before 04/04/2018 regarding the regulatory requirements for resident council committee. The Resident Council Committee meeting minutes will be reviewed by the Administrator/ Designee to ensure that follow-up response to grievances is communicated to the council and documented each month. 4. Results of the review will be discussed by the Administrator/Designee at the QAPI meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated to sustain substantial compliance. 5. 04/04/18	

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F 565	Continued From page 4 The surveyor reviewed the Resident Group Council minutes from December 6, 2017, December 13, 2017, January 3, 2018 and February 7, 2018. The surveyor noted that "Old Business/Follow-Up" was not addressed/documented on the subsequent Resident Council Group meeting minutes. The Notes read in part ... "12/6/17 Old Business/Follow up- NA. Concerns 1. Room 216 Hole in Ceiling. 2. Staff not knocking before entering room. 3. Residents going into room and going through drawers. 4. Family members not knocking when entering." "12/13/17 Old Business/Follow up (name of resident withheld) pants were found. Concerns ..." No concerns were listed/documented. No follow up of the previous Resident Council meeting 12/6/17 concerns/grievances were addressed/documented. "1/3/18" No old business/follow up was documented, additionally no concerns were documented. "2/7/18 Old Business/Follow up (name of Resident withheld) concern resolved. New resident council members (name of resident withheld) President, (name of Resident withheld) Vice President, Secretary (name of resident withheld). Concerns 1. (name of resident withheld) needs bigger shoes" (sic) On February 28, 2018 at 2 p.m. the surveyor conducted the Resident Council Group meeting with 6 alert and oriented Resident's. The surveyor asked what happened when the Resident Council Group voiced grievances/concerns during the meeting. The group stated that the Activities Director (AD) sat in on the Resident Council Group meeting and took notes. When asked specifically if follow up	F 565		

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F 565	Continued From page 5 was ever discussed or addressed with the Resident Council on the subsequent meetings, the Resident Group stated, "No." On March 1, 2018 at 8 a.m. the surveyor notified the Director of Nursing (DON) that the facility had not follow up with the Resident Council on the previous Resident Council voiced grievances/concerns. The surveyor reviewed the Resident Council meeting minutes with the DON. The surveyor pointed out that the facility had not addressed the grievances voiced during the Resident Council meetings. On March 1, 2018 at 9:45 a.m. the survey team met with the Administrator (Adm), DON, Regional Minimum Data Set (MDS) Nurse, the Corporate Compliance Nurse (CCN) and New Administrator. The surveyor notified the Administrative Team (AT) that the facility did not follow up with voiced Resident Council Group grievances/concerns. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow up with the Resident Council Group meeting grievances/concerns.	F 565		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain admission orders for 1 of 27 residents in the survey sample (Resident #378). The findings included:	F 635	F 635 Admission Physician Orders for Immediate Care 1. For Resident #378, the medical record and orders have been reviewed by the physician on or before 04/04/2018. 2. Residents that are newly admitted or readmitted to the facility have the potential to be affected. Residents that currently reside in the facility that have been admitted/readmitted in the previous (30) thirty days have had their medical record reviewed by the DON/Designee to ensure that admission orders were obtained upon admission/readmission.	04/04/18

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F 635	Continued From page 6 Resident #378 was readmitted to the facility on 2/24/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, atrial fibrillation, high blood pressure, peripheral vascular disease and chronic obstructive pulmonary disease. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey. The resident was alert to person, place and time and did require extensive assistance of 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #378 on 2/28/18 and 3/1/18. The surveyor noted that there were no physician orders signed or given to staff as a verbal telephone order when the resident was readmitted to the facility on 2/24/18. However, the resident's medications had been reordered and given to the resident as written on the discharge summary from the hospital on 2/24/18. The surveyor notified the director of nursing of the above documented findings on 3/1/18 at approximately 1:30 pm. The director of nursing reviewed the clinical record of the resident and stated, "You are correct in saying there were no admission orders from the MD (medical doctor). I could not find any either. The nurses' should had called the physician and obtained a verbal order from the MD for the resident's care. They didn't do this." The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 3/1/18.	F 635	3. In-servicing has been provided to Licensed Nurses by the DON/Designee on or before 04/04/18 regarding obtaining admission/ readmission orders appropriately. The DON/ Designee will conduct a review for (5) five new admits/readmits per week for (3) three months to ensure that admission/readmission orders have been obtained appropriately upon admission/readmission. 4. The results of the reviews will be discussed by the Administrator/Designee at the QAPI committee meeting monthly for (3) months. The IDT Committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. 04/04/18	

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F 641 SS=E	Continued From page 7 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure accurate MDS (minimum data set) assessments for four of 27 Residents, Residents #32, #33, #41, and #71. The findings included. 1. For Resident #32, the facility staff coded the Resident was a weight gain when in fact she was a weight loss. The record review revealed that Resident #32 had been readmitted to the facility 11/17/17. Diagnoses included, but were not limited to, neurogenic bladder, metabolic encephalopathy, pain, Alzheimer's disease, diabetes, hypothyroidism, and hypertension. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/04/17 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section K (swallowing/nutritional status) had been coded to indicate the Resident was 64 inches tall, weighed 109 pounds and was a weight gain. A review of the Residents MDS assessments revealed the following. Significant change MDS assessment with an ARD of 03/08/17 weight 122 pounds. Quarterly assessment with an ARD of	F 641 F 641	F 641 Accuracy of Assessments 1. For Resident #32, a modification was completed for the assessment with Assessment Reference Date 12/04/17 for Section K. For Resident #33, a modification was completed for the assessment with Assessment Reference Date 12/05/17 for Section K. For Resident #41, a modification was completed for the assessment with Assessment Reference Date 01/03/18 for Section K. For Resident #71, a modification was completed by the Minimum Data Set (MDS) Coordinator for the assessment with Assessment Reference Date 01/24/18 for Section I, to include the urinary tract infection. 2. For current residents residing in the facility, the most recent MDS assessment has been reviewed on or before 04/04/2018 by the Administrator/Designee to ensure that Section K and Section I are accurately coded. 3. In-servicing has been completed by the Administrator/Designee with the current MDS Coordinators regarding accurately coding Section I and Section K. A review will be completed by the Administrator/Designee for (5) five MDS assessments per week for (3) months to ensure that Section I and Section K have been coded accurately. 4. Results of the reviews will be discussed by the Administrator/Designee at the QAPI meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated to sustain substantial compliance. 5. 04/04/18	04/04/18

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F 641	Continued From page 8 06/05/17 weight 127 pounds. Quarterly assessment with an ARD of 09/04/17 weight 107 pounds. On 02/27/18, the food service manager and dietician provided the surveyor with a copy of the Residents weights with the following weights circled. 02/03/17 weight 122 03/03/17 weight 114 05/19/17 weight 127 07/06/17 weight 112 09/04/17 weight 107 11/01/17 weight 105.20 12/01/17 weight 109 After reviewing the Residents weights, the food service manager verbalized to the surveyor that the MDS assessment for 12/04/17 should have been coded as a weight loss. The administrative staff were notified of the inaccurate MDS assessment during a meeting with the survey team on 02/28/17 at 1:34 p.m. and again on 03/01/17 at 4:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #33 the facility staff failed to ensure a complete and accurate Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/05/17. The facility staff failed to accurately code a significant weight loss in Section K. Resident #33 was a 92 year old female who was admitted on 9/18/17. Admitting diagnoses included, but were not limited to: encephalopathy, atrial fibrillation, hypertension, muscle weakness,	F 641		

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F 641	Continued From page 9	F 641		

dementia without behaviors, gout and anxiety.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS with an Assessment Reference Date (ARD) of 12/27/17. The facility staff coded that Resident #33 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #33 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section K. Swallowing and Nutritional Status, the facility staff coded that Resident #33 weighed 169 pounds. Resident #33 was not documented as having a Significant Weight loss.

On February 27, 2018 at 1 p.m., the surveyor reviewed Resident #33's clinical record. Review of the clinical record produced Resident #33's weights since admission. Resident #33 weight was documented as weighing 198 pounds on admission. The surveyor calculated that Resident #33 had a 14.65% weight loss from 9/18/17 through 12/05/17. The surveyor requested to speak with the MDS Nurse.

On February 27, 2018 at 3:45 p.m. the MDS Nurse, who was a Registered Nurse, approached the surveyor. The surveyor notified the MDS Nurse that Resident #33 was admitted weighing 198 pounds and that on 12/5/17 Resident #33's weight was 169 pounds. The surveyor notified the MDS Nurse that Resident #33 had a Significant Weight loss of 14.65% during the time frame of 9/18/17 through 12/5/17. The surveyor notified the MDS Nurse that a Significant Change MDS was done on 12/5/17 and that the MDS did not capture/code Resident #33's Significant Weight loss of 14.64%. The MDS Nurse and surveyor reviewed Resident #33's weights and the Significant Change MDS with the ARD of

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F 641	Continued From page 10	F 641		

12/5/17. The surveyor pointed out that the MDS did not capture Resident #33's Significant Weight loss. The MDS Nurse stated that the dietary manager completed Section K of the MDS. The MDS Nurse stated that the Significant Change MDS with the ARD of 12/5/17 should have been coded to reflect Resident #33's Significant Weight loss.

On February 27, 2018 at 4:30 p.m., the surveyor notified the Administrator (Adm), Director of Nursing (DON) and ADON that Resident #33 was receiving Coumadin every day. The surveyor notified the Administrative Team (AT) that Resident #33 had a Significant Weight loss from 9/18/17 through 12/5/17. The surveyor notified the AT that the Significant Weight loss was not coded/captured on the Significant Change MDS with the ARD of 12/5/17.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #33.

3. For Resident #41 the facility staff failed to ensure a complete and accurate Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/3/18. The facility staff inaccurately coded that Resident #41 had a Significant Weight loss in Section K.

Resident #41 was a 93 year old female who was admitted on 8/19/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypertension, major depression, anxiety, Alzheimer's, chronic kidney disease and adult failure to thrive.

The most current MDS located in the clinical

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record was an Annual MDS assessment with an ARD of 1/3/18. The facility staff coded that Resident #41 had a Cognitive Summary Score of 6. The facility staff also coded that Resident #41 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section K. Swallowing and Nutritional Status, the facility staff coded that Resident #41 weighed 113 pounds. The facility staff additionally coded that Resident #41 had a Significant Weight loss of 5% in the past 30 days or 10% in the past 6 months.

On February 27, 2018 at 4 p.m., the surveyor reviewed Resident #41's clinical record. Review of the clinical record produced documents that identified that Resident #41 was receiving Comfort Care. Comfort Care measures initiated on 1/4/16 and identified that the family wanted to "discontinue all weights."

Further review of the clinical record documented that Resident #41's weight was obtained on 12/3/15 and was 113. No weights had been obtained since 12/3/15. The surveyor requested the MDS Nurse to come and speak with the surveyor about Resident #41.

On February 27, 2018 at 6 p.m. a MDS Nurse, who was a Licensed Practical Nurse (LPN), came and spoke with the surveyor. The surveyor notified the MDS Nurse (LPN) that Resident #41 was on Comfort Care and that weights had not been obtained since 12/3/15. The surveyor then notified the MDS Nurse (LPN) that an Annual MDS with an ARD of 1/3/18 was coded that Resident #41 had a Significant Weight loss. The surveyor reviewed Resident #41's clinical record with the MDS Nurse (LPN). The surveyor specifically reviewed Resident #41's comfort care orders, weights and the Annual MDS with the

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ARD of 1/3/18. The surveyor pointed out that Resident #41's MDS was inaccurately coded with a Significant Weight loss. The MDS Nurse (LPN) stated she did not complete Section K of the MDS. The MDS Nurse stated that the dietary manager completed Section K. The MDS Nurse (LPN) stated that the MDS was coded inaccurately as Resident #41 had not been weighed since 12/3/15.

On February 28, 2018 at 9:45 a.m., the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #41's Annual MDS with the ARD of 1/3/18 was inaccurate. The surveyor notified the Administrative Team (AT) that Resident #41 was on Comfort Care and that her weight had not been obtained since 12/3/15. The surveyor notified the AT that Resident #41's Annual MDS with the ARD of 1/3/18 was coded for a Significant Weight loss.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #41. The facility staff inaccurately coded that Resident #41 had a Significant weight loss on the Annual MDS assessment with the ARD of 1/3/18.

4. For Resident #71 the facility staff failed to ensure a complete and accurate Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/24/18. The facility staff failed to accurate code a Urinary Tract Infection in the last 30 days in Section I. Active Diagnoses.

Resident #71 was a 64 year old male who was originally admitted on 8/8/12 and readmitted on 1/20/18. Admitting diagnoses included, but were

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not limited to: cholecystitis, chronic kidney disease, hypertension and cerebrovascular accident with left hemiparesis.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 1/24/18. The facility staff coded that Resident #71 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #71 required extensive (3/2) assistance with Activities of Daily Living (ADL's). In Section I. Active Diagnoses, a Urinary Tract Infection in the last 30 days was not coded.

On February 27, 2018 at 12 noon, the surveyor interviewed Resident #71. Resident #71 informed the surveyor that he had recently been in the hospital with a urinary tract infection.

On February 27, 2018 at 1:20 p.m., the surveyor reviewed Resident #71 clinical record. Review of the clinical record produced nurses' notes that documented that Resident #71 had been ill and that the family requested that he be sent to a local hospital on 1/8/18.
Continued review of the clinical record revealed a Hospital Progress Note dated 1/17/18 that documented that Resident #71 had a "bacterial" urinary tract infection associated with an indwelling urethral catheter. Resident #71 had a positive urinalysis and culture and sensitivity and was treated with Zosyn and Augmentin (antibiotics).

On February 27, 2018 at 1:45 p.m., the surveyor spoke with the MDS Nurse, who was a Licensed Practical Nurse (LPN). The surveyor notified the MDS Nurse (LPN) that Resident #71's Quarterly MDS with the ARD of 1/24/18 was incorrect. The

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surveyor reviewed Resident #71's clinical record with the MDS Nurse (LPN). The surveyor pointed out that Resident #71 had been ill and was sent to the hospital on 1/8/18. The surveyor then reviewed Resident #71's Hospital Progress Notes that documented a positive urinalysis and culture and sensitivity, treatment with antibiotics and a physician diagnosis of a urinary tract infection. The surveyor then reviewed the Quarterly MDS with the MDS Nurse (LPN). The surveyor pointed out that Section I did not code/capture a urinary tract infection in the past 30 days. The MDS Nurse (LPN) stated that she would look into the matter. The surveyor requested the MDS Nurse to obtain the Resident Assessment Instructions (RAI) manual and bring the manual to the surveyor for review.

On February 27, 2018 at 3 p.m. a different MDS Nurse, a Registered Nurse (RN), approached the surveyor and informed the surveyor that she had never coded a urinary tract infection associated with a recent hospital admission. The surveyor informed the MDS Nurse (RN) that the lookback period for a urinary tract infection was 30 days and therefore if a Resident had a urinary tract infection within a 30 period of the MDS assessment it must be coded/captured regardless of it was during a hospital stay. The surveyor opened up the surveyor's copy of the RAI manual and reviewed the RAI guidelines for coding a urinary tract infection with the MDS Nurse (RN).

On February 28, 2018 at 9:45 a.m., the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #71's Quarterly MDS with the ARD of 1/24/18 was inaccurate. The surveyor notified the Administrative Team (AT) that Resident #71 had a urinary tract

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F 641	Continued From page 15 infection during his recent admission in the hospital (1/8/18 through 1/20/18). The surveyor notified the AT that the urinary tract infection should have been coded/captured on the MDS assessment with the ARD of 1/24/18. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #71. The facility staff failed to code/capture a urinary tract infection in the past 30 days.	F 641		
F 655 SS=E	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	F 655	F 655 Baseline Care Plan 1. Resident #386 no longer resides in the facility. Resident #26 no longer resides in the facility. Resident #172 no longer resides in the facility. For Resident #381, Resident #378, Resident #387 and Resident #124 the care plan has been presented to and reviewed with the resident or responsible party. 2. There has been a review conducted by the Administrator/Designee for current residents residing in the facility to ensure that baseline care plans have been initiated and provided/reviewed with the resident and/or responsible party. 3. In-servicing has been provided by the Administrator/Designee regarding the requirements for initiating a baseline care plan and presenting it to the resident or responsible party. A review will be completed by the Administrator/Designee for (5) five newly admitted/readmitted residents per week for (3) three months to ensure that the baseline care plan has been initiated and presented to the resident or the responsible party.	04/04/18

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F 655	Continued From page 16 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This Requirement is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review the facility staff failed to provide a written summary of the baseline care plan for 7 of 27 (Resident's #381, #386, #26, #378, #387, #124 and #172). The findings included: 1. The facility staff failed to provide the resident or representative with a baseline care plan when Resident #381 was admitted to the facility on 2/23/18. Resident #381 was admitted to the facility on 2/23/18 with the following diagnoses of, but limited to heart attack, high blood pressure, diabetes, congestive heart failure and generalized weakness. The resident did not have a completed MDS (Minimum Data Set) due to being admitted to the facility on 2/23/18. According to the nursing documentation at the	F 655	4. Results of the review will be discussed by the Administrator/Designee at the QAPI committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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time of admission, the resident was alert and oriented to person, place and time. The resident also required extensive assistance of 1 staff member for bathing.

The surveyor conducted a resident interview with Resident #381 on 2/27/18 at 2:39 pm. The surveyor asked the resident if she had been given a copy of the base line care plan when she was admitted on 2/23/18. The resident stated, "I don't remember them going over this with me last Friday when I came in."

The surveyor reviewed the clinical record of Resident #381 on 2/28/18. During this review, the surveyor noted that the baseline care plan was dated for 2/23/18. The baseline care plan was completed but on the last page of the care plan there were no signatures from the resident or representative stating they had received copies of the baseline care plan or that this care plan had been reviewed with them by the facility staff.

The surveyor notified the above documented findings to the director of nursing on 2/28/18 at approximately 1:30 pm. The director of nursing stated that she would find out if this care plan had been given to the resident or representative.

The surveyor notified the administrative team of the above documented findings on 2/28/18 at 1:40 pm. The director of nursing stated, "I have talked with staff and they did not go over the information on the baseline care plan with the resident or representative. They said they haven't started that yet."

At 4 pm, the director of nursing provided the surveyor with the facility's policy titled "Baseline Care Plan". Under the section of "Policy

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Explanation and Compliance Guidelines, the policy stated the following:

" ...4. A written summary of the baseline care plan shall be provided to the resident or representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following:

a. The initial goals of the resident.

b. A summary of the resident's medications and dietary instructions.

c. Any services and treatments to be administrated by the facility and personnel acting on behalf of the facility ..."

No further information was provided to the surveyor prior to the exit conference on 3/1/18.

2. The facility staff failed to provide a copy of the baseline care plan when Resident #386 was admitted to the facility on 2/23/18.

Resident #386 was admitted to the facility on 2/23/18 with the following diagnoses of, but not limited to chronic obstructive pulmonary disease and oxygen dependent. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey since the resident was admitted to the facility on 2/23/18. According to the admission assessment documentation, the resident was alert and oriented to person, place and time. The resident also required limited supervision of 1 staff member for bathing.

The surveyor conducted a resident interview with Resident #386 on 2/27/18. The surveyor asked the resident if he had received a copy of the baseline care plan when he was admitted to the facility on 2/23/18. The resident stated, "I don't

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remember getting anything on this when I was brought in last week."

The surveyor conducted a clinical record review of Resident #386's chart. The surveyor noted a baseline care plan dated for 2/23/18. The baseline care plan was completed but on the last page of the care plan there were no signatures from the resident or representative stating they had received copies of the baseline care plan or that this care plan had been reviewed with them by the facility staff.

The surveyor notified the above documented findings to the director of nursing on 2/28/18 at approximately 1:30 pm. The director of nursing stated that she would find out if this care plan had been given to the resident or representative.

The surveyor notified the administrative team of the above documented findings on 2/28/18 at 1:40 pm. The director of nursing stated, "I have talked with staff and they did not go over the information on the baseline care plan with the resident or representative. They said they haven't started that yet."

At 4 pm, the director of nursing provided the surveyor with the facility's policy titled "Baseline Care Plan". Under the section of "Policy Explanation and Compliance Guidelines, the policy stated the following:

"...4. A written summary of the baseline care plan shall be provided to the resident or representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following:

a. The initial goals of the resident.
b. A summary of the resident's

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F 655	Continued From page 20 medications and dietary instructions. c. Any services and treatments to be administrated by the facility and personnel acting on behalf of the facility ..." No further information was provided to the surveyor prior to the exit conference on 3/1/18. 3. The facility staff failed to provide copies of the baseline care plan to Resident #26 when the resident was admitted to the facility on 1/8/18. Resident #26 was admitted to the facility on 1/8/18 with the following diagnoses of, but not limited to dementia, Alzheimer's disease, high blood pressure, anxiety disorder, and major depressive disorder. Resident #26 was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of 15 on the admission MDS (Minimum Data Set). The resident was also coded as requiring extensive assistance of 1 staff member for personal hygiene and bathing. The surveyor conducted a representative interview due to the resident being confused and unable to answer questions on 2/28/18. The surveyor asked the representative for the resident if she remembered getting a copy of the base line care plan when the resident was admitted to the facility on 1/8/18. The representative stated, "I don't remember getting any copies of paper of what you have described. I know I had to sign a lot of papers when he was admitted." The surveyor conducted a clinical record review on Resident #26's clinical record. The surveyor could not find documentation of the facility staff explaining or provided the resident or representative a copy of the baseline care plan when the resident was admitted to the facility on	F 655		

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F 655	Continued From page 21 1/8/18. The surveyor notified the above documented findings to the director of nursing on 2/28/18 at approximately 1:30 pm. The director of nursing stated that she would find out if this care plan had been given to the resident or representative. The surveyor notified the administrative team of the above documented findings on 2/28/18 at 1:40 pm. The director of nursing stated, "I have talked with staff and they did not go over the information on the baseline care plan with the resident or representative. They said they haven't started that yet." At 4 pm, the director of nursing provided the surveyor with the facility's policy titled "Baseline Care Plan". Under the section of "Policy Explanation and Compliance Guidelines, the policy stated the following: " ...4. A written summary of the baseline care plan shall be provided to the resident or representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administrated by the facility and personnel acting on behalf of the facility ..." No further information was provided to the surveyor prior to the exit conference on 3/1/18. 4. The facility staff failed to provide a copy of the baseline care plan to the resident or representative when Resident #378 was	F 655		

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F 655	Continued From page 22 readmitted to the facility on 2/24/18. Resident #378 was readmitted to the facility on 2/24/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, atrial fibrillation, high blood pressure, peripheral vascular disease and chronic obstructive pulmonary disease. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey. The resident was alert to person, place and time and did require extensive assistance of 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #378 on 2/28/18 and 3/1/18. The surveyor could not find documentation of the facility staff explaining or provided the resident or representative a copy of the baseline care plan when the resident was admitted to the facility on 1/8/18. The surveyor notified the above documented findings to the director of nursing on 2/28/18 at approximately 1:30 pm. The director of nursing stated that she would find out if this care plan had been given to the resident or representative. The surveyor notified the administrative team of the above documented findings on 2/28/18 at 1:40 pm. The director of nursing stated, "I have talked with staff and they did not go over the information on the baseline care plan with the resident or representative. They said they haven't started that yet." At 4 pm, the director of nursing provided the surveyor with the facility's policy titled "Baseline Care Plan". Under the section of "Policy Explanation and Compliance Guidelines, the	F 655		

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F 655	Continued From page 23 policy stated the following: " ...4. A written summary of the baseline care plan shall be provided to the resident or representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. b.A summary of the resident's medications and dietary instructions. c.Any services and treatments to be administrated by the facility and personnel acting on behalf of the facility ..." No further information was provided to the surveyor prior to the exit conference on 3/1/18. 5. For Resident #387 the facility staff failed to provide the Resident/Resident representative with a written summary of the baseline care plan. Resident #387 was admitted to the facility on 02/16/18. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, osteoporosis, anxiety, depression and schizophrenia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/28/18 coded the Resident as 8 of 15 in section C, cognitive status. This is an admission MDS. The Resident's baseline care plan was reviewed on 02/27/18. The section of the care plan entitled "written summary" was blank. The care plan was dated as having been completed on 02/16/18 and dated as having been reviewed with the Resident on 02/19/18. Surveyor spoke with the Resident on 02/27/18 at	F 655		

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F 655	Continued From page 24 approximately 0900. Resident stated that she had not received a written summary of her baseline care plan. Surveyor spoke with the DON regarding the baseline care plan on 02/28/18 at approximately 1705. DON could not provide information as to whether or not the written summary had been provided to the Resident. The DON provided the surveyor with a policy entitled "Baseline Care Plan" which read in part "1. The baseline cafe plan will: a. Be developed within 48 hours of a Resident's admission." and 4. A written summary of the baseline care plan shall be provided to the Resident and representative in a language that the Resident/representative can understand". The concern of a written summary of the baseline care plan not being provided was discussed the administrative team during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit. 6. For Resident #124 the facility staff failed to provide a written summary of the baseline care plan to the Resident and/or representative. Resident #124 was admitted to the facility on 02/13/18. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, anxiety, schizoaffective disorder, attention deficit hyperactivity disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/22/18 coded the Resident as 13 of 15 in section C, cognitive patterns. This is an admission MDS.	F 655		

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F 655	Continued From page 25 The Resident's baseline care plan was reviewed on 02/27/18. The section of the care plan entitled "written summary" was blank. The care plan was dated as having been completed on 02/13/18 and dated as having been reviewed with the Resident on 02/16/18. Surveyor spoke with the Resident on 02/27/18 at approximately 0925. Resident stated that she had not received a written summary of her baseline care plan. Surveyor spoke with the DON regarding the baseline care plan on 02/28/18 at approximately 1705. DON could not provide information as to whether or not the written summary had been provided to the Resident. The DON provided the surveyor with a policy entitled "Baseline Care Plan" which read in part "1. The baseline cafe plan will: a. Be developed within 48 hours of a Resident's admission." and 4. A written summary of the baseline care plan shall be provided to the Resident and representative in a language that the Resident/representative can understand". The concern of a written summary of the baseline care plan not being provided was discussed the administrative team during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit. 7. For Resident #172, facility staff failed to initiate a baseline care plan, including the resident's goals for care, and share it with the resident. Resident #172 was admitted to the facility from home on 2/15/18. The admission Minimum Data Set assessment with assessment reference date 2/26/18 indicated the resident scored 15/15 on the brief interview for mental status and was	F 655		

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F 655	Continued From page 26 without symptoms of delusions, psychosis, or behavior affecting self or others. The resident was listed as the responsible party. The resident's diagnoses included hypertension, renal insufficiency, anthropophagi reflux disease, and diabetes mellitus. During an brief interview during the entrance tour on 2/26/18, the resident reported concerns with discharge planning, diabetes care, and therapy services. On 2/27/18, the surveyor conducted a more extensive interview with the resident. The resident reported agreeing to a family request that she enter the facility for a month to gain strength after a fall at home that resulted in an Emergency Department visit without an admission. The resident reported that, while therapy staff have discussed discharge goals, there seems to be little effort to assist with increasing walking strength. Therapy consists mainly of riding a stationary bicycle. An aid assisted with walking in the hall once at the resident's specific request. The resident was also concerned that the insulin and antianxiety medication orders had been changed without prior discussion. On 2/27/18, the surveyor spoke with the resident's nurse about the resident's concern. The nurse said that the resident was mistaken about short-term placement. The resident was admitted for long term care. The nurse reported that the resident's grandson had shown some of the staff pictures on a cell phone that precluded the resident being discharged to the home. The nurse did not know if Adult Protective Services had been contacted about the danger to the resident. On 02/27/18 11:46 AM, the care plan in the	F 655		

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F 655	Continued From page 27 electronic medical record was dated 2006. The baseline care plan was located and was incomplete and unsigned. The baseline care plan documented that the resident was to remain long term care. Sections addressing therapy, functional goals, psychosocial needs, discharge plans, barriers to resident's discharge goals, resident or caregiver educational needs, signatures of interdisciplinary team members contributing to the baseline care plan, and written summary of baseline care plan were blank. The final page stated that the incomplete, unsigned baseline care plan had been shared with the resident on 2/19/18. When asked why there was no summary of the care plan, the MDS coordinator reported that the resident did not want a summary. On 2/28/18, the surveyor reported the concerns with the incomplete plan of care and failure to address the resident's stated goals in the care plan and failure to provide summaries of the care plan to the resident and a representative.	F 655		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.	F 660	F 660 Discharge Planning Process 1. For Resident #172, discharge planning was initiated and the resident was discharged from the facility on 03/20/18. 2. Residents currently residing in the center have had their care plan reviewed on or before 04/04/18 for goals and discharge plans.	04/04/18

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F 660	Continued From page 28 (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized	F 660	3. In-servicing has been provided by the Administrator/Designee on or before 04/04/2018 to the IDT regarding initiation of discharge planning upon admission, initiation of a baseline care plan and presentation of the baseline care plan to the resident or responsible party. A review will be conducted by the Administrator/Designee for (5) five residents per week for (3) three months to ensure that discharge planning has been initiated upon admission/readmission, a baseline care plan has been initiated with appropriate goals and it has been presented to the resident or responsible party. 4. Results of the reviews will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 660	Continued From page 29 patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This Requirement is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide discharge planning for 1 of 27 Residents, #172. For Resident #172, facility staff failed to initiate a baseline care plan, including the resident's goals for care, and share it with the resident. Resident #172 was admitted to the facility from home on 2/15/18. The admission Minimum Data Set assessment with assessment reference date 2/26/18 indicated the resident scored 15/15 on the brief interview for mental status and was without symptoms of delusions, psychosis, or behavior affecting self or others. The resident was listed as the responsible party. The resident's diagnoses included hypertension, renal insufficiency, anthropophagi reflux disease, and diabetes mellitus. During an brief interview during the entrance tour on 2/26/18, the resident reported concerns with	F 660		

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F 660	Continued From page 30	F 660		

discharge planning, diabetes care, and therapy services. On 2/27/18, the surveyor conducted a more extensive interview with the resident. The resident reported agreeing to a family request that she enter the facility for a month to gain strength after a fall at home that resulted in an Emergency Department visit without an admission. The resident reported that, while therapy staff have discussed discharge goals, there seems to be little effort to assist with increasing walking strength. Therapy consists mainly of riding a stationary bicycle. An aid assisted with walking in the hall once at the resident's specific request. The resident was also concerned that the insulin and antianxiety medication orders had been changed without prior discussion.

On 2/27/18, the surveyor spoke with the resident's nurse about the resident's concern. The nurse said that the resident was mistaken about short-term placement. The resident was admitted for long term care. The nurse reported that the resident's grandson had shown some of the staff pictures on a cell phone that precluded the resident being discharged to the home. The nurse did not know if Adult Protective Services had been contacted about the danger to the resident.

On 02/27/18 11:46 AM, the care plan in the electronic medical record was dated 2006. The baseline care plan was located and was incomplete and unsigned. The baseline care plan documented that the resident was to remain long term care. Sections addressing therapy, functional goals, psychosocial needs, discharge plans, barriers to resident's discharge goals, resident or caregiver educational needs, signatures of interdisciplinary team members

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F 660	Continued From page 31 contributing to the baseline care plan, and written summary of baseline care plan were blank. The final page stated that the incomplete, unsigned baseline care plan had been shared with the resident on 2/19/18. When asked why there was no summary of the care plan, the MDS coordinator reported that the resident did not want a summary. The facility policy titled Discharge planning process indicated that discharge planning would begin on admission and that the resident's discharge goals would be included in the aseline care plan. 02/27/18 11:46 AM There appeared to have been some discussion of return to community. The social worker said there were pictures on a family member's phone which preclude return to the home. Also, the resident had not met the goals set to allow the resident to go home. Those goals would be available in therapy. There was no care plan at day 15 of the resident being held at the facility without a plan of care. On 03/01/18 02:18 PM the surveyor spoke with director of nursing about discharge planning. Requested a discharge planning policy and evidence that planning was occurring for the resident. The Director of nursing provided a copy of a notice card indicating a care plan meeting would be held on March 6 at 10 AM and a note stating that the daughter and grandson would attend the meeting.	F 660		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684	F 684 Quality of Care	04/04/18

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F 684	Continued From page 32 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This Requirement is not met as evidenced by: Based on staff interview and clinical record review the facility staff to follow physician's orders for 2 of 27 Residents, #387 and 172. The finding included: 1. For Resident #387 the facility staff failed to administer the medication Lovaza per the physician's orders According to the Physician's Desk Reference, Lovaza is a medication used to help reduce triglycerides. Resident #387 was admitted to the facility on 02/16/18. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, osteoporosis, anxiety, depression and schizophrenia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/28/18 coded the Resident as 8 of 15 in section C, cognitive status. This is an admission MDS. Resident #387's clinical record was reviewed on 02/27/18. It contained a physician's order summary for the month of February which read in part "Lovaza 1 gram cap by mouth q (every) day". The Resident's eMAR (electronic medication administration record) for February 2018 was reviewed and contained an entry, which read in part "Lovaza 1 gram cam by mouth q day order	F 684	1. For resident #387, the responsible party and the physician were notified. There were no adverse effects to the resident associated with the medication variance. For Resident #72, the responsible party and the physician were notified. There were no adverse effects to the resident associated with the medication variance. 2. For current residents residing in the facility a review has been completed by the DON/Designee for the previous (30) thirty days of physician's order sets and telephone orders as compared with the Medication Administration Record to identify further discrepancies. The responsible party and physician will be notified as indicated necessary. 3. In-servicing has been provided to the licensed nurses by the DON/Designee regarding following physicians orders, administering medications as ordered by the physician and discontinuing medications when ordered by the physician. A quality review will be completed by the DON/Designee for (5) five residents/week for (3) months to ensure that physician's orders are followed to include administering medications per physician's order and discontinuing medications when ordered by the physician. 4. The results of the reviews will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 684	Continued From page 33 date: 02/16/18, start date: 02/16/18 discontinue date: 02/191/8". This entry had not been signed as having been administered at any time during this time frame. The surveyor spoke with the DON (director of nursing) on 02/28/18 regarding the medication having not been administered. The DON could not offer an explanation as to why the eMAR had not been signed, not could she confirm that the medication had been administered. The concern of not following the physician's orders was discussed with the administrative team during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit. 2. For Resident #72, facility staff failed to discontinue a medication when the physician ordered. Resident #72 was admitted to the facility on 1/22/17 with diagnoses including hypertension, Alzheimer's disease, dementia with behavior disturbance, anemia, anxiety delusional disorders, and urinary tract infection. On the annual minimum data set assessment with assessment reference date 1/25/18, the resident scored 3/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting self or others, During clinical record review, the surveyor noted a physician telephone order dated 12/18/17 to discontinue Seroquel when Risperdal Consta arrived and to start Risperdal Consta 12.5 mg IM every 2 weeks. The medication administration record (eMAR) indicated that the resident	F 684		

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F 684	Continued From page 34 received the first dose of Risperdal Consta on 1/6/18. Seroquel 25 milligrams two times per day continued until 2/19/18 after an order "seroquel was stopped on 12/18/17 please verify that" was written and signed by the physician. A nursing communication form dated 219/19 stated under nurse's comments "seroquel had not been dcd (discontinued) 12/18/18 when Risperdal Consta arrived. Risperdal Consta dcd 21918 (February 19, 2018). The administrator and director of nursing were notified of the concern during a summary meeting on 2/28/19.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure an accident free environment for 1 of 27 residents (Resident #104). The findings included: The facility staff failed to ensure an oxygen tank was secured in a cart/stand in Resident #104's room. The clinical record of Resident #104 was reviewed 2/27/18 through 3/1/18. Resident #104	F 689	F 689 Free of Accident Hazards/Supervision/ Devices 1. For Resident #104, the oxygen tank was removed during the survey. There were no adverse effects to the resident. 2. Environmental rounds/observations were conducted by the Administrator/Designee to ensure that there were no other oxygen tanks/e-cylinders in resident rooms that were not secured in a cart/stand. 3. In-servicing has been provided by the Administrator/Designee to current employees regarding ensuring that when oxygen tanks/e-cylinders are in use that these are utilized, transported and secured in a cart/stand. Environmental rounds/observations will be conducted by the Administrator/Designee (5) five times/week for (3) three months to ensure that oxygen tanks/e-cylinders are not left unsecured in resident rooms and to ensure that if these are in use, that they are secured appropriately in a cart/stand.	04/04/18

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F 689	Continued From page 35 was admitted to the facility 1/30/18 and readmitted 2/16/18 with diagnoses that included but not limited to high fever, likely due to aspiration pneumonitis, acute bronchitis, severe protein malnutrition with albumin of 1.4, gastrointestinal hemorrhage, atrial fibrillation, iron deficiency anemia, diastolic heart failure, cerebral infarction, hemiplegia following cerebral infarction affecting right dominant side, muscle wasting, dysphagia, status post PEG tube placement secondary to stroke, fracture of femur, hypertension, dementia without behavioral disturbances, sacral pressure ulcer, hyperlipidemia, constipation, dry mouth, and urinary tract infection. Resident #104's 5 day admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/18 assessed the resident with no issues with short-term memory, issues with long-term memory, and modified independence with some difficulty in new situations. During the initial tour on 2/26/18 beginning at 6:45 p.m., the surveyor observed a free-standing oxygen cylinder in Resident #104's room. Resident #104 was currently receiving oxygen via the oxygen concentrator. The surveyor informed licensed practical nurse #2 of the above concern. L.P.N. #2 stated she did not know why the oxygen was in the room and removed the oxygen tank. The surveyor informed the interim administrator and the director of nursing of the above concern on 2/28/18 at 1:32 p.m. and requested the facility policy on oxygen storage.	F 689	4. The results of the rounds/observations will be discussed by the Administrator/ Designee at the QAPI Committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 689	Continued From page 36 The surveyor reviewed the facility policy titled "Fire Safety and Prevention" on 2/28/18. The policy read in part "Oxygen Safety f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area." No further information was provided prior to the exit conference on 3/1/18.	F 689		
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	F 690 Bowel/Bladder Incontinence, Catheter, UTI 1. For Resident #115, the physician was notified regarding diagnosis for the Foley catheter. Resident #115 was reassessed regarding appropriateness for a bowel and bladder training program. For Resident #115, the Foley catheter was anchored upon identification during the survey process. For Resident #32 and Resident #33, the Foley catheter was anchored upon identification during the survey process. 2. Rounds/Observations have been conducted by the DON/Designee for current residents residing in the facility with physician's orders for catheters to ensure that catheters are anchored appropriately. A review has been completed by the DON/Designee for current residents residing in the facility with physician's orders for catheters to ensure that there is an appropriate diagnosis and that the assessment for bowel and bladder retraining has been completed and followed up on appropriately.	04/04/18

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F 690	Continued From page 37 §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, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to anchor an indwelling Foley catheter, failed to implement an assessment for timed voiding, and/or failed to obtain a diagnosis for the indwelling Foley catheter for 3 of 27 residents (Resident #115, Resident #32 and Resident #33). The findings included: 1. The facility staff to obtain a diagnosis for Resident #115's indwelling Foley catheter, failed to anchor the indwelling Foley catheter and failed to implement a bowel and bladder training program when the resident was assessed to be a "good candidate." The clinical record of Resident #115 was reviewed 2/27/18 through 3/1/18. Resident #115 was admitted to the facility 11/2/17 and readmitted 11/10/17 with diagnoses that included but not limited to acute posthemorrhagic anemia, carpal tunnel syndrome, atrial fibrillation, hypertension, iron deficiency anemia, polyosteoarthritis, chronic pain syndrome, morbid obesity, major depressive disorder and constipation. Resident #115's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/9/18 assessed the resident with a	F 690	3. In-servicing has been provided by the Administrator/Designee to current nursing staff regarding an appropriate diagnosis for catheter use and completing the bowel and bladder training assessment and appropriate follow up if indicated. A review will be completed by the DON/Designee for (5) five residents/week for (3) months to ensure that residents with physician's orders for catheters have appropriate diagnosis, bowl and bladder training assessments have been completed and followed up on as indicated, and catheters are anchored appropriately. 4. The results of the review will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 690	Continued From page 38	F 690		

BIMS of 15. Section H Bladder and Bowel was marked for an indwelling catheter and urinary continence was marked as 9-not rated, resident had a catheter.

(a). The surveyor was unable to locate a diagnosis for the indwelling Foley catheter in the clinical record and spoke with licensed practical nurse #1 on 2/27/18 at 10:05 a.m. regarding the diagnosis. L.P.N. #1 stated she would find out.

(b). The surveyor interviewed Resident #115 on 2/27/18 at 10 a.m. During the interview, the surveyor asked if the Foley catheter was anchored with a piece of tape or Velcro. Resident #115 stated she didn't think it was. The surveyor asked licensed practical nurse #1 to check the Foley catheter for anchorage on 2/27/18 at 10:16 a.m. LPN #1 checked the Foley catheter and stated the Foley was unanchored.

(c). The surveyor reviewed Resident #115's "Assessment for Bowel and Bladder Training" completed 11/3/17. The assessment total was 3. Based on the legend at the top of the page, Resident #115 was a good candidate for individual training. The legend for good candidate for individual training was 00-06.

The surveyor interviewed minimum data set (MDS) registered nurse on 2/28/18 at 11:27 a.m. regarding diagnosis for the Foley. MDS RN stated Resident #115 was obese and had vaginal bleeding with surgery and insertion of a mirena device. MDS RN stated those are the only diagnoses for the Foley catheter. The surveyor reviewed the initial assessment for bowel and bladder dated 11/3/17 that identified the resident would be a candidate for toileting. The surveyor asked the MDS RN who would be responsible for

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F 690	Continued From page 39	F 690		

the initiation of the training program after the assessment and recommendation had been completed. MDS RN stated the assessment was not implemented.

The surveyor informed the administrative staff of the above concerns in the end of the day meeting on 2/28/18 at 1:32 p.m. and requested the facility policy on catheters.

The surveyor reviewed the facility policy titled "Catheter Care Policy" on 2/28/18. The policy read in part "Policy Explanation and Compliance Guidelines: Female: 15. Secure catheter tubing to the thigh to prevent movement on the urethra or excessive tension."

No further information was provided prior to the exit conference on 3/1/18.

2. For Resident #32, the facility failed to anchor an indwelling foley catheter.

The record review revealed that Resident #32 had been readmitted to the facility 11/17/17. Diagnoses included, but were not limited to, neurogenic bladder, metabolic encephalopathy, pain, Alzheimer's disease, diabetes, hypothyroidism, and hypertension.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/04/17 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section H (bladder and bowel) was coded to indicate the Resident has an indwelling catheter (foley).

On 02/26/18 during initial tour of the facility, the

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F 690	Continued From page 40 surveyor observed that Resident #32 had a foley catheter in place. On 02/28/18 at approximately 8:20 a.m., the surveyor and CNA (certified nursing assistant) #2 checked the foley catheter to see if it had been anchored. After checking the foley catheter CNA #2 verbalized to the surveyor that the foley catheter was not anchored. The Residents comprehensive care plan included the problem area potential for infection related to presence of indwelling catheter. The facility policy/procedure titled "Catheter Care Policy" included "...Secure catheter tubing to the thigh to prevent movement on the urethra or excessive tension..." The administrative team were notified that Resident #32's foley catheter was not anchored during a meeting with the survey team on 03/01/18 at approximately 4:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #33 the facility staff failed to anchor an indwelling Foley catheter to prevent excessive tension on the urinary meatus. Resident #33 was a 92 year old female who was admitted on 9/18/17. Admitting diagnoses included, but were not limited to: encephalopathy, atrial fibrillation, hypertension, muscle weakness, dementia without behaviors, gout and anxiety. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS with an Assessment	F 690		

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F 690	Continued From page 41 Reference Date (ARD) of 12/27/17. The facility staff coded that Resident #33 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #33 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section H. Bladder and Bowel, the facility staff coded that Resident #3 had an indwelling Foley catheter. On February 27, 2018 at 1 p.m. the surveyor reviewed Resident #33's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to: "CHECK PLACEMENT OF FOLEY AND ANCHOR Q (every) SHIFT." (sic) On February 27, 2018 at 2:50 p.m., the surveyor asked a Licensed Practical Nurse (LPN) to accompany the surveyor to Resident #33's room. The surveyor and LPN walked down to Resident #33's room and the surveyor requested to see Resident #33's Foley catheter. The LPN pulled back Resident #33's bed linens and exposed Resident #33's legs. The surveyor noted that Resident #33 had an indwelling Foley catheter that contained clear amber urine. The surveyor noted that Resident #33's Foley catheter was not anchored. The surveyor pointed out to the LPN that Resident #33's Foley was not anchored. The LPN stated the Foley was supposed to be anchored. On February 27, 2018 at 4:30 p.m. the surveyor notified the Administrator (Adm), Director of Nursing (DON) and Assistant Director of Nursing (ADON) that Resident #33's Foley catheter was not anchored. The surveyor requested for the facility Policy and Procedure for Foley catheter care.	F 690		

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F 690	Continued From page 42 On February 28, 2018 at 10:20 a.m., the surveyor reviewed the facility Policy and Procedure titled, "Catheter care Policy" that had been left in the conference room. The policy and procedure read in part ... "15. Secure catheter tubing to the thigh to prevent movement on the urethra or excessive tension." (sic) No additional information was provided prior to exiting the facility as to why Resident #33's Foley catheter was not anchored.	F 690		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This Requirement is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a physician supervised the Resident's care for 1 of 27 residents in the survey sample (Resident #378). The findings included:	F 710	F 710 Resident's Care Supervised by a Physician 1. For Resident #378, the physician has reviewed the resident's medical record. Resident #378 has been seen by the physician. 2. For residents currently residing in the facility, a review has been completed by the DON/Designee to ensure that each resident has been seen by the physician and that each resident has their care supervised by a physician. 3. In-servicing has been provided by the DON/Designee to the physicians, physician's extenders and licensed nurses regarding ensuring that each resident has their care supervised by a physician and that they are seen in a timely fashion by the physician. A review will be completed by the DON/Designee for (5) five residents/week for (3) months including new admissions/readmits to ensure that the resident has been seen by a physician and the resident's care is supervised by a physician.	04/04/18

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F 710	Continued From page 43 Resident #378 was readmitted to the facility on 2/24/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, atrial fibrillation, high blood pressure, peripheral vascular disease and chronic obstructive pulmonary disease. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey. The resident was alert to person, place and time and did require extensive assistance of 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #378 on 2/28/18 and 3/1/18. During the review, the surveyor noted that the resident had not been seen by the physician on readmission to the facility, nor was there a physician progress note found in the clinical record of Resident #378. The surveyor notified the director of nursing on 3/1/18 at 1:30 pm. The director of nursing reviewed the clinical record of the resident and stated, "I cannot find where the resident has been seen by the physician since the resident had been readmitted to the facility on 2/24/18. Let me call and talk to medical records and see if they have a dictation note from the physician on this resident." At 2 pm, the director of nursing returned to the surveyor and stated, "I have found copies of a progress note from the nurse practioner (NP) dated for 2/27/18 but the physician has not seen the resident since he was readmitted back to the facility on 2/24/18. The last progress note on the clinical record was dated for 2/21/18 and it was by the NP also." At 4:44 pm, the surveyor notified the administrative team of the above documented	F 710	4. The results of the review will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 710	Continued From page 44 findings in the conference room. No further information was provided to the surveyor prior to the exit conference on 3/1/18.	F 710		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732	F 732 Posted Nurse Staffing Information 1. The daily nurse staffing information identified as incomplete was corrected during the survey. 2. Daily nurse staffing information for the previous 30 days has been reviewed by the DON/Designee. 3. In-servicing has been provided by the DON/Designee to the designated person who posts daily nurse staffing information. Observations will be completed by the DON/ Designee (5) five times/week for (3) months to ensure that daily nurse staffing information is accurately posted. 4. The results of the observations will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	04/04/18

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F 732	Continued From page 45 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This Requirement is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to complete the daily staffing summary posting/sheet. The findings included. The facility had not updated the staffing summary sheet to include the clinical staffing hours for 02/28/18 and had not posted the staffing summary sheet for 03/01/18. A review of the staffing summary sheet on 03/01/18 at approximately 7:35 a.m. revealed that the facility had not updated the staffing summary for 02/28/18 to include the clinical staff's hours for the second and third shifts and had not posted the staffing summary sheet for 03/01/18. The DON (director of nursing) was notified of same. The administrative staff were notified of the above in a meeting with the survey team on 03/01/18 at approximately 4:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755	F755 Pharmacy Srvcs/Procedure/Pharmacist/ Records	04/04/18

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F 755	Continued From page 46 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This Requirement is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure medications were available for administration for 4 of 27 Residents, #387, #378, #381, #26. The findings included: 1. For Resident #387 the facility staff failed to ensure the medication Ativan was available for administration. According to the Physician's Desk Reference, Ativan is a medication used to treat anxiety.	F 755	1. Resident #26 no longer resides in the facility. For Resident #387, Ativan is available for administration. The physician and the RP were notified. There was no adverse effect to the resident related to the medication variance on 02/16/18, 02/17/18 and 02/18/18. For Resident #378, medications are available for administration. Atrovent HFA inhaler was discontinued on 02/21/18. The physician and responsible party were notified. There were no adverse effects to the resident related to the medication variance on 02/17/18. For Resident #381, medications are available for administration. Medrol Dose Pack and Ranexa ER have been discontinued. Tizanidine HCL is available for administration. The physician and the responsible party have been notified. There were no adverse effects to the resident related to the medication variance on 02/25/18. 2. For current residents residing in the facility, a review has been completed by the DON/Designee of current physician's orders including physician's order sets and telephone orders for the previous (30) thirty days and compared to medications available to ensure that medications are available as ordered by the physician. 3. In-servicing has been provided to the Licensed Nurses by the DON/Designee regarding obtaining medications and administering medications as ordered by the physician. Medication administration observations will be completed by the DON/ Designee for (5) five residents/week for (3) three months to ensure that physician's orders are followed including ensuring that medications are available and administered per the physician's order in order to minimize medication variances.	

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F 755	Continued From page 47 Resident #387 was admitted to the facility on 02/16/18. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, osteoporosis, anxiety, depression and schizophrenia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/28/18 coded the Resident as 8 of 15 in section C, cognitive status. This is an admission MDS. Resident #387's eMAR (electronic medication administration record) was reviewed on 02/27/18. It contained an entry, which read in part "Ativan 0.5 mg tablet by mouth twice a day order date: 02/1/6/18 start date: 02/16/18 discontinue date: 02/19/18" This entry had been signed with "N" on 02/16-02/18/18 for the 5 pm dose. The comments section of the eMAR contained entries for these dates which read in part "11:40PM, 2/17/18 (Scheduled: 5:00PM, 2/17/18; Ativan 0.5.mg Tablet) Ativan 0.5mg tablet by mouth twice da...scheduled for 02/17/2018 5:00 PM was not administered-other" and "5:03 PM, 2/18/18 (scheduled: 5:00 PM, 2/18/18; Ativan 0.5mg tablet) Ativan 0.5mg tablet by mouth twice a da...scheduled for 02/18/2018 5:00 PM was not administered-other. Awaiting arrival from pharmacy" The surveyor requested and was provided with a copy of the contents of the facility Cubex (stat medication box). This list contained the medication Ativian 0.5mg tablets. Surveyor spoke with the DON (director of nursing) regarding the medication not being available for administration. DON could not offer an explanation as to why the medication was not taken from the Cubex.	F 755	4. The results of the medication administration observations will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 755	Continued From page 48 The concern of the medication not being available for administration was discussed during a meeting with the administrative staff during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit. 2. The facility staff failed to ensure that Resident #378 had medications available for administration. Resident #378 was readmitted to the facility on 2/24/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, atrial fibrillation, high blood pressure, peripheral vascular disease and chronic obstructive pulmonary disease. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey. The resident was alert to person, place and time and did require extensive assistance of 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #378 on 2/28/18 and 3/1/18. The surveyor also reviewed the resident's MAR (Medication Administration Record) at that time. The MAR for the month of February 2018 had an "N" in the box for 2/17/18 for each of the following medications and times the medication was to be administered: " ...Hydralazine 25 mg (milligram) 3 tablets by mouth every 8 hours" which was to be administered at 6 am and 10 pm. "Creon DR 24,000 units 1 capsule by mouth three times daily" which was to be administrated at 6 am. "Atrovent HFA Inhaler 2 puffs by inhalation three times daily" which was to be administrated at 6 am.	F 755		

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F 755	Continued From page 49	F 755		

On the "History" sheets for the month of February, the documentation stated for each of the above documented medications was "Medication is not available".

On 3/1/18 at 2 pm, the surveyor notified the director of nursing (DON) of the above documented findings. The DON stated to the surveyor, "I reviewed the chart and the resident was readmitted the afternoon on 2/16/18. The nurses should had had time to receive this from the pharmacy and if not, should use the backup pharmacy. I was not here then so I cannot answer to exactly why this medication was not available."

The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm in the conference room.

3. The facility staff failed to ensure that Resident #381 had medications available for administration.

Resident #381 was admitted to the facility on 2/23/18 with the following diagnoses of, but limited to heart attack, high blood pressure, diabetes, congestive heart failure and generalized weakness. The resident did not have a completed MDS (Minimum Data Set) due to being admitted to the facility on 2/23/18. According to the nursing documentation at the time of admission, the resident was alert and oriented to person, place and time. The resident also required extensive assistance of 1 staff member for bathing.

The surveyor conducted a review of Resident #381's clinical record including the MAR

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F 755	Continued From page 50 (Medication Administration Record) for the month of February, 2018. The following medications were noted not to "available from pharmacy" for the following dates and times the medications were to be administrated: 2/25/18 at 6:00 am, 12 pm and 5 pm Medrol Dose Pak 4 mg (milligram) po (by mouth) 2/25/18 at 9 am Ranexa ER (extended release) 500 mg po 2/25/18 at 2 pm Tizanidine HCL 4 mg po. The surveyor notified the director of nursing (DON) at 2 pm on 3/1/18 of the above documented findings. The DON stated, "I don't understand why this wasn't here from the pharmacy. This is definitely an area for improvement." The surveyor notified the administrative team of the above documented findings at 4:44 pm on 3/1/18. No further information was provided to the surveyor prior to the exit conference on 3/1/18. 4. The facility staff failed to ensure that Resident #26 had medications available for administration. Resident #26 was admitted to the facility on 1/8/18 with the following diagnoses of, but not limited to dementia, Alzheimer's disease, high blood pressure, anxiety disorder, and major depressive disorder. Resident #26 was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of 15 on the admission MDS (Minimum Data Set). The resident was also coded as requiring extensive assistance of 1 staff member for personal hygiene and bathing. The surveyor noted a telephone order that was	F 755		

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F 755	Continued From page 51 written by the Hospice nurse on 2/28/18 at 9:45 am. The order read in part " ...Ativan 2 mg/ml (milligram/milliliter) vial 0.25 ml by mouth or sublingual twice daily for agitation ..." On the MAR (Medication Administration Record) for 2/28/18 at 9 pm, the surveyor noted documentation of "N" in the box, which represented that the medication was not administrated to the resident. The surveyor notified the unit manager of the above documented findings at 11:30 am. The unit manager stated, "I just received this medication this morning and signed for it." The surveyor asked the unit manager which pharmacy she received this medication from. The unit manager stated, "It was from _____ (name of pharmacy)." The surveyor asked the unit manager if the named pharmacy was used as the backup pharmacy to obtain this medication. The unit manager stated, "Yes." The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm by the surveyor. No further information was provided to the surveyor prior to the exit conference on 3/1/18.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756	F756 Drug Regimen Review, Report Irregular, Act On 1. Resident #53 has had a drug regimen review completed. 2. A review has been completed by the DON/Designee for the previous 30 days for current residents residing in the facility to ensure that drug regimen reviews have been completed in a timely fashion.	04/04/18

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F 756	Continued From page 52 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a drug regimen review for one of 27 Residents, Resident #53. The findings included: Resident #53 did not have a drug regimen review completed for the month of September 2017.	F 756	3. In-servicing has been provided by the Administrator/Designee to pharmacy representatives regarding the requirements for drug regimen reviews. A quality review will be completed by the DON/Designee for (5) five residents/week for (3) three months to ensure that drug regimen reviews have been completed in a timely fashion. 4. The results of the quality reviews will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 756	Continued From page 53 The clinical record review revealed that Resident #53 had been admitted to the facility 12/05/13. Diagnoses included, but were not limited to, congestive heart failure, diabetes, dementia, and chronic kidney disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/10/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record did not include a pharmacy review for September 2017. On 03/01/18 at 8:35 a.m., the unit secretary verbalized to the surveyor that they (the facility) were unable to find a pharmacy review for September. The administrative staff were notified of missing pharmacy review in a meeting with the survey team on 03/01/18 at approximately 4:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 756		
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	F 758	F758 Free from Unnec Psychotropic Meds/ PRN Use 1. For Resident #387 the PRN Ativan has been discontinued.	04/04/18

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F 758	Continued From page 54 (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 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 and clinical record review the facility staff failed to ensure 1 of 27 Residents	F 758	2. Residents currently residing in the facility with physician's orders for psychotropic medication s have the potential to be affected. A review has been completed by the DON/ Designee to ensure that psychotropic medications are appropriately ordered and that necessary PRN psychotropics have appropriate time frames ordered as well. 3. In-servicing has been provided by the DON/Designee to physicians, physician extenders and licensed nurses regarding making sure psychotropic medications are ordered when necessary and that as needed psychotropic medications are ordered for limited time frames up to, but not to exceed (14) fourteen days. A quality review will be completed by the DON/Designee for (5) residents/week with physician's orders for psychotropic medications to ensure that psychotropic medications ordered are necessary and that as needed psychotropic medications are ordered for a limited time frame only up to, but not to exceed (14) fourteen days. 4. The results of the reviews will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 758	Continued From page 55 were free of unnecessary medications #387. The findings included: For Resident #387 the facility staff failed to discontinue the prn medication Ativan after 14 days. Resident #387 was admitted to the facility on 02/16/18. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, osteoporosis, anxiety, depression and schizophrenia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/28/18 coded the Resident as 8 of 15 in section C, cognitive status. This is an admission MDS. Resident #387's clinical record was reviewed on 02/27/18. It contained a physician's order summary for the month of February which read in part "Ativan 0.5 mg tablet by mouth two times a day prn (as needed) anxiety". This entry had an order date of 02/16/18, but did not have a discontinue date listed. The concern of the prn Ativan not having a discontinue date was discussed with the administrative team during a meeting on 03/01/8 at approximately 1635. No further information was provided prior to exit.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This Requirement is not met as evidenced by:	F 760	F 760 Residents are Free of Significant Med Errors 1. For Resident #33, the physician and responsible party have been notified. There were no adverse effects to the resident associated with the medication variance.	04/04/18

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F 760	Continued From page 56 Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 1 of 27 Residents in the sample survey was free of Significant Medication Error. The Findings Included: Resident #33 was a 92 year old female who was admitted on 9/18/17. Admitting diagnoses included, but were not limited to: encephalopathy, atrial fibrillation, hypertension, muscle weakness, dementia without behaviors, gout and anxiety. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS with an Assessment Reference Date (ARD) of 12/27/17. The facility staff coded that Resident #33 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #33 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section N. Medications, the facility staff coded that Resident #33 received 7 days of an anticoagulant. On February 27, 2018 at 1 p.m., the surveyor reviewed Resident #33's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to: "Coumadin 4 mg by mouth daily." (sic) The order initiated on 2/15/18. Continued review of the clinical record produced the February 2018 Medication Administration Records (MAR's). The February 2018 MAR's did not document the administration of the Coumadin 4 mg on 2/25/18. On February 27, 2018 at 4:15 p.m., the surveyor notified the Assistant Director of Nursing (ADON)	F 760	2. For current residents residing in the facility, a review has been completed by the DON/Designee for the previous (30) thirty days of physician's order sets and telephone orders as compared with the Medication Administration Record (MAR) to identify further discrepancies. The responsible party and physicians will be notified as indicated necessary. 3. In-servicing has been provided to the licensed nurses by the DON/Designee regarding following physician orders and administering medications as ordered by the physician. A quality review will be completed by the DON/ Designee for (5) five residents/week for (3) three months to ensure that physician's orders are followed to include administering medications per the physician's order to minimize medication variances. 4. The results of the review will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) three months. The IDT Committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 760	Continued From page 57	F 760		

that Resident #33 had physician orders for Coumadin 4 mg every day. The surveyor notified the ADON that review of the February 2018 MAR's failed to document the administration of the Coumadin 4 mg on 2/25/18. The surveyor reviewed Resident #33's clinical record with the ADON. The surveyor pointed out the specific order for the Coumadin 4 mg every day. The surveyor also reviewed the February 2018 MAR's with the ADON. The surveyor specifically pointed out that the Coumadin 4 mg had not been documented as administered on 2/25/18. The ADON walked over to the medication cart located in front of the nurses' station and obtained the Coumadin 4 mg medication blister pack. The ADON brought the medication blister pack back to the surveyor who was sitting at the nurses' station. The ADON stated that the card had been recently delivered to the facility and that the February 2018 MAR's correctly reflected the number of Coumadin 4 mg tablets missing from the medication blister pack. The surveyor looked at the Coumadin 4 mg blister pack. The surveyor asked the ADON if the Coumadin had been administered on 2/25/18 and the ADON shook her head side to side, indicating "No." The surveyor notified the ADON that the facility not administering the physician ordered Coumadin was considered a significant medication error.

On February 27, 2018 at 4:30 p.m., the surveyor notified the Administrator (Adm), Director of Nursing (DON) and ADON that Resident #33 was receiving Coumadin every day. The surveyor notified the Administrative Team (AT) that the February 2018 MAR's failed to document the administration of the Coumadin on 2/25/18. The surveyor notified the AT that the ADON and surveyor had reviewed the Coumadin blister pack and that the count accurately reflected the

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F 760	Continued From page 58 number of Coumadin pills that were documented as given on the February 2018 MAR's. The surveyor notified the AT that a Significant Medication error had been identified, as Resident #33 had not received the physician ordered Coumadin No additional information was provided to the survey team prior to exiting the facility as to why Resident #33 had a significant medication error related to the physician ordered Coumadin not being administered.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered lab test for two of 27 Residents, Residents #42 and #72. The findings included. 1. For Resident #42, the facility failed to obtain a physician ordered laboratory test. The record review revealed that Resident #42 had been admitted to the facility 05/13/16. Diagnosis included, but were not limited to, gastroesophageal reflux disease, benign prostatic hyperplasia, dementia, chronic obstructive	F 770	F 770 Laboratory Services 1. For Resident #42, the urinalysis, culture and sensitivity have been collected. The physician and responsible party have been notified for Resident #72. The physician and the responsible party were notified. 2. For residents currently residing in the facility a review has been completed by the DON/Designee for the previous (30) days comparing physicians order sets and telephone orders to lab results to ensure that labs have been obtained per physician's order. The physician and responsible party have been notified. 3. In-servicing has been provided by the DON/Designee regarding obtaining lab tests as ordered by the physician, following up per the physician's orders on lab results, and ensuring the results are present on the medical record. A quality review will be competed by the DON/ Designee for (5) five residents/week for (3) three months to ensure that labs are obtained and followed up on per the physician's order, and results are present on the medical record.	04/04/18

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F 770	Continued From page 59 pulmonary disease, and chronic kidney disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/05/18 included a BIMS (brief interview for mental status) summary score of four out of a possible 15 points. The clinical record included a physician's telephone order dated 02/23/18 to recheck "UTI (urinary tract infection) C+S (culture and sensitivity)." The surveyor was unable to locate any results for this lab test in the clinical record. On 02/27/18 at 11:09 a.m., the surveyor asked LPN (licensed practical nurse) #1 about the missing lab test. On 02/28/18 at 10:47 a.m., the surveyor and the unit manager (LPN #2) reviewed the clinical record. After reviewing the clinical record and calling the contracting lab, LPN #2 verbalized to the surveyor that the lab did not have anything on this lab test. RN (registered nurse) #1 then stated that she had been the nurse to obtain this lab test on 02/24/18, as the Resident was agitated on 02/23/18. The administrator and DON were notified of the missing lab test on 02/28/18 at 1:34 p.m. during a meeting with the survey team. On 03/01/18, the facility provided the surveyor with a copy of nursing notes transcribed on 02/28/18. "LE (late entry) for 2/24/18 ...Resident has decreased agitation this afternoon. Clean catch U/A obtained. Sent to _____ Lab. Awaiting	F 770	4. The results of the reviews will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 770	Continued From page 60 results." and "This nurse called _____ lab for results on 2-25-18 UA C&S. Lab was sent to _____ and UA was not done but culture is in process and will be complete tomorrow." No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #72, facility staff failed to discontinue a medication when the physician ordered. Resident #72 was admitted to the facility on 1/22/17 with diagnoses including hypertension, Alzheimer's disease, dementia with behavior disturbance, anemia, anxiety delusional disorders, and urinary tract infection. On the annual minimum data set assessment with assessment reference date 1/25/18, the resident scored 3/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting self or others. Clinical record review on 2/18/18 revealed a physician order dated 2/23/27 for "OBX3-anemia (test stool for occult blood 3 times for anemia)". A nursing communication form dated 2/27/17 under Nurse's Comments "Order written for occult blood X 3 on 2/23/17. No specimens obtained as of 2/27/17. Staff report no signs/sx of bleeding. Do you want to D/C (discontinue)." The physician responded on the same form on 2/28/27 "stool of OB X1 please- normocytic anemia". A physician order dated 3/2/17 "please collect stool for OBx1 (ordered 2/28)- anemia." The record contained results for a stool for occult blood dated 3/3/18 result positive. Tge results had a note to start medication and place the resident on the list for rounds Monday 3/6/17). An order dated 3/6/18	F 770		

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F 770	Continued From page 61 "stool for occult blood X1- anemia" and another dated 3/16/18 "Need results for OB please - Previous results +(positive) ordered on 3/6". There was a result for a stool for occult blood dated 3/16/17 result positive. The first result on 3/3/17 test was dated 9 days after the original order and 5 days after the second order. The second result was dated 10 days after the original order and obtained on the day of the second order. The administrator and director of nursing were notified of the concern during a summary meeting on 3/1/18.	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This Requirement is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to	F 812	F 812 Food Procurement Store/Prepare/Serve-Sanitary 1. The ham salad identified as expired on 02/25/18 was removed and discarded on 02/26/18. The opened box of raisins identified with no open date were removed and discarded on 02/26/18. The deep pan of yeast rolls that were only partially covered with Saran wrap and not dated were removed and discarded on 02/26/18. The tray of pureed peaches identified as expired on 02/24/18 were removed and disposed of on 02/26/18. 2. Observations have been conducted in the kitchen by the Administrator/Designee to ensure that there are no other expired items, that food items are covered appropriately and that food items have appropriate dates including open dates.	04/04/18

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F 812	Continued From page 62 remove expired food items from the refrigerators and failed to ensure the covering on food was secured. The findings included: The facility staff failed to ensure food items with expired dates were removed from the refrigerators and failed to ensure the covering on food items was secured. The surveyor toured the kitchen 2/26/18 beginning at 6:14 p.m. with the evening cook. In the walk-in refrigerator was a container of ham salad with an expiration date of 2/25/18. The surveyor asked the evening cook if the ham salad should be removed and the evening cook stated "Yes" and promptly removed the container from the refrigerator. The surveyor observed an opened box of raisins with a "use by date" of 9/28/18 but no date when opened by the dietary staff. The evening cook stated the raisins probably should be dated. The surveyor observed a deep pan full of yeast rolls partially covered with saran wrap but had no date. The evening cook stated the rolls were hard and were thrown away. The surveyor observed a tray of pureed peaches dated 2/24/18. The evening cook stated the peaches should have been dumped and removed the tray from the refrigerator. The surveyor informed the dietary manager of the above concerns on 2/26/18 at 6:45 p.m. and requested the facility policy on storage/labeling/discarding food items.	F 812	3. In-servicing has been provided by the Administrator/Designee to dietary employees regarding disposing of expired food items, covering and dating food items appropriately including dating items when opened. Observations of the kitchen will be conducted by the Administrator/Designee (5) five times/ week for (3) three months to ensure that food items are not expired, covered appropriately and dated appropriately, including the date the food item was opened. 4. The results of the observations will be discussed at the QAPI Committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 812	Continued From page 63 The surveyor reviewed the facility policy provided on 2/27/18 at 12:50 p.m. from the regional dietary manager. The policy titled "3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking" read in part "READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5°(degrees) C (centigrade) (41 °F (Fahrenheit) or less for a maximum of 7 days." The surveyor informed the interim administrator and the director of nursing of the above concern on 2/28/18 at 1:32 p.m. and the administrative staff again on 3/1/18 at 4:37 p.m. No further information was provided prior to the exit conference on 3/1/18.	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;	F 842	F 842 Resident Records – Identifiable Information 1. For Resident #378, the admission assessment was completed for readmission to facility on 02/24/18 and placed in the appropriate resident's medical record. 2. For Residents that currently reside in the facility, a review has been conducted by the DON/Designee for the previous (30) days to ensure that for newly admitted or readmitted residents an admission assessment has been completed and is present in the appropriate resident's medical record.	04/04/18

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F 842	Continued From page 64 (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, 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;	F 842	3. In-servicing has been provided by the DON/Designee to licensed nurses regarding completion of admission assessments upon admission/readmission as well as maintaining resident information in the appropriate resident's medical record. A review will be conducted by the DON/Designee for (5) newly admitted/readmitted residents/week for (3) three months to ensure that admission assessments have been completed in a timely fashion and are present in the appropriate resident's medical record. 4. The results of the reviews will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) three months. The IDT committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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F 842	Continued From page 65 (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 interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 27 residents in the survey sample (Resident #378). The findings included: Resident #378 was readmitted to the facility on 2/24/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, atrial fibrillation, high blood pressure, peripheral vascular disease and chronic obstructive pulmonary disease. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey. The resident was alert to person, place and time and did require extensive assistance of 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #378 on 2/28/18 and 3/1/18. The surveyor noted on 3/1/18 that there was not an admission assessment in the electronic or paper clinical record for Resident #378 when he was readmitted back to the facility on 2/24/18. . The surveyor notified the director of nursing of the above documented findings on 3/1/18 at 2 pm. The director of nursing returned to the surveyor at 2:30 pm and stated, "We found the resident's admission assessment documented in another	F 842		

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F 842	Continued From page 66 resident's record with the same last name. We know it is this resident's because the other resident has not been readmitted to the facility since he was originally admitted to the facility." The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm. No further information was provided to the surveyor prior to the exit conference on 3/1/18.	F 842		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This Requirement is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure that the Quality Assurance Committee met at least quarterly. The Findings Included: On March 1, 2018 at 9:45 a.m., the surveyor met	F 868	F 868 QAA Committee 1. A Quality Assurance Performance Improvement Committee meeting was held on or before 04/04/18. 2. A Quality Assurance Performance Improvement(QAPI) Committee meeting was held on or before 04/04/18. 3. In-servicing has been provided to the Administrator, DON and the Medical Director on or before 04/04/18 by the Regional Director of Clinical Operations regarding the Quality Assurance Process including Quality Assurance meetings and frequency of meetings. The Regional Director of Clinical Operations (RDCO)/Designee will participate in the monthly QAPI meeting for (3) three months to ensure that QAPI meetings are being conducted appropriately. 4. Results of the observations by the RDCO/Designee will be discussed by the Administrator/Designee at the QAPI meeting monthly. The IDT/RDCO/Designee will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18.	04/04/18

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F 868	Continued From page 67 with the Administrator (Adm), Director of Nursing (DON), Regional Minimum Data Set (MDS) Nurse, Corporate Compliance nurse (CCN) and New Administrator. The surveyor discussed the facility's Quality Assurance (QA) program and requested to see the QA meeting signature sheets of the people who attended the QA meetings. The DON stated that the QA Committee met monthly and at least quarterly. The Adm produced the QA manual. The surveyor reviewed the manual and noted that the facility had conducted QA meetings on 5/3/17, 11/29/17, 12/27/17 and 1/29/18. The surveyor noted that the facility should have had a QA committee meeting in February 2017 and in August 2017. The surveyor pointed out to the survey team that the facility had not had Quarterly QA meetings. No additional information was provided to the survey team prior to exiting the facility as to why the facility failed to have Quarterly QA meetings for the facility.	F 868		
F 880 SS=E	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,	F 880	F 880 Infection Prevention & Control 1. For Resident #381, Resident #386 and Resident #378 the handheld nebulizer device was stored in a plastic bag on 02/27/18 by the DON/Designee. For Resident #378, the empty 1000cc IV bag and tubing were removed and discarded by the DON on 02/27/18. For Resident #104, the nebulizer facemask was stored in a plastic bag by the DON/Designee on 02/27/18. 2. Observations have been conducted by the DON/Designee for current residents residing in the center to ensure that nebulizer equipment is stored in a plastic bag and that residents receiving Intravenous(IV) fluids do not have old IV bag/tubing still hung in the room.	04/04/18

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F 880	Continued From page 68 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 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.	F 880	3. In-servicing has been provided to current employees by the DON/Designee regarding appropriately storing nebulizer equipment in a sanitary fashion in a plastic bag and discarded IV tubing/bag after use. Observations will be conducted by the DON/ Designee for (5) five residents/week for (3) months with orders for nebulizer and IV fluids to ensure nebulizer equipment is stored in a sanitary fashion in a plastic bag and the IV bags/tubing are discarded after use. 4. The results of the observations will be discussed by the Administrator/Designee at the QAPI Committee meeting monthly for (3) three months. The IDT will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 04/04/18	

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	495349	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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§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 and facility document review the facility staff failed to follow established infection control guidelines for 4 of 27 residents in the survey sample (Resident #381, # 386, # 378 and #104).

The findings included:

1. The facility staff failed to store the hand held nebulizer device in a plastic bag for Resident #381.

Resident #381 was admitted to the facility on 2/23/18 with the following diagnoses of, but limited to heart attack, high blood pressure, diabetes, congestive heart failure and generalized weakness. The resident did not have a completed MDS (Minimum Data Set) due to being admitted to the facility on 2/23/18. According to the nursing documentation at the time of admission, the resident was alert and oriented to person, place and time. The resident also required extensive assistance of 1 staff member for bathing.

The surveyor observed the hand held mouthpiece of the nebulizer was lying on the table beside of the resident's bed and was not stored in a plastic bag. The surveyor made this observation on 2/27/18 at 9:30 am. The director of nursing was notified of this observation at 9:40 am. The

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F 880	Continued From page 70	F 880		

director of nursing stated, "I'll take care of this." The surveyor requested a copy of the policy on storage of nebulizer equipment.

The surveyor received a copy of the facility's policy titled "Administrating Medications through a Small Volume (Handheld) Nebulizer" at 10:30 am from the director of nursing. The policy stated, " ...When equipment is completely dry, store in plastic bag with the resident's name and the date on it ..."

The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm.

No further information was provided to the surveyor prior to the exit conference on 3/1/18.

2. The facility staff failed to store the hand held nebulizer device in a plastic bag for Resident #386.

Resident #386 was admitted to the facility on 2/23/18 with the following diagnoses of, but not limited to chronic obstructive pulmonary disease and oxygen dependent. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey since the resident was admitted to the facility on 2/23/18. According to the admission assessment documentation, the resident was alert and oriented to person, place and time. The resident also required limited supervision of 1 staff member for bathing.

The surveyor made an observation on 2/27/18 at 9:45 am of the hand held mouthpiece of the resident's nebulizer to be lying out on a table beside of the bed. This equipment was not

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F 880	Continued From page 71 stored in a plastic bag. The director of nursing (DON) walked by the resident's room when the surveyor made this observation and the surveyor asked the DON to come into the resident's room. The Don stepped into the resident's room and the surveyor pointed out to the DON that the nebulizer equipment was lying out on the table and was not stored in a plastic bag. The DON stated, "I will take care of this immediately." The surveyor received a copy of the facility's policy titled "Administrating Medications through a Small Volume (Handheld) Nebulizer" at 10:30 am from the director of nursing. The policy stated, " ...When equipment is completely dry, store in plastic bag with the resident's name and the date on it ..." The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm. No further information was provided to the surveyor prior to the exit conference on 3/1/18. 3. The facility staff failed to store the hand held nebulizer device in a plastic bag for Resident #378. The surveyor went into Resident #378's room at 9:15 am on 2/27/18 and observed the following: The hand held mouthpiece of the nebulizer was lying out in the room and was not stored in a plastic bag and A 1000cc empty bag of IV fluids was hanging on a pole in the resident's room with the tubing still attached. At 9:30 am, the surveyor asked the director of nursing (DON) to come to the resident's room.	F 880		

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F 880	Continued From page 72 The DON came into the resident's room and the surveyor notified her of the observations as documented above. The DON began taking down the empty IV bag and placed in the resident's trash can. The DON stated, "I will take care of the rest and replace the nebulizer equipment." The surveyor received a copy of the facility's policy titled "Administrating Medications through a Small Volume (Handheld) Nebulizer" at 10:30 am from the director of nursing. The policy stated, " ...When equipment is completely dry, store in plastic bag with the resident's name and the date on it ..." The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm. No further information was provided to the surveyor prior to the exit conference on 3/1/18. 4. The facility staff failed to ensure the nebulizer facemask was contained in a plastic bag when not used by Resident #104. The clinical record of Resident #104 was reviewed 2/27/18 through 3/1/18. Resident #104 was admitted to the facility 1/30/18 and readmitted 2/16/18 with diagnoses that included but not limited to high fever, likely due to aspiration pneumonitis, acute bronchitis, severe protein malnutrition with albumin of 1.4, gastrointestinal hemorrhage, atrial fibrillation, iron deficiency anemia, diastolic heart failure, cerebral infarction, hemiplegia following cerebral infarction affecting right dominant side, muscle wasting, dysphagia, status post PEG tube placement secondary to stroke, fracture of femur, hypertension, dementia without behavioral	F 880		

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disturbances, sacral pressure ulcer, hyperlipidemia, constipation, dry mouth, and urinary tract infection.

Resident #104's 5 day admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/18 assessed the resident with no issues with short term memory, issues with long term memory, and modified independence with some difficulty in new situations.

The surveyor observed Resident #104 on 2/27/18 at 8:37 a.m. Resident #104 was in bed with the head of the bed elevated. On the nightstand, the surveyor observed a nebulizer machine with mask. The mask was not in use and was not contained in a protective covering.

The surveyor spoke with licensed practical nurse #1 on 2/27/18 at 8:40 a.m. and showed L.P.N. #1 the nebulizer mask. L.P.N. #1 stated masks were supposed to be kept in bags when not in use. "I'm going to get a bag now," L.P.N. #1 stated.

The surveyor requested the facility policy on storage of nebulizer equipment from L.P.N. #1.

The surveyor received the policy titled "Administering Medications through a Small Volume (Handheld) Nebulizer" on 2/27/18 at 1:28 p.m. The policy read in part "When equipment is completely dry, store in a plastic bag with the resident's name and the date on it."

The surveyor informed the interim administrator and the director of nursing of the above concern on 2/28/18 at 1:32 p.m. and the administrative staff again on 3/1/18 at 4:37 p.m.

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F 880	Continued From page 74 No further information was provided prior to the exit conference on 3/1/18.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495349	DATE SURVEY COMPLETE: 03/01/2018
NAME OF PROVIDER OR SUPPLIER: CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 990 HOLSTON RD WYTHEVILLE, VA. 24382	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This Requirement is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to provide two Residents with Advance Beneficiary Notice's prior to Medicare services ending, supplemental Resident #1 and supplemental Resident #2. The findings included: 1. For supplemental Resident's #1 the facility staff failed to provide the Resident with an Advance Beneficiary Notice prior to services ending. Supplemental Resident #1 was admitted to the facility on 10/19/17 and Medicare Part A services ended on 11/29/17. The DON (director of nursing) informed the surveyor on 02/28/28 at approximately 1555 that the facility had not provided the Resident and/or representative with an Advance Beneficiary Notice prior to Medicare services ending. The concern of the Advance Beneficiary Notice not being provided to the Resident/representative prior to services ending was discussed with the administrative team during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit

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.

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495349	DATE SURVEY COMPLETE: 03/01/2018
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1 2. For supplemental Resident #2, the facility staff failed to provide the Resident with an Advance Beneficiary Notice prior to services ending. Supplemental Resident #2 was admitted to the facility on 12/28/17 and Medicare Part A services ended on 02/16/18. The Advance Beneficiary Notice was signed by the Resident's representative on 02/21/18; 5 days after services had ended. The concern of the Advance Beneficiary Notice not being provided to the Resident/representative prior to services ending was discussed with the administrative team during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit.

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The above isolated deficiencies pose no actual harm to the residents

State of Virginia

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 02/26/18 through 03/01/18. 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. One complaint was investigated during the survey. The census in this 137 certified bed facility was 121 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3 closed record reviews.	F 000	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.**	
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 Policies and Procedures 12 VAC 5-371-140- cross reference to F849 Residents Rights 12 VAC 5-371-150- cross reference to F550, F565, and F582 Quality Assurance 12 VAC 5-371-170- cross reference to F868 Infection Control 12 VAC 5-371-180- cross reference to F812 and F880	F 001	As this years survey was an Annual Licensure and Recertification Survey, the attached Plan of Correction will cross reference to the statement of deficiencies for the State Licensure requirements. Policies and Procedures 12 VAC 5-371-140- cross reference to F849 Residents Rights 12 VAC 5-371-150- cross reference to F550, F565, and F582 Quality Assurance 12 VAC 5-371-170- cross reference to F868 Infection Control 12 VAC 5-371-180- cross reference to F812 and F880	04/04/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	03/26/2018

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F 001	Continued From Page 1 Nurse Staffing 12 VAC 5-371-210 (B)- cross reference to F732 Nursing Services 12 VAC 5-371-220- cross reference to F684, F760 and F758 Physician Services 12 VAC 5-371-240- cross reference to F635 and F710 Resident Assessment and Care Planning 12 VAC 5-371-250- cross reference to F641, F655, F660 and F690 Pharmacy Services 12 VAC 5-371-300- cross reference to F755 and F756 Diagnostic Services 12 VAC 5-371-310- cross reference to F770 Administration 12 VAC 5-371-360- cross reference to F360, F689 and F842	F 001	Nurse Staffing 12 VAC 5-371-210 (B)- cross reference to F732 Nursing Services 12 VAC 5-371-220- cross reference to F684, F760 and F758 Physician Services 12 VAC 5-371-240- cross reference to F635 and F710 Resident Assessment and Care Planning 12 VAC 5-371-250- cross reference to F641, F655, F660 and F690 Pharmacy Services 12 VAC 5-371-300- cross reference to F755 and F756 Diagnostic Services 12 VAC 5-371-310- cross reference to F770 Administration 12 VAC 5-371-360- cross reference to F360, F689 and F842	