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

PRINTED: 03/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(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 2/04/18 through 3/1/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under the State and Federal law. This plan of correction will serve as the facility's allegation of substantial compliance.	
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.	E 006	F 006 1. Emergency Preparedness Plan requirements regarding evidence of documentation that the facility-based and community-based risk assessment, utilizing an all hazard plan per regulation. 4/10/18 2. Quality review of Emergency Preparedness Plan requirements regarding evidence of documentation that the facility-based and community-based risk assessment, utilizing an all hazard plan per regulation Executive Director (ED)/ designee. 4/10/18 3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding evidence of documentation that the facility-based and community-based risk assessment, utilizing an all hazard plan per regulation 4/10/18	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — DATE: 4/3/18

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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E 006	Continued From page 1 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 have a complete emergency preparedness plan. The facility staff failed to maintain an emergency preparedness plan that included a documented, facility based and community-based risk assessment, utilizing an all-hazards approach including missing resident. Include strategies for addressing emergency events identified by the risk assessment. The findings include: An interview was conducted with administrative staff member (ASM) #1, the administrator and other staff member (OSM) # 7, the director of maintenance on 3/1/18 at 4:35 p.m. When the emergency preparedness policy was reviewed, the policy failed to include a documented, facility based and community-based risk assessment, utilizing an all-hazards approach including missing resident. The emergency preparedness policy also failed to include strategies for addressing emergency events identified by the risk assessment. ASM #1 stated they did not have it. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	E 006	4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan requirements regarding evidence documentation that the facility-based and community-based risk assessment, utilizing an all hazard plan per regulation is completed annually per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018	4/10/18 4/10/18
E 018	Procedures for Tracking of Staff and Patients	E 018		

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E 018 SS=C	Continued From page 2 CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of	E 018	E018 1. Emergency Preparedness Plan requirement regarding policy and procedures of a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility's documenting the specific name and location of the receiving location per regulation. 2. Quality review of Emergency Preparedness Plan requirement regarding policy and procedures of a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility's documenting the specific name and location of the receiving location per regulation. completed by the Executive Director (ED)/ designee.	4/10/18 4/10/18

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E 018	Continued From page 3 communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. 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 have a complete emergency preparedness plan. The facility staff failed to have a system to track the location of on-duty staff and sheltered	E 018	3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding policy and procedures of a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility's documenting the specific name and location of the receiving location per regulation is completed annually per regulation. 4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan requirements regarding policy and procedures of a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility's documenting the specific	4/10/18 4/10/18

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E 018	Continued From page 4 patients in the LTC (long term care) facility during an emergency. The policy also failed to include a way to document the specific name and location of the receiving facility or other location of on-duty staff, and sheltered patients, relocated during the emergency. The findings include: An interview was conducted with administrative staff member (ASM) #1, the administrator and other staff member (OSM) # 7, the director of maintenance on 3/1/18 at 4:35 p.m. When the emergency preparedness policy was reviewed, the policy failed to have a system to track the location of on-duty staff and sheltered patients in the LTC (long-term care) facility during an emergency. The policy also failed to include a way to document the specific name and location of the receiving facility or other location of on-duty staff, and sheltered patients, relocated during the emergency. ASM #1 stated they did not have it. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	E 018	name and location of the receiving location per regulation. weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018	4/10/18
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 023		

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E 023	Continued From page 5 this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. 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 have a complete emergency preparedness plan. The facility staff failed to develop plocies and procedures to preserve patient information, protect confidentiality of palient information,	E 023	E 023 1. Emergency Preparedness Plan requirements regarding a system of medical documentation that preserves patient information protects confidentiality of patient information and secures and maintains availability of records. 2. Quality review of Emergency Preparedness Plan requirements regarding a system of medical documentation that preserves patient information protects confidentiality of patient information and secures and maintains availability of records per regulation completed by the Executive Director (ED)/ designee. 3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding a system of medical documentation that preserves patient information protects confidentiality of patient information and secures and maintains availability of records is completed annually per regulation.	4/10/18 4/10/18 4/10/18

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E 023	Continued From page 6 secure and maintain availability of records. The findings include: An interview was conducted with administrative staff member (ASM) #1, the administrator and other staff member (OSM) # 7, the director of maintenance on 3/1/18 at 4:35 p.m. When the emergency preparedness policy was reviewed, the policy failed to include a system of medical documentation that preserves patient information protects confidentiality of patient information, secure and maintain availability of records. ASM #1 stated they did not have it. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	E 023	4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan requirements regarding a system of medical documentation that preserves patient information protects confidentiality of patient information and secures and maintains availability of records.is completed annually per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	4|10|18
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role	E 024	5. Date of Compliance 04/10/2018	4|10|18

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E 024	Continued From page 7 for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. 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 have a complete emergency preparedness plan. The facility staff failed to develop and ensure policies and procedures that include the use of volunteers In an emergency or other emergency staffing strategies, including the process and role of integration of State and Federally designated health care professionals to address surge needs during an emergency. The findings include: An Interview was conducted with administrative staff member (ASM) #1, the administrator and other staff member (OSM) # 7, the director of maintenance on 3/1/18 at 4:35 p.m. When the emergency preparedness policy was reviewed, the policies and procedures failed to include the use of volunteers in an emergency, or other emergency staffing strategies, including the process and role of integration of State and Federally designated health care professionals to address surge needs during an emergency. ASM #1 stated they did not have it.	E 024	maintains availability of records.is completed annually per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018 E024 1. Emergency Preparedness Plan requirements regarding the development and implementation of strategies for the use of volunteers in an emergency including the process and role for the integration of State and Federally designated healthcare professionals to address surge needs in an emergency per regulation. 2. Quality review of Emergency Preparedness Plan requirements regarding the development and implementation of strategies for the use of volunteers in an emergency including the process and role for the integration of State and Federally designated healthcare professionals to address surge needs in an emergency per regulation completed by the Executive Director (ED)/ designee.	4/10/18 4/10/18 4/10/18

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E 024	Continued From page 8 ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	E 024	3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding the development and implementation of strategies for the use of volunteers in an emergency including the process and role for the integration of State and Federally designated healthcare professionals to address surge needs in an emergency per regulation is completed annually per regulation.	4/10/18
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. 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 have a complete emergency preparedness plan. The facility staff failed to demonstrate the method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. The findings include: An interview was conducted with administrative staff member (ASM) #1, the administrator and other staff member (OSM) # 7, the director of maintenance on 3/1/18 at 4:35 p.m. When the	E 035	4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan requirements regarding the development and implementation of strategies for the use of volunteers in an emergency including the process and role for the integration of State and Federally designated healthcare professionals to address surge needs in an emergency per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018	4/10/18 4/10/18

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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 035	Continued From page 9 emergency preparedness policy was reviewed, the policy failed to demonstrate the method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. ASM #1 stated they did not have it. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	E 035	E035 1. Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives per regulation.	4/10/18
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of	E 039	2. Quality review of Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives per regulation completed by the Executive Director (ED)/ designee. 3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives is completed annually per regulation. 4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives is completed annually per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be	4/10/18 4/10/18 4/10/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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E 039	Continued From page 10 the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plans. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. 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 have a complete emergency preparedness plan	E 039	reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018 E039 1. Emergency Preparedness Plan requirements conducted exercises to test the emergency plan per regulation. 2. Quality review of Emergency Preparedness Plan conducted exercises to test the emergency plan per regulation completed by the Executive Director (ED)/ designee. 3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements conducted exercises to test the emergency plan per regulation is completed annually per regulation. 4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan conducted exercises to test the emergency plan per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018	4/10/18 4/10/18 4/10/18 4/10/18 4/10/18

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E 035	Continued From page 9 emergency preparedness policy was reviewed, the policy failed to demonstrate the method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. ASM #1 stated they did not have it. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	E 035	E035 1. Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives per regulation. 2. Quality review of Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives per regulation completed by the Executive Director (ED)/ designee. 3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives is completed annually per regulation. 4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan requirements regarding evidence of documentation that the communication plan included a method for sharing the information with residents/clients and their families or representatives is completed annually per regulation weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be	4/10/18 4/10/18 4/10/18 4/10/18
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of	E 039		

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E 039	Continued From page 10 the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. 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 have a complete emergency preparedness plan.	E 039	reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018 E039 1. Emergency Preparedness Plan requirements conducted exercises to test the emergency plan per regulation. 2. Quality review of Emergency Preparedness Plan conducted exercises to test the emergency plan per regulation completed by the Executive Director (ED)/ designee. 3. ED re-educated by the Regional Vice President of Operations (RVPO) ensuring Emergency Preparedness Plan requirements conducted exercises to test the emergency plan per regulation. is completed annually per regulation. 4. ED/designee to conduct quality monitoring of Emergency Preparedness Plan to ensure Emergency Preparedness Plan conducted exercises to test the emergency plan per regulation. weekly x 2 weeks, monthly x 2 months, then quarterly and PRN and indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 04/10/2018	4/10/18 4/10/18 4/10/18 4/10/18 4/10/18

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E 039	Continued From page 11 The facility staff failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the facility exercise analysis. The findings include: An interview was conducted with administrative staff member (ASM) #1, the administrator and other staff member (OSM) # 7, the director of maintenance on 3/1/18 at 4:35 p.m. When the emergency preparedness policy was reviewed, the policy failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the facility's exercise analysis. ASM #1 stated they did not have it. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	E 039		
F000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/27/18 through 3/1/18. Corrections are required for compliance with 42 Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 84 certified bed facility was 77 at the time of the survey. The survey sample consisted of 20 current Resident record reviews	F 000		

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F 000	Continued From page 12 (Residents # 128, 42, 57, 67, 44, 61, 55, 28, 58, 46, 40, 39, 11, 180, 27, 178, 71, 9, 65, 30) and three closed resident record reviews, (79, 80, 78).	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		

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F 583	Continued From page 13 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide privacy during the medication administration observation for one of 23 residents in the survey sample, Resident # 9. The facility nurse failed to provide privacy to Resident #9 when administering medications. LPN (licensed practical nurse) # 3 administered Resident # 9's medication in the hallway in full view of other residents and staff members. The findings include: Resident # 9 was admitted to the facility on 02/23/18 with diagnoses that included but were not limited to hemiplegia (1), cellulitis of the left lower limb (leg) (2), aphasia (3), cerebrovascular disease (4) and kidney failure. Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/17, coded Resident # 9 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) being severely impaired of cognition for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff member for activities of daily living. On 02/28/18 at approximately 8:30 a.m. during the medication administration observation LPN (licensed practical nurse) # 3 was observed administering medications to Resident # 9 from a	F 583	F 583 1. Resident #9's privacy observed as maintained during medication administration. Individual re-education provided to LPN # 3 by the Director of Nursing on provision of privacy during medication administration. 2. Quality Observation of resident medication administration for privacy conducted by Director of Nursing/Designee. Follow up based on findings. 3. Licensed Nurses received re-education by Director of Nursing/Designee regarding provision of privacy during medication administration. 4. Director of Nursing/Designee to complete random Quality Improvement Observation for privacy during medication administration weekly x 1 month, biweekly x 1 month, then monthly and prn thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified as needed based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18 4/10/18 4/10/18 4/10/18

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F 583	Continued From page 14 medication cup in the form of pills and tablets. Resident # 9 was in his wheelchair in the hallway. LPN # 3 was at her medication cart in the same hallway as Resident # 9. After LPN # 3 dispensed the medications of Oxybutynin (5) ER (extended release) 5 MG (milligram), Aspirin (6) 81 MG and Metoprolol (7) (12.5 MG) for Resident # 9 into a medication cup, she obtained a cup of water from the medication cart, approached Resident # 9 who was propelling himself in his wheelchair down the hallway toward the medication cart. LPN # 3 asked Resident # 9 if he was ready for his medications and handed him the medication cup and cup of water while in the hallway. Further observation failed to evidence LPN # 3 providing privacy for the administration of Resident # 9's medication. The POS (physician's order sheet) dated February 2018 for Resident # 9 documented, "Oxybutynin (5) ER (extended release) 5 MG (milligram). Take 1 (one) Tab (tablet) by mouth every day for bladder. Aspirin (6) 81 MG. 1 tab by mouth daily for anti-coagulant. Metoprolol (7). 0.5 tab (12.5 MG) by mouth every 12 hours for hypertension." On 02/28/18 at approximately 10:05 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding privacy during the administration of medications to residents. When asked to describe the procedure, ASM # 2 stated, "Nurses should provide privacy when administering medications and not administer them in the hallway. Nurses should initiate asking the resident to go to their room to give the medication but also honor the resident's right not to." When asked what	F 583		

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F 583	Continued From page 15 standard of practice the facility followed, ASM # stated, "Perry and Potter." On 02/28/18 at 11:10 a.m. an interview was conducted with LPN # 3 regarding providing privacy to a resident when administering medications. LPN # 3 stated, "If the resident is not in their room you should ask the resident to go to their room to take their medication. If the resident is in their room you should provide privacy be closing the door or the curtain. Sometimes the resident has a preference and you should respect their preference." When asked if she asked Resident # 9 to go to his room and administer his medications, LPN # 3 stated, "No. I should have asked him if he wanted to go to his room." On 03/01/18 at 9:10 a.m., an interview was conducted with ASM # 2. When asked what standards of practice the facility refers to and uses ASM # 2 stated, "We use a combination of Potter & Perry, Lippincott, state and federal regulations, CDC (Centers for Disease Control) guidelines and company policies." The facility's policy "Privacy" documented, "2. The Resident's privacy will always be respected." The facility's policy "Resident Rights" documented, "It is the policy of The Company to: 2. Ensure the resident's rights are known to staff." The facility's policy "Virginia Resident's Rights and Responsibilities" documented, "Privacy. C. To have privacy when care or medical treatment is being provided." On 03/01/18 at 5:25 p.m. ASM (administrative	F 583		

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F 583	Continued From page 16 staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, divisional nurse were made aware of the above findings. No further information was provided prior to exit. References: (1) Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (2) A common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was obtained from the website: https://medlineplus.gov/ency/article/000855.htm. (3) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html (4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:	F 583		

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F 583	Continued From page 17 https://medlineplus.gov/ency/article/000726.htm . (5) Used to treat overactive bladder (a condition in which the bladder muscles contract uncontrollably and cause frequent urination, urgent need to urinate, and inability to control urination) control urgent, frequent, or uncontrolled urination in people who have overactive bladder (a condition in which the bladder muscles have uncontrollable spasms. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682141.html. (6) Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen). Nonprescription aspirin is also used to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack. Nonprescription aspirin is also used to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682878.html (7) Used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682864.html.	F 583		

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623	F 623 1. Resident #61 returned to facility 2/19/18. Resident #61 and responsible party informed of written timely Discharge Notification Process and acknowledged understanding. Resident #11 and responsible party informed of written timely Discharge Notification Process. 2. The Director of Nursing/Designee conducted a Quality Review of residents discharged over the last thirty days for timely written notification of discharge. Resident Council meeting conducted reviewing timely written Discharge Notification Process. Follow up based on findings.	4/10/18 4/10/18

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495236	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 19 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623	3. Licensed Nurses provided re-education by Director of Nursing/Designee regarding written timely Discharge Notification Process. Administrator provided re-education to Interdisciplinary Team regarding written timely Discharge Notification Process 4. Administrator/Director of Nursing/Designee to conduct Quality Improvement Monitoring of resident/responsible party receiving timely written Discharge Notification utilizing Morning Meeting process 5x/week x 4 weeks, weekly x 4 weeks, then monthly and prn thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18 4/10/18

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F 623	Continued From page 20 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide the resident and/or resident representative notification of a transfer, in writing, for two of 23 residents in the survey sample; Residents #61 and #11. 1. The facility staff failed to notify Resident #61's responsible party in writing of a facility-initiated transfer and admission to the hospital on 2/12/18 and 2/16/18. 2. The facility staff failed to provide notice of transfer, in writing, to the resident and resident representative for Resident #11. The findings include: 1. The facility staff failed to notify Resident #61's responsible party in writing of a facility-initiated	F 623		

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F 623	Continued From page 21 transfer and admission to the hospital on 2/12/18 and 2/16/18. Resident #61 was admitted to the facility on 6/16/15 with the diagnoses of but not limited to Parkinson's disease, stroke, dysphagia, anal cancer, high blood pressure, high cholesterol, and seizure disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/3/17. The resident was coded as being mildly impaired in ability to make daily life decisions, scoring a 12 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing; supervision for eating; as independent for all other area of activities of daily living; and as continent of bowel and bladder. A review of the clinical record revealed Resident #61 was sent to the hospital on 2/12/18 related to a fall with a fracture, returned 2/15/18, and sent back to hospital again on 2/16/18 related to altered mental status, and returned 2/19/18. Review of the clinical record failed to reveal evidence that the responsible party (RP) was notified in writing of the facility-initiated transfers to the hospital for both dates. On 2/28/18 at 3:06 p.m., OSM #5 (Other Staff Member, Business Development) stated, "the RP is not provided written notification of transfer to hospital. I don't send anything in writing." A review of the facility policy, "Notification of Change in Condition" documented, "The nurse to notify the attending physician and Resident Representative when there is a(n):...A transfer or	F 623		

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F 623	Continued From page 22 discharge from the Center....In the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible..." The policy did not provide any direction for providing notification in written format as well. On 3/01/18 at 3:58 p.m., the Director of Nursing (DON, ASM #2, Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. On 3/1/18 at the end of day meeting at approximately 6:00 p.m., the Administrator stated she would obtain details of the concern from the DON, that it wasn't necessary to go over it again. 2. The facility staff failed to provide notice of transfer, in writing, to the resident and resident representative for Resident #11. Resident #11 was admitted to the facility on 12/15/17 with a recent readmission on 2/23/18, with diagnoses that included but were not limited to: high blood pressure, quadriplegia (paralysis affecting all four limbs and trunk of the body below the level of spinal cord injury) (1), muscle wasting, contractures, neurogenic bladder, and stiffness of both shoulders. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 2/14/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating	F 623		

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F 623	Continued From page 23 the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living except eating in which she required limited assistance of one staff member. The physician order dated, 2/20/18, documented, "Send resident out to ER (emergency room) for evaluation and treatment. Please have IDT (interdisciplinary team) assess resident for sepsis." The nurse's note dated, 2/20/18 at 7:42 p.m. documented, "Resident sent to ER for change in mental status. RP (responsible party) made aware." Further review of the clinical record for Resident #11 failed to evidence documentation that the resident or their representative were provided with written notification of Resident #11's transfer to the hospital. On 3/1/18 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how the resident or resident representative notified when a resident is transferred to the emergency room. LPN #2 stated, "We call them on the phone." When asked if they give either the resident or the resident representative anything in writing, LPN #2 stated, "No, we just call them and document it in the clinical record." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/1/18 at 4:14 p.m. When asked when about	F 623		

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F 623	Continued From page 24 the process staff follows when a resident is transferred to the emergency room, ASM #2 stated, "It should be documented in the clinical record, why the resident is being transferred to the hospital. Notify the family or responsible party." When asked how the facility staff notify the family or resident representative, ASM #2 stated, "It's mainly done by phone." When asked if they give the resident or resident representative anything in writing as to why they are going to the emergency room, ASM #2 stated, "Not at this point." The facility policy, Transfers/Discharges notification and Right to Appeal" did not address the written notification of the resident/resident representative upon transfer to the emergency room. The administrator, ASM #2, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 489.	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a	F 624		

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F 624	Continued From page 25 form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to document the preparation, and orientation of the resident or responsible party prior to transfer to the hospital for one of 23 residents in the survey sample, (Resident #61). The facility staff failed to document that Resident #61 was oriented and prepared for hospital transfers that occurred on 2/12/18 and 2/16/18. The findings include: Resident #61 was admitted to the facility on 6/16/15 with the diagnoses of but not limited to Parkinson's disease, stroke, dysphagia, anal cancer, high blood pressure, high cholesterol, and seizure disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/3/17. The resident was coded as being mildly impaired in ability to make daily life decisions, scoring a 12 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #61 was coded as requiring extensive assistance for bathing; supervision for eating; as independent for all other area of activities of daily living; and as continent of bowel and bladder. A review of the clinical record revealed that Resident #61 was sent to the hospital on 2/12/18 related to a fall with a fracture, returned 2/15/18, and sent back to hospital again on 2/16/18	F 624	**F 624** 1. Resident # 61 returned to the facility on 2/19/18. No further discharge/transfers have occurred. Resident/responsible party notified of orientation/preparation of resident/responsible party for transfer and acknowledged understanding. 2. Director of Nursing/Designee conducted a Quality Review of residents transferred/discharged over the last thirty days for documentation of orienting/preparing for discharge. Follow up based on findings. 3. Licensed Nurses re-educated by Director of Nursing/Designee regarding documentation of orienting/preparing residents for discharge.	4/10/16 4/10/16 4/10/16

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F 624	Continued From page 26 related to altered mental status, and returned 2/19/18. Review of the clinical record failed to reveal evidence that the resident or responsible party were oriented to and prepared for transfer to the hospital. On 2/28/18 at 3:16 p.m., LPN #2 (Licensed Practical Nurse) stated when a resident is being sent to the hospital, staff should notify resident what they are going to the hospital for, and if they (the resident) are their own responsible party (RP), staff should ask them if they want someone called. If the resident is not their own RP, then staff should call the RP. She stated staff should document how the resident left and that doctor and RP were made aware. On 2/28/18 at 3:27 p.m., RN #3 (Registered Nurse) stated the nurse should explain to the resident the situation and that they are going to the hospital, for what reason, and which hospital, let them know their family and doctor are aware, and what all to expect, i.e., might get x-rays etc. She reviewed the record for Resident #61 and stated she didn't see the documentation the resident was oriented. She stated, she could not say that the resident was oriented, as it was not documented. A review of the facility policy, Notification of Change in Condition" and the policy "Transfers/Discharges Notification and Right to Appeal" did not include criteria for orienting and preparing a resident for transfer, and documenting the same, for a resident in need of transfer to an acute care hospital.	F 624	4. Director of Nursing/Designee to conduct Quality Improvement Review of discharge orientation/preparation documentation utilizing the Morning Meeting process 5x/week x 4 weeks, weekly x4 weeks, monthly and prn thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18

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F 624	Continued From page 27 On 3/01/18 at 3:58 p.m., the Director of Nursing (DON, ASM #2, Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. On 3/1/18 at the end of day meeting at approximately 6:00 p.m., the Administrator stated she would obtain details of the concern from the DON, that it wasn't necessary to go over it again.	F 624		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625	**F625** 1. Resident # 61 returned to the facility on 2/19/18. Bed Hold Policy reviewed with resident and responsible party and acknowledged understanding. Resident # 11 returned to the facility on 2-23-18. Bed Hold Policy reviewed with resident and acknowledged understanding. 2. Director of Nursing/Designee conducted a Quality Review of residents transferred to the hospital over the last 30 days for written Bed Hold notification. Follow up based on findings.	4/10/18 4/10/18

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F 625	Continued From page 28 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to provide a written bed hold policy/notification to the resident and/or responsible party, within 24 hours of a transfer to the hospital for two of 23 residents in the survey sample; Residents #61 and #11. 1. The facility staff failed to provide a written bed hold policy/notification to Resident #61 and/or responsible party, within 24 hours of a transfer and admission to the hospital on 2/12/18 and 2/16/18. 2. The facility staff failed to provide a written bed hold policy/notification to Resident #11 and/or the resident representative within 24 hours of a transfer and admission to the hospital on 2/20/18. The findings include: 1. The facility staff failed to provide a written bed hold policy/notification to Resident #61 and/or responsible party, within 24 hours of a transfer and admission to the hospital on 2/12/18 and 2/16/18. Resident #61 was admitted to the facility on 6/16/15 with the diagnoses of but not limited to Parkinson's disease, stroke, dysphagia, anal cancer, high blood pressure, high cholesterol, and seizure disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment	F 625	3. Licensed Nurses received re-education on Bed Hold Policy by Director of Nursing/Designee. Social Services Director, Admissions Director and Business Office Manager received re-education by Administrator regarding Bed Hold Policy. 4. Director of Nursing/Designee to conduct Quality Improvement Review of Bed Hold timely notification utilizing Morning Meeting Process 5x/week x 4 weeks, weekly x4 weeks, biweekly x 4 weeks, monthly and prn thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings 5. Date of compliance 04/10/18	4/10/18 4/10/18 4/10/18

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F 625	Continued From page 29 with an ARD (Assessment Reference Date) of 11/3/17. The resident was coded as being mildly impaired in ability to make daily life decisions, scoring a 12 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident required extensive assistance for bathing; supervision for eating; was independent for all other area of activities of daily living; and was continent of bowel and bladder. A review of the clinical record revealed that Resident #61 was sent to the hospital on 2/12/18 related to a fall with a fracture, returned 2/15/18, and sent back to hospital again on 2/16/18 related to altered mental status, and returned 2/19/18. Review of the clinical record failed to reveal evidence that the Resident #61 and or the responsible party (RP) was provided written notification of the bed hold policy for either hospitalization date above. On 2/28/18 at 3:06 PM, OSM #5 (Other Staff Member, Business Development) stated, "I am told when the resident goes out. I check with the nurse to see if the resident was admitted. I call the family and talk to them about the bed hold. I have them come in and sign it if they want it. If not, nothing is provided in writing. I don't send anything in writing. I just keep trying to call them. I do the best I can." OSM #5 stated she was not able to reach the RP for Resident #61 by phone for either above hospitalization date. A review of the facility policy, "Bed Hold Authorization" documented, "This is to confirm your choice to hold a bed while you (your family member) is in the hospital. We will hold a bed	F 625		

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F 625	Continued From page 30 provided you agree to pay the following room rate of (blank space) for each day of the leave and you keep the account current throughout the leave. If you choose not to hold a bed, we cannot guarantee availability of a bed when you are ready for readmission. Please indicate your choice below and return this letter as soon as possible.... { } I wish to hold a bed until I inform you otherwise, { } I do not wish to hold a bed, { } Undecided (will inform facility within 24 hours)..." On 3/01/18 at 3:58 p.m., the Director of Nursing (DON, ASM #2, Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. On 3/1/18 at the end of day meeting at approximately 6:00 p.m., the Administrator stated she would obtain details of the concern from the DON, that it wasn't necessary to go over it again. 2. The facility staff failed to provide a written bed hold policy/notification to Resident #11 and/or the resident representative within 24 hours of a transfer and admission to the hospital on 2/20/18. Resident #11 was admitted to the facility on 12/15/17 with a recent readmission on 2/23/18, with diagnoses that included but were not limited to: high blood pressure, quadriplegia (paralysis affecting all four limbs and trunk of the body below the level of spinal cord injury) (1), muscle wasting, contractures, neurogenic bladder, and stiffness of both shoulders.	F 625		

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F 625	Continued From page 31 The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 2/14/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living except eating in which she was coded as requiring limited assistance of one staff member. The physician order dated, 2/20/18, documented, "Send resident out to ER (emergency room) for evaluation and treatment. Please have IDT (interdisciplinary team) access resident for sepsis." The nurse's note dated, 2/20/18 at 7:42 p.m. documented, "Resident sent to ER for change in mental status. RP (responsible party) made aware." On 3/1/18 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if the staff give the resident a bed hold notice when a resident is transferred to the emergency room. LPN #2 stated, "Only if the resident is admitted does the resident or family get asked about a bed hold and admissions or the social worker will call the resident representative." An interview was conducted with Resident #11 on 3/1/18 at 1:52 p.m. When asked if she is asked to hold the bed when she goes to the hospital, Resident #11 stated, they never ask me for a bed hold because they know I don't have the money	F 625		

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F 625	Continued From page 32 to pay for a bed hold." When asked if her son is given written information about holding a bed, Resident #11 stated, "Not that I am aware of." An interview was conducted with other staff member (OSM) #5, the business development coordinator/admission coordinator, on 3/1/18 at 2:22 p.m., regarding what happens when a resident is transferred to the emergency room and is admitted. OSM #5 stated, "I find out the next day, if the resident is admitted, I try to call the family. Many times, I can't get a hold of the family. That's where it ends. I learned I need to be mailing it out. I just started doing the bed hold in November." When asked if she was given any training to complete the bed holds, OSM #5 stated, "No, just told to call for bed holds." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/1/18 at 4:14 p.m. When asked how bed holds are handled when a resident goes out to the emergency room, ASM #2 stated, "The admission department notifies the resident representative or resident by phone or in person." When asked if they receive anything in writing, ASM #2 stated, "Not at this time, they don't." The administrator, ASM #2, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F656	Continued From page 33 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656	F 656 1. Resident #42 has a current comprehensive care plan for Oxygen implemented. 2. MDS Coordinator/Designee conducted a Quality Review of residents receiving oxygen therapy for comprehensive care plan. Follow up based on findings. 3. Licensed Nurses received re-education by Director of Nursing/Designee regarding - Comprehensive Care Plan implementation for residents receiving oxygen therapy. MDS Coordinator received individual re-education regarding Comprehensive Care Plan implementation for residents receiving oxygen therapy.	4|10|16 4|10|16 4|10|16

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F 656	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for one of 23 residents in the survey sample, Resident #42. The facility staff failed to implement the oxygen care plan for Resident # 42. The findings include: Resident # 42 was admitted to the facility on 12/08/17 and a readmission of 01/03/18 with diagnoses that included but were not limited to intracerebral hemorrhage (1), methicillin resistant staphylococcus aureus (2), dysphagia (3), and hydrocephalus (4). Resident # 42's MDS (minimum data set), a 30-day assessment with an ARD (assessment reference date) of 01/31/18 coded Resident # 42 as being severely impaired of cognition for daily decision-making. Resident # 42 was coded as being totally dependent of one staff person with ADLs (activities of daily living). On 02/28/18 at 3:35 p.m., Resident #42 was observed in her room. Resident # 42 was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed oxygen was being delivered between one and a half and two liters per minute. On 02/28/18 at 4:05 p.m., Resident #42 was observed in her room. Resident # 42 was lying in	F 656	4. MDS Coordinator/Designee to conduct Quality Improvement Monitoring of residents receiving oxygen therapy for validation of comprehensive care plan utilizing the Morning Clinical Meeting Process 5x/week x 4 weeks, weekly x4 weeks, monthly and prn thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18

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F 656	Continued From page 35 bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed oxygen was being delivered between one and a half and two liters per minute. The "Physician's Telephone Order," dated 02/28/18 documented, "O2 (oxygen) at 2LPM (two liters per minute) continuous." The TAR (treatment administration record) dated February 2018 documented the administration of oxygen at two liters per minute on 02/28/18. The comprehensive care plan dated 12/11/17 for Resident # 42 documented, "Focus. The resident has ineffective breathing pattern r/t (related to) Dyspnea and SOB (shortness of breath)." Under "Interventions" it documented, "Oxygen as ordered. Date Initiated: 12/11/2017." On 03/01/18 at 12:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the purpose of the care plan LPN # 4 stated, "So everyone has a picture of the treatment for that resident." LPN #4 was informed of the observations of Resident # 42's oxygen flow rate set between one and a half liters and two liters. The "Physician's Telephone Order" dated 02/28/18 and care plan dated 12/11/17, were reviewed with LPN #4. When asked if the care was being followed for oxygen administration. LPN # 4 stated, "No." On 03/01/18 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the purpose of the care plan, ASM # 2 stated, "To help the health care team to	F 656		

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F 656	Continued From page 36 coordinate care. If it is documented on the care plan it should be carried out." On 03/01/18 at 5:25 p.m. ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, divisional nurse were made aware of the above findings. No further information was provided prior to exit. References: (1) Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm. (2) MRSA is a "staph" germ that does not get better with the type of antibiotics that usually cure staph infections. When this occurs, the germ is said to be resistant to the antibiotic. This information was obtained from the website: https://medlineplus.gov/ency/article/007261.htm. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) A buildup of fluid inside the skull that leads to brain swelling. This information was obtained from the website: https://medlineplus.gov/ency/article/001571.htm. F 658 SS=D Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 656 F 658	**F658:** 1. Resident #9 did not exhibit any signs/symptoms of negative psychosocial effects r/t medication administered in the hallway. Resident #9 care plan updated as indicated to reflect resident's choice regarding medication administration in the hallway. LPN #3 re-educated by the Director of Nursing (DON) 3/6/18 regarding privacy and dignity r/t medication pass per professional standards along with process for honoring resident's choice. Resident #71 did not suffer any signs/symptoms of adverse effects r/t identified medications being administered outside of the "1 hour window" on 3/18/18. Resident #71 continues to receive medications per physician order. LPN #4 re-educated 3/6/18 by the DON regarding ensuring medications are administered between the 1 hour before and 1 hour after the scheduled timeframe per professional standards along with the process of contacting the physician when medications are administered outside the allotted time-frame of 1 hour before and 1 hour after the scheduled time per professional standards.	4/10/18

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F 658	Continued From page 37 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 23 residents in the survey sample. Resident # 9 and # 71. 1. The facility failed to follow professional standards of practice by not providing privacy during the medication administration observation for Resident # 9's. 2. Resident #71's 8:00 a.m., and 9:00 a.m., medications were not administered until 11:21 a.m., on 2/27/18. The findings include: 1. The facility failed to follow professional standards of practice by not providing privacy during the medication administration observation for Resident # 9's. Resident # 9 was admitted to the facility on 02/23/18 with diagnoses that included but were not limited to hemiplegia (1), cellulitis of the left lower limb (leg) (2), aphasia (3), cerebrovascular disease (4) and kidney failure. Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/17, coded Resident # 9 as scoring a 3 (three) on the brief	F 658	F 658 2. Quality review completed by the DON/Unit Managers (UM)/designee regarding ensuring privacy is maintained during medication pass per professional standards. Follow up as indicated. Quality review of current residents Medication Administration Record (MAR) completed by the DON/UM/designee regarding ensuring medications are administered between the allotted time-frame of 1 hour before and 1 hour after the scheduled time per professional standards. Follow up as indicated. Quality review of current residents completed by the DON/UM/designee to ensure the physician is contacted when medications are administered outside the allotted time-frame of 1 hour before and 1 hour after the scheduled time per professional standards.	4/10/18

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F 658	Continued From page 38 interview for mental status (BIMS) of a score of 0 - 15, 3 (three) being severely impaired of cognition intact for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff member for activities of daily living. On 02/28/18 at approximately 8:30 a.m. during the medication administration observation, LPN (licensed practical nurse) # 3 was observed administering medications to Resident # 9 from a medication cup in the form of pills and tablets. Resident # 9 was in his wheelchair in the hallway. LPN # 3 was at her medication cart in the same hallway as Resident # 9. After LPN # 3 dispensed the medications of Oxybutynin (5) ER (extended release) 5 MG (milligram), Aspirin (6) 81 MG and Metoprolol (7) (12.5 MG) for Resident # 9 into a medication cup, she obtained a cup of water from the medication cart, approached Resident # 9 who was propelling himself in his wheelchair down the hallway toward the medication cart. LPN # 3 asked Resident # 9 if he was ready for his medications and handed him the medication cup and cup of water while in the hallway. Further observation failed to evidence LPN # 3 providing privacy for the administration of Resident # 9's medication. The POS (physician's order sheet) dated February 2018 for Resident # 9 documented, "Oxybutynin (5) ER (extended release) 5 MG (milligram). Take 1 (one) Tab (tablet) by mouth every day for bladder. Aspirin (6) 81 MG. 1 tab by mouth daily for anti-coagulant. Metoprolol (7). 0.5 tab (12.5 MG) by mouth every 12 hours for hypertension."	F 658	3. Licensed nurses re-educated by the DON/UM ensuring privacy is maintained during medication pass per professional standards. Licensed nurses re-educated by the DON/UM ensuring medications are administered between the allotted time-frame of 1 hour before and 1 hour after the scheduled time per professional standards. Licensed nurses re-educated by the DON/UM regarding the process of contacting the physician when medications are administered outside the allotted time-frame of 1 hour before and 1 hour after the scheduled time per professional standards. Medication skills checklist competency conducted as indicated.	4/10/18

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F 658	Continued From page 39 On 02/28/18 at approximately 10:05 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding privacy during the administration of medications to residents. When asked to describe the procedure, ASM # 2 stated, "Nurses should provide privacy when administering medications and not administer them in the hallway. Nurses should initiate asking the resident to go to their room to give the medication but also honor the resident's right not to." On 02/28/18 at 11:10 a.m. an interview was conducted with LPN (licensed practical nurse) # 3 regarding privacy to a resident when administering medications. LPN # 3 stated, "If the resident is not in their room you should ask the resident to go to their room to take their medication. If the resident is in their room you should provide privacy be closing the door or the curtain. Sometimes the resident has a preference and you should respect their preference." When asked if she asked Resident # 9 to go to, his room and administer his medications, LPN # 3 stated, "No. I should have asked him if he wanted to go to his room." On 03/01/18 at 9:10 a.m., an interview was conducted with ASM # 2. When asked what standards of practice the facility refers to and uses, ASM # 2 stated, "We use a combination of Potter & Perry, Lippincott, state and federal regulations, CDC (Centers for Disease Control) guidelines and company policies." The facility's policy "Virginia Resident's Rights and Responsibilities" documented, "Privacy. C. To have privacy when care or medical treatment is being provided."	F 658	4. DON/UM/designee to conduct random medication pass observation quality reviews of current licensed nurses to ensure privacy is maintained during medication pass per professional standards 3 times weekly x 4 weeks, 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. DON/UM/designee to conduct random medication pass observations quality reviews of current Licensed nurses to ensure medications are administered between the allotted time-frame of 1 hour before and 1 hour after the scheduled time 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. Medication skills checklist competency conducted as indicated. DON/UM/designee to conduct random quality reviews of current licensed nurses to ensure medications are administered outside the allotted time-frame of 1 hour before and 1 hour after the scheduled time per professional standards and physician notified if medications administered outside the allotted time 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated.	4/10/18

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	495236	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 40 On 03/01/18 at 5:25 p.m. ASM (adminjstrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, divisional nurse were made aware of the above findings. No further information was provided prior to exit. References: (1) Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (2) A common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was obtained from the website: https://medlineplus.gov/ency/article/000855.htm. (3) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html (4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting	F 658	Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18

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F 658	Continued From page 41 damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (5) Used to treat overactive bladder (a condition in which the bladder muscles contract uncontrollably and cause frequent urination, urgent need to urinate, and inability to control urination) control urgent, frequent, or uncontrolled urination in people who have overactive bladder (a condition in which the bladder muscles have uncontrollable spasms. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682141.html. (6) Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen). Nonprescription aspirin is also used to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack. Nonprescription aspirin is also used to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682878.html (7) Used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: https:	F 658		

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F 658	Continued From page 42 https://medlineplus.gov/druginfo/meds/a682864.html. 2. Resident #71's 8:00 a.m., and 9:00 a.m., medications were not administered until 11:21 a.m., on 2/27/18. Resident #71 was admitted to the facility on 1/11/17 with the diagnoses of but not limited to dysphagia, chronic embolism and thrombosis (blood clots), osteoarthritis, high cholesterol, dementia, psychotic disorder, depression, anxiety disorder, high blood pressure, and fracture of the left clavical. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 1/19/18. The resident was coded as being significantly impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing; as independent for all other areas of activities of daily living; and as continent of bowel and bladder. On 2/27/18 at 11:21 a.m., LPN #4 (Licensed Practical Nurse) was observed preparing and administering the following medications for Resident #71: Metoprolol [1] 25 mg (milligrams), 1/2 tab (tablet) (12.5 mg) Zoloft [2] 100 mg and 50 mg tabs to equal 150 mg. Seroquel [3] 100 mg tab Senna [4] 8.6 mg tab Xarelto [5] 20 mg tab On 2/27/18 at approximately 12:30 p.m., a review of the clinical record revealed the following orders	F 658		

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F 658	Continued From page 43 for the above medications: Metoprolol 25mg, 1/2 tab (12.5mg) by mouth every morning. Seroquel 100mg 1 tab by mouth daily. Senna 8.6mg 1 tab by mouth twice daily. Zoloft 100mg 1 tab by mouth every morning Zoloft 50mg 1 tab by mouth every morning, take with current 100mg dose to equal 150mg. Xarelto 20mg 1 tab by mouth every day. A review of the February 2017 MAR (Medication Administration Record) revealed the Seroquel was scheduled for administration at 8:00 a.m., and the Metoprolol, Senna, Zoloft, and Xarelto were all scheduled to be administered at 9:00 a.m. LPN #4 administered the medications at 11:21 a.m. On 2/27/18 at 12:40 p.m., in an interview with LPN #4, he stated that meds (medications) are to be given 1 hour before to 1 hour after the scheduled time. LPN #4 stated, "I am running behind." When asked the facility protocol for administering medications outside of the ordered time frame, LPN #4 stated he did not know if there was a protocol. A review of the facility policy, "Medications - Oral Administration Of" did not document the required time frame of administering medications between 1 hour before to 1 hour after the scheduled time; and did not specify what staff are to do if they are not able to administer the medications timely. On 3/01/18 at 3:58 p.m., the Director of Nursing (DON, ASM #2, Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 658		

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F 658	Continued From page 44 On 3/1/18 at the end of day meeting at approximately 6:00 p.m., the Administrator stated she would obtain details of the concern from the DON, that it wasn't necessary to go over it again. According to Fundamentals of Nursing 6th Edition, 2005: Patricia A. Potter and Anne Griffin Perry; Mosby, Inc., page 843, "All routinely ordered medications should be given within 60 minutes of the times ordered." According to Fundamentals of Nursing, Craven and Hirnle; Lippincott, Williams &Wilkins page 566; Many institutions consider a medication to be given "on time" if it is administered within 30 minutes to 1 hour before or after the scheduled dose time." [1] Metoprolol is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html [2] Zoloft is used to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html [3] Seroquel is used to treat symptoms of schizophrenia and bipolar disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html [4] Senna is used to treat constipation Information obtained from https://medlineplus.gov/druginfo/meds/a601112.ht	F 658		

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F 658	Continued From page 45 ml [5] Xarelto is used to prevent blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a611049.html	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide wound care in manner to promote healing for one of 23 residents in the survey sample, Resident #11. The facility staff failed to obtain a physician order for the application of a wound vac (vacuum) [1] for Resident #11, and failed to administer a treatment in a manner to promote healing and prevent infection.	F 686	1. Resident #11 physician order obtained for frequency of application of the wound vac on 3/1/18. Resident # 11 did not suffer any signs/symptoms of infection to the identified sacral wound. LPN #2 re-educated on 3/6/18 by the Director of Nursing (DON) regarding ensuring physician orders are obtained for residents requiring wound care/wound vac. LPN #2 clean dressing change skills competency checklist conducted 3/15/18. 2. Quality review completed by the Director of Nursing (DON)/Unit Managers (UM)/designee Treatment Administration Record (TAR) regarding ensuring physician orders are obtained for residents requiring wound care/wound vac. Follow up as indicated. Quality review completed by the Director of Nursing (DON)/Unit Managers (UM)/designee Treatment Administration Record (TAR) regarding ensuring physician orders are obtained for residents requiring a wound vac. Follow up as indicated.	4/10/18 4/16/18

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F 686	Continued From page 46 The findings include: Resident #11 was admitted to the facility on 12/15/17 with a recent readmission on 2/23/18, with diagnoses that included but were not limited to: high blood pressure, quadriplegia (paralysis affecting all four limbs and trunk of the body below the level of spinal cord injury) [2], muscle wasting, contractures, neurogenic bladder, and stiffness of both shoulders. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 2/14/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living except eating in which she required limited assistance of one staff member. In Section M - Skin Conditions, the resident was coded as having a Stage 3 pressure ulcer. On 2/27/18 at approximately 4:00 p.m., LPN (licensed practical nurse) #2 was observation applying a wound vac to Resident #11's sacral wound. Observation was made of LPN #2 applying a wound vac to the sacral wound for Resident #11 on 2/27/18 at approximately 4:00 p.m. LPN #2 gathered her supplies. She proceeded to spray the wound with normal saline wound cleanser. She took a gauze pad and wiped from the inside to the outside of the wound. She took a second gauze pad and wiped the wound from the inside to the outside. Then using the same gauze, wiped down the edges of the	F 686	3. Licensed Nurses re-educated by the DON/UM regarding ensuring physician orders are obtained for residents requiring wound care/wound vac. Clean dressing change skills competency checklist conducted as indicated. 4. DON/UM/designee to conduct random quality reviews of current residents TAR to ensure physician orders are obtained for residents requiring wound care 3 times weekly x 4 weeks, 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. Clean dressing change skills competency checklist conducted as indicated. DON/UM/designee to conduct random quality reviews of current residents TAR to ensure physician orders are obtained for residents requiring a wound vac 3 times weekly x 4 weeks, 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18 4/10/18

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F 686	Continued From page 47 skin outside the wound and then went back to the center of the wound. Review of the clinical record did not reveal any documented physician order for the application of the wound vac. The comprehensive care plan dated, 12/20/17, documented in part, "Focus: The resident has impaired skin integrity: Sacrum - wound vac." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness." An interview was conducted with LPN #2 on 2/28/18 02:32 p.m., regarding how a wound should be cleaned. LPN #2 stated, "You must clean it from the inside out." At this time, the observation of her wound care on 2/27/18 was shared with LPN #2. A second interview was conducted with LPN #2 on 3/1/18 at 1:44 p.m. When asked about a physician's order for the wound vac that she applied on 2/27/18, LPN #2 showed this writer the order dated, 2/23/18, which documented, "Use (other dressing) until wound vac arrives." When asked if there was a physician's order for how often to change the dressing, LPN #2 stated, "Primarily it is changed three times a week." When asked where that order is written, LPN #2 searched the clinical record and stated, "There is no order for the wound vac." An interview was conducted with administrative staff member (ASM) #2, on 3/1/18 at 4:14 p.m.	F 686		

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F 686	Continued From page 48 When asked if there needs to be a physician order for the use of a wound vac that includes how often the dressing is to be changed, ASM #2 stated, "Yes, Ma'am." When asked how staff should clean a wound, ASM #2 stated, "They apply the physician ordered wound cleanser and then wipe the wound from the center outward, never going up and down or back and forth." ASM #2 was asked if a nurse should not go over an area that she has already cleaned with the same gauze pad, ASM #2 stated, "Yes, wipe from the center out then get a new gauze." The observation of the wound care was shared with ASM #2. The facility policy, "Dressing Change" documented in part, "Policy: A clean dressing will (be) (sic) applied by a nurse to a wound as ordered to promote healing." "Cleanse wound as ordered, dispose of gauze." The administrator, ASM #2, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m. No further information was provided prior to exit. (1) Negative pressure wound therapy is not a new concept in wound therapy. It is also called sub atmospheric pressure therapy, vacuum sealing, vacuum pack therapy and sealing aspirate therapy. The aim of the procedure is to use negative pressure to create suction, which drains the wound of exudate (i.e., fluids, cells and cellular waste that has escaped from blood vessels and seeped into tissue) and influences the shape and growth of the surface tissues in a	F 686		

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F 686	Continued From page 49 way that helps healing. During the procedure, a piece of foam is placed over the wound, and a drain tube is placed over the foam. A large piece of transparent tape is placed over the whole area, including the healthy tissue, to secure the foam and drain the wound. The tube is connected to a vacuum source, and fluid is drawn from the wound through the foam into a disposable canister. Thus, the entire wound area is subjected to negative pressure. The device can be programmed to provide varying degrees of pressure either continuously or intermittently. It has an alarm to alert the provided or patient if the pressure seal breaks or the canister is full. Negative pressure wound therapy may be used for patients with chronic and acute wounds; subacute wounds (dehised incisions); chronic, diabetic wound s or pressure ulcers; meshed grafts (before and after); flaps. It should not be used for patients with fistulae to organs/body cavities, necrotic tissue that has not been debrided, untreated osteomyelitis, wound malignance, wounds that require homeostasis or for patients who are taking anticoagulants." This information was obtained from the following website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3379164/ (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 489.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		

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F 695	Continued From page 50 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to administer oxygen at the physician ordered rate for two of 23 residents in the survey sample; Residents # 42 and # 11. 1. The facility staff failed to administer Resident # 42's oxygen according to the physician's orders. 2. Resident #11 was observed receiving oxygen at 2 liters per minute via a nasal cannula connected to an oxygen concentrator. The facility staff failed to have a physician order for Resident #11 to receive oxygen. The findings include: 1. The facility staff failed to administer Resident # 42's oxygen according to the physician's orders. Resident # 42 was admitted to the facility on 12/08/17 and a readmission of 01/03/18 with diagnoses that included but were not limited to: intracerebral hemorrhage (1), methicillin resistant staphylococcus aureus (2), dysphagia (3), and hydrocephalus (4). Resident # 42's MDS (minimum data set), a 30-day assessment with an ARD (assessment reference date) of 01/31/18 coded Resident # 42 as being severely impaired of cognition for daily	F 695	1. Resident #42's oxygen flow rate adjusted 3/1/18 per physician order. Resident #42 physician notified 3/1/18 with documentation in the medical record. Physician order obtained 3/1/18 for resident #11 r/t administration of oxygen. RN #2 re-educated by the Director of Nursing (DON) 3/22/18 regarding ensuring resident's receive oxygen per physician order. RN #2 re-educated by the DON 3/22/18 regarding ensuring physician orders are obtained for residents who require use of oxygen. 2. Quality review completed by the DON/Unit Managers (UM)/designee regarding ensuring physician orders are obtained for residents who require use of oxygen. Follow up as indicated. Quality review completed by the DON/UM/designee of current resident receiving oxygen to ensure oxygen flow rate is administered per physician order. Follow up as indicated.	4/10/18 4/10/18

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F 695	Continued From page 51 decision-making. Resident # 42 was coded as being totally dependent of one staff person with ADLs (activities of daily living). On 02/28/18 at 3:35 p.m., Resident #42 was observed in her room. Resident # 42 was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed oxygen was being delivered at a flow rate between one and a half and two liters per minute. On 02/28/18 at 4:05 p.m. Resident #42 was observed in her room. Resident # 42 was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed oxygen was being delivered at a flow rate between one and a half and two liters per minute. The "Physician's Telephone Order," dated 02/28/18 documented, "O2 (oxygen) at 2LPM (two liters per minute) continuous." The TAR (treatment administration record) dated February 2018 documented the administration of oxygen at two liters per minute on 02/28/18. The comprehensive care plan dated 12/11/17 for Resident # 42 documented, "Focus. The resident has ineffective breathing pattern r/t (related to) Dyspnea and SOB (shortness of breath)." Under "Interventions" it documented, "Oxygen as ordered. Date Initiated: 12/11/2017." On 02/28/18 at 4:35 p.m., an interview was conducted with RN (registered nurse) # 2, regarding the procedure for determining oxygen flow rate. When asked how often a resident's	F 695	3. Licensed Nurses re-educated by the DON/UM/designee regarding ensuring physician orders are obtained for residents who require use of oxygen. Licensed Nurses re-educated by the DON/UM/designee regarding to ensure oxygen flow rate is administered per physician order. 4. DON/UM/designee to conduct random quality reviews through mock survey rounds of current residents to ensure oxygen flow rate is administered per physician order 3 times weekly x 4 weeks, 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. DON/UM/designee to conduct random quality reviews of current residents Medication Administration Record (MAR) to ensure physician orders are obtained for residents who require use of oxygen 3 times weekly x 4 weeks, 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18 4/10/18

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F 695	Continued From page 52 oxygen flow rate is checked RN # 2 stated, "Once a shift and prn (as needed)." When asked how to read the flow rate on the oxygen concentrator, RN # 2 stated, "The liter line on the float tube should pass through the middle of the ball. When asked what Resident # 42's oxygen flow rate should set at, RN # 2 stated, "It is two liters per minute." RN # 2 was asked to accompany this surveyor to Resident # 42's room. Upon entering Resident # 42's room RN # 2 was asked to read the oxygen flow rate setting of Resident # 42's oxygen concentrator. RN # 2 stated, "It's between one and a half and two liters per minute." RN # 2 then proceeded to adjust the oxygen flow rate on Resident # 42's oxygen concentrator to two liters per minute. On 03/01/18 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked how the read the flow rate on the oxygen concentrator ASM # 2 stated, "The liter line on the float tube should pass through the middle of the ball." On 03/01/18 at 5:25 p.m. ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, divisional nurse were made aware of the above findings. No further information was provided prior to exit. References: (1) Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm.	F 695		

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F 695	Continued From page 53 (2) MRSA is a "staph" germ that does not get better with the type of antibiotics that usually cure staph infections. When this occurs, the germ is said to be resistant to the antibiotic. This information was obtained from the website: https://medlineplus.gov/ency/article/007261.htm. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) A buildup of fluid inside the skull that leads to brain swelling. This information was obtained from the website: https://medlineplus.gov/ency/article/001571.htm. 2. Resident #11 was observed receiving oxygen at 2 liters per minute via a nasal cannula connected to an oxygen concentrator. The facility staff failed to have a physician order for Resident #11 to receive oxygen. Resident #11 was admitted to the facility on 12/15/17 with a recent readmission on 2/23/18, with diagnoses that included but were not limited to: high blood pressure, quadriplegia (paralysis affecting all four limbs and trunk of the body below the level of spinal cord injury) (1), muscle wasting, contractures, neurogenic bladder, and stiffness of both shoulders. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 2/14/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily	F 695		

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F 695	Continued From page 54 cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living except eating in which she required limited assistance of one staff member. Observation was made of Resident #11 on 2/27/18 at approximately 12:00 p.m., in her bed, with oxygen on via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) connected to an oxygen concentrator set at 2L/min (liters/minute). Observation was made of Resident #11 on 2/28/18 at 10:14 a.m. The resident was receiving oxygen via nasal cannula connected to an oxygen concentrator set at 2L/min. Observation was made of Resident #11 on 3/1/18 at 1:41 p.m. accompanied by LPN (licensed practical nurse) #2. The resident had oxygen on at 2L/min via a nasal cannula connected to an oxygen concentrator. Review of the physician orders since readmission on 2/23/18, did not evidence a physician order for oxygen. Review of the baseline care plan dated, 2/13/18, failed to evidence documentation regarding the use of oxygen by Resident #11. Review of the comprehensive care plan dated, 12/20/17, failed to evidence documentation regarding the use of oxygen by Resident #11. Review of the February and March MAR (medication administration record) and the TAR	F 695		

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F 695	Continued From page 55 (treatment administration record) failed to evidence any documentation related to the use of oxygen by Resident #11. On 3/1/18 at 1:44 p.m., LPN #2 was asked to locate the physician order for oxygen in the clinical record. After 15 minutes of looking, LPN #2 stated, "There is no order for the oxygen." When asked if there needs to be a physician order for oxygen, LPN #2 stated, "Yes." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/1/18 at 4:15 p.m. When asked if there needs to be a physician order for the administration of oxygen, ASM #2 stated, "Yes." The facility policy, "Oxygen Therapy" documented in part, "Procedure: 1. The nurse will organize the oxygen therapy as ordered by the resident's physician...7. Adjust the flow of oxygen as ordered by the physician." According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." The administrator, ASM #2, and ASM #3, the divisional nurse, were made aware of the above findings on 3/1/18 at 5:25 p.m.	F 695		

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F 695	Continued From page 56 No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 489.	F 695		
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 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.	F 756	1. Resident #30 re-assessed by the Nurse practitioner on 3/14/18. No signs/symptom of adverse reactions was identified with documentation as such in the medical record. Resident #30's need for use of Remeron reviewed by the Nurse Practitioner 3/14/18. New order received to discontinue Remeron 3/14/18. 2. Quality review of current residents completed by the Consultant Pharmacist to ensure residents receiving Remeron have an appropriate diagnosis documented in the medical record. Follow up as indicated. Quality review of current residents medication regimen completed by the Consultant Pharmacist to ensure an appropriate diagnosis is documented for each medication. Follow up as indicated. Quality review of current residents Pharmacy Recommendations completed by DON to ensure identified medication irregularities are reported to the physician. Follow up as indicated.	4/10/18 4/10/18

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F 756	Continued From page 57 §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, clinical record review, and facility document review, it was determined that the facility pharmacy failed to identify and report medication irregularities to the facility physician for one of 23 residents in the survey sample; Resident #30. For Resident #30, the facility pharmacy staff failed to recognize the medication Remeron was prescribed without the proper diagnosis, and did not report this irregularity to the facility physician. The findings include: Resident #30 was admitted to the facility on 11/26/10 with the diagnoses of but not limited to left ulna fracture, chronic obstructive pulmonary disease, high cholesterol, diabetes, osteoporosis, heart failure, cataracts, high blood pressure, hypothyroidism, and generalized edema. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/13/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for all other areas of activities of daily living; limited assistance for eating; and as incontinent of bowel and bladder.	F 756	3. Consultant Pharmacist re-educated by the Supervising Pharmacist regarding ensuring medications have an appropriate diagnosis documented in the medical record. Consultant Pharmacist re-educated by the Supervising Pharmacist regarding ensuring medication irregularities identified are reported to the physician through monthly Pharmacy Recommendations by facility. Consultant Pharmacist re-educated by the Supervising Pharmacist regarding ensuring residents receiving Remeron have an appropriate diagnosis.	4/10/18

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F 756	Continued From page 58 A review of the clinical record revealed an order dated 8/11/17 for "Remeron 7.5 mg (milligram) tab (tablet), 1 tab PO (by mouth) at bedtime daily, appetite loss." According to MedlinePlus.gov, Remeron is an antidepressant and is used to treat depression. Resident #30 did not have a diagnosis of depression in her clinical record. On 3/1/18 at 2:25 p.m., in an interview with ASM #3 (Administrative Staff Member, the Nurse Practitioner), she stated that it is borderline if Resident #30 has depression or not. She stated that the appetite stimulant medication Megace [2] has medical risks for exacerbating congestive heart failure, etc., and that she was not sure about what other options are available. A review of the clinical record revealed the monthly pharmacy "Medication Regimen Review" for August 2017 through February 2018. There was no documentation evidencing the pharmacy had identified and reported the concern of using Remeron for reasons not approved by the FDA (Food and Drug Administration), for the 6 months, the resident had been on the medication. On 3/1/18 at 2:40 p.m., in an interview with OSM #7 (Other Staff Member, the pharmacist), he stated that a GDR (Gradual Dose Reduction) was recommended "last week" from 7.5 to 3.75 mg. He stated he was not aware of a requirement that medications must be FDA (Food and Drug Administration) approved for the specific use it is being ordered for, just for the overall safety of the medication. He stated he will not reject a script because it is ordered for an off-label use if it is the	F 756	4. Consultant Pharmacist to conduct quality reviews through monthly Drug Regimen Review to ensure medications have an appropriate diagnosis documented in the medical record monthly and PRN as indicated. Consultant Pharmacist to conduct quality reviews through monthly Drug Regimen Review to ensure identified medication irregularities are reported to the physician. Consultant Pharmacist to conduct quality reviews through monthly Drug Regimen Review to ensure residents receiving Remeron have an appropriate diagnosis. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	3 4 | 10 | 18

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F 756	Continued From page 59 resident's best clinical interest (note: only a physician or physician extender can make clinical determinations.) He stated, "I'm not going to say that it is inappropriate." The resident was on the medication from August 2017 through February 2017 without a proper diagnosis and without the pharmacy identifying and reporting this. A review of the facility policy, "Monthly Drug Regimen Review" documented, "During the drug regimen review the consultant pharmacist will identify apparent irregularities. Apparent irregularities to be communicated to the attending physician, the Medical Director and the DCS/designee...." A review of the facility policy, "Psychoactive Medications" documented, "Treat the resident's medical or psychiatric condition in accordance with acceptable standards of practice, and the right to be free of unnecessary medication....Drug Regimen reviews to be conducted monthly by the pharmacist for unnecessary use, excessive doses or duration in absence of acceptable medical diagnosis according to standard of practice. Recommendations to be communicated to the attending physician." On 3/01/18 at 3:58 p.m., the Director of Nursing (DON, ASM #2, Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. The facility was not able to locate the GDR that OSM had referred too. On 3/1/18 at the end of day meeting at approximately 6:00 p.m.,, the Administrator stated she would obtain details of the concern from the DON, that it wasn't necessary to go over it again.	F 756		

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F 756	Continued From page 60 [1] Remeron is used to treat depression Information obtained from https://medlineplus.gov/druginfo/meds/a697009.html [2] Megace - Megestrol tablets are used to relieve the symptoms and reduce the suffering caused by advanced breast cancer and advanced endometrial cancer (cancer that begins in the lining of the uterus). Megestrol suspension is used to treat loss of appetite, malnutrition, and severe weight loss in patients with acquired immunodeficiency syndrome (AIDS). Megestrol should not be used to prevent loss of appetite and severe weight loss in patients who have not yet developed this condition. Information obtained from https://medlineplus.gov/druginfo/meds/a682003.html	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that—	F 758		

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F 758	Continued From page 61 §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, clinical record review, and facility document review, it was determined that the facility staff failed to ensure one of 23 residents in the survey sample, (Resident #30), was free of unnecessary medications; .	F 758	1. Resident #30 Remeron discontinued 3/14/18. 2. Quality review of current residents completed by the Consultant Pharmacist to ensure residents receiving Remeron have an appropriate diagnosis documented in the medical record. Follow up as indicated. Quality review of current residents medication regimen completed by the Consultant Pharmacist to ensure an appropriate diagnosis is documented in the medical record for residents receiving Anti-depressant medication(s). Follow up as indicated. Quality review of current residents completed by the DON/UM to ensure Pharmacy Recommendations identified by the Consultant Pharmacist are reported to the physician as indicated. Follow up as indicated. Quality review of current residents completed by the Consultant Pharmacist to ensure residents are free from unnecessary medications r/t Psychotropic medication. Follow up as indicated.	4/10/18 4/10/18

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F 758	Continued From page 62 The facility staff failed to ensure a proper diagnosis for the administartion of Remeron to Resident #30. The findings include: Resident #30 was admitted to the facility on 11/26/10 with the diagnoses of but not limited to left ulna fracture, chronic obstructive pulmonary disease, high cholesterol, diabetes, osteoporosis, heart failure, cataracts, high blood pressure, hypothyroidism, and generalized edema. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/13/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for all other areas of activities of daily living; limited assistance for eating; and as incontinent of bowel and bladder. A review of the clinical record revealed an order dated 8/11/17 for "Remeron 7.5 mg (milligram) tab (tablet), 1 tab PO (by mouth) at bedtime daily, appetite loss." According to MedlinePlus.gov, Remeron is an antidepressant and is used to treat depression. Resident #30 did not have a diagnosis of depression in her clinical record. On 3/1/18 at 2:25 p.m., in an interview with ASM #3 (Administrative Staff Member, the Nurse Practitioner), she stated that it is borderline if Resident #30 has depression or not. She stated	F 758	3. Consultant Pharmacist re-educated by the Supervising Pharmacist regarding ensuring residents receiving Remeron have an appropriate diagnosis documented in the medical record. Consultant Pharmacist re-educated by the Supervising Pharmacist regarding ensuring an appropriate diagnosis is documented in the medical record for residents receiving Anti-depressant medication. Consultant Pharmacist re-educated by the Supervising Pharmacist regarding ensuring irregularities identified by the Consultant Pharmacist are reported to the physician. Consultant Pharmacist re-educated by the Supervising Pharmacist regarding ensuring residents are free from unnecessary medications r/t Psychotropic medication.	4/10/18

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F 758	Continued From page 63 that the appetite stimulant medication Megace [2] has medical risks for exacerbating congestive heart failure, etc., and that she was not sure about what other options are available. A review of the clinical record revealed the monthly pharmacy "Medication Regimen Review" for August 2017 through February 2018. There was no documentation evidencing the pharmacy had identified and reported the concern of using Remeron for reasons not approved by the FDA (Food and Drug Administration), for the 6 months, the resident had been on the medication. On 3/1/18 at 2:40 p.m., in an interview with OSM #7 (Other Staff Member, the pharmacist), he stated that a GDR (Gradual Dose Reduction) was recommended "last week" from 7.5 to 3.75 mg. He stated he was not aware of a requirement that medications must be FDA (Food and Drug Administration) approved for the specific use it is being ordered for, just for the overall safety of the medication. He stated he will not reject a script because it is ordered for an off-label use if it is the resident's best clinical interest (note: only a physician or physician extender can make clinical determinations.) He stated, "I'm not going to say that it is inappropriate." The resident was on the medication from August 2017 through February 2017 without a proper diagnosis and without the pharmacy identifying and reporting this. A review of the facility policy, "Monthly Drug Regimen Review" documented, "During the drug regimen review the consultant pharmacist will identify apparent irregularities. Apparent irregularities to be communicated to the attending physician, the Medical Director and the DCS/designee..."	F 758	4. Consultant Pharmacist to conduct quality reviews through monthly Drug Regimen Review to ensure residents receiving Remeron have an appropriate diagnosis documented in the medical record monthly and PRN as indicated. Consultant Pharmacist to conduct quality reviews through monthly Drug Regimen Review ensuring an appropriate diagnosis is documented in the medical record for residents receiving Anti-depressant medication monthly and PRN as indicated. Consultant Pharmacist to conduct quality reviews through monthly Drug Regimen Review ensuring irregularities identified by the Consultant Pharmacist is reported to the physician. Consultant Pharmacist to conduct quality reviews through monthly Drug Regimen Review ensuring residents is free from unnecessary medications r/t Psychotropic medication. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18

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F 758	Continued From page 64 A review of the facility policy, "Psychoactive Medications" documented, "Treat the resident's medical or psychiatric condition in accordance with acceptable standards of practice, and the right to be free of unnecessary medication....Drug Regimen reviews to be conducted monthly by the pharmacist for unnecessary use, excessive doses or duration in absence of acceptable medical diagnosis according to standard of practice. Recommendations to be communicated to the attending physician." On 3/01/18 at 3:58 p.m., the Director of Nursing (DON, ASM #2, Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. The facility was not able to locate the GDR that OSM had referred too. On 3/1/18 at the end of day meeting at approximately 6:00 p.m.,, the Administrator stated she would obtain details of the concern from the DON, that it wasn't necessary to go over it again. [1] Remeron is used to treat depression Information obtained from https://medlineplus.gov/druginfo/meds/a697009.html [2] Megace - Megestrol tablets are used to relieve the symptoms and reduce the suffering caused by advanced breast cancer and advanced endometrial cancer (cancer that begins in the lining of the uterus). Megestrol suspension is used to treat loss of appetite, malnutrition, and severe weight loss in patients with acquired immunodeficiency syndrome (AIDS). Megestrol	F 758		

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F 758	Continued From page 65 should not be used to prevent loss of appetite and severe weight loss in patients who have not yet developed this condition. Information obtained from https://medlineplus.gov/druginfo/meds/a682003.html	F 758		
F 812 SS=D	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 ensure sanitary conditions for the preparation of food. The convection oven used in the preparation of food was not clean. The findings include:	F 812	1. The identified convection oven cleaned 2/27/18; 2. Quality review of the kitchen convection oven completed by the Dietary Manager (DM) / Executive Director (ED), to ensure food is prepared in sanitary conditions in accordance with professional standards. Follow up as indicated. Quality review of kitchen equipment completed by the DM/ED to ensure food is prepared in sanitary conditions in accordance with professional standards. Follow up as indicated. 3. DM re-educated by the ED regarding to ensure the kitchen prepares food in sanitary conditions in accordance with professional standards. DM re-educated by the ED regarding the kitchen convection oven/kitchen equipment is maintained to ensure food is prepared in sanitary conditions in accordance with professional standards.	4/10/18 4/10/18 4/10/18

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F 812	Continued From page 66 During the initial tour of the kitchen in the presence of OSM (other staff member) # 1, the dietary manager, on 2/27/18 at approximately 10:30 a.m. the observation of the convection oven was made. The inside of the doors of the convection oven were observed with a brown dried on matter that could be scraped off with a fingernail. The convection oven was in use with food to be served at the lunchtime meal inside. During an interview with OSM # 1 at 10:50 a.m., OSM # 1 was asked if there was a cleaning schedule. OSM # 1 stated, "There is (a cleaning schedule) and there isn't. I have a correction log. I try to look at everything daily—I should have caught it (the convection oven)." At this time, a copy of the facility policy on cleaning and any cleaning schedule or documentation that OSM # 1 wanted to present was requested. This concern was revealed during an interview on 2/28/18 at 4:42 p.m. with ASM (Administrative Staff Member) # 1, the administrator. Review of the facility policy: "Food: Preparation" Under "Policy Statement" revealed: "All foods are prepared in accordance with the FDA (Food and Drug Administration) Food Code." Under "Procedures ...3. All utensils, food contact equipment and food contact surfaces will be cleaned and sanitized after every use." Original 5/2014, Revised 9/2017. The following information was taken from the FDA (Food and Drug Administration) website: http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/	F 812	4. DM/ED to conduct random quality reviews of kitchen equipment to ensure food is prepared in sanitary conditions in accordance with professional standards 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. DM/ED to conduct random quality reviews of the kitchen convection oven to ensure food is prepared in sanitary conditions in accordance with professional standards 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	4/10/18 4/10/18

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F 812	Continued From page 67 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. No further information was provided by the end of the survey.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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F 880	Continued From page 68 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. §483.80(e) Linens. Personnel must handle, store, process, and	F 880	1. Resident #180 no longer resides in the facility. Discharged to home 3/15/18. 2. Quality review of current residents with wounds completed by the Director of Nursing (DON)/Unit Manager (UM)/designee to ensure soiled bed pad/chuck/contaminated field are replaced prior to the clean dressing change. Follow up as indicated. Quality review of current residents with wounds completed by the DON/UM/designee to ensure scissors are properly cleaned per infection control standards prior to the clean dressing change. Follow up as indicated. LPN #2 re-educated on Wound Care with Competency Checklist. DON completed Wound Care observation with LPN #2 for completing wound care following infection control standards. Quality reviews of current residents with wounds completed by the DON/UM/designee to ensure soiled dressings are not in contact with sheets/bed linen. Follow up as indicated	4/10/18 4/10/18

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F 880	Continued From page 69 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 and staff interview, it was determined that the facility staff failed to implement infection control practices to prevent the development and transmission of infection, for one of 23 residents in the survey sample, Resident # 180. The facility staff replace a contaminated field (bed pad/chuck) before applying Resident # 180's clean dressing; the clean dressing was observed in contact with the contaminated field during application; failed to properly disinfect scissors used during the dressing change and failed to change Resident #180's sheets after a soiled dressing was observed in direct contact with the bed sheets. The findings include: Resident # 180 was admitted on 02/23/18 with diagnoses that included but were not limited to: Chronic obstructive pulmonary disease (1), laceration (deep cut) to the right knee, cirrhosis of the liver (2), heart failure, anxiety (3), hypertension (4), and gastroesophageal reflux disease (5). Resident # 180's MDS (Minimum Data Set) was not due at the time of the survey. The admission assessment for Resident # 180 dated 02/23/18 documented he was orientated to person, place,	F 880	Quality review of current residents with wounds completed by the Director of Nursing DON/UM/designee to ensure infection control practices are maintained per professional standards with clean dressing changes. Follow up as indicated. Clean dressing skills competency skills checklist as indicated. 3. Licensed nurses re-educated by the DON/UM regarding ensuring soiled bed pad/chuck/contaminated field are replaced prior to clean dressing changes. Licensed nurses re-educated by the DON/UM regarding ensuring scissors are properly cleaned per infection control standards prior to the clean dressing changes. Licensed nurses re-educated by the DON/UM ensuring soiled dressings are not in contact with sheets/bed linen. Licensed nurses re-educated by the DON/UM ensuring ensure infection control practices are maintained per professional standards with clean dressing changes. DON/UM to completed random wound care observations with licensed nurses for following infection control standards. Follow up based on findings.	4/10/16

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F 880	Continued From page 70 time and situation. On 03/01/18 at 10:50 a.m., an observation was conducted of LPN (licensed practical nurse) # 2 performing Resident # 180's right knee dressing change. Resident # 180 was lying in his bed with the head of the bed slightly elevated and his right knee at a slight bend. Observation of Resident # 180's bed prior to the start of the dressing change revealed a bed pad or chuck under Resident # 180's thighs, extending to the calves of both legs. LPN # 2 began the dressing change by providing a clean barrier on Resident # 180's over the bed table and placing clean dressings, gauze pads, gauze wrap, ace bandage and four small vials of normal saline solution. LPN # 2 then placed a clean, empty trash bag on the mattress at the foot of Resident # 180's bed. LPN # 2 was observed reaching into her pockets for a pair of scissors and was unable to locate any. LPN # 2 went to Resident # 180's door, opened it and requested a pair of scissors from another nurse. The nurse came back to Resident # 180's room after retrieving a pair of scissors from the nurse's station. LPN # 2 took the scissors and went to the sink in Resident # 180's room, turned on the water, removed a couple of paper towels from the wall mounted dispenser, applied some soap from the hand soap dispenser mounted on the wall next to the sink, washed and rinsed the scissors in the sink then placed them on the clean barrier to dry. After putting on clean gloves, LPN # 2 removed and cut the old dressings using the scissors she cleaned with hand soap and placed the old dressing in the trach bag that was positioned on the bed. Further observations of LPN # 2 discarding the old dressing revealed that one of the old gauze pads fell onto Resident # 180's bed near his right foot and was resting on	F 880	4. DON/UM/designee to conduct random quality reviews of current resident with wounds to ensure soiled bed pad/chuck/contaminated field are replaced prior to clean dressing changes 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. DON/UM/designee to conduct random quality reviews of current resident with wounds to ensure scissors are properly cleaned per infection control standards prior to the clean dressing changes 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. DON/UM/designee to conduct random quality reviews of current resident with wounds to ensure soiled dressings are not in contact with sheets/bed linen 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. DON/UM/designee to conduct random wound care observation quality reviews with licensed nurses on current resident with wounds to ensure infection control practices are maintained per professional standards with clean dressing changes 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated.	4/10/18

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F 880	Continued From page 71 the bed sheet. After the old dressing was removed and the laceration on the knee could be viewed, LPN # 2 was asked if there was any drainage coming from the laceration. LPN # 2 stated, "There is some." LPN # 2 opened two vials of normal saline and poured them o- laceration and using a gauze pad -' of the saline that wet the side ,nis procedure was done a second .ne same way when the first two vials of s_ine were empty. Further observation of this procedure revealed portions of the saline ran off the laceration fell onto the bed pad/chuck under Resident # 180's right knee. Wet areas from the saline rinse could be observed on the bed pad/chuck. After Resident # 180's knee dried LPN # 2 placed several clean gauze pads over the laceration and then proceeded to use the roll of gauze to wrap the knee. After tapping the gauze in place, LPN # 2 used the ace bandage to wrap around the clean dressing. Observation of LPN # 2 conducting this procedure revealed that when she started to wrap Resident # 180's knee the ace bandage dropped onto the bed pad/chuck where it was wet from the saline rinse of the laceration. Further observation of this process revealed LPN # 2's gloved hand and the roll of ace bandage brushed against the wet bed pad/chuck each time LPN # 2 passed the ace bandage wrap under Resident # 180's knee. During the process of the dressing change, LPN # 2 changed gloves several times and tossed them to the trash bag that was positioned on Resident # 180's bed. Further observation of this activity revealed a pair of used gloves fell off the pile of old dressing stacked in the trash bag and rolled onto Resident # 180's bed sheet next to his left foot. After the clean dressing was secured on Resident # 180's knee, LPN # 2 proceeded to pick the trash bag up off the bed. LPN # 2 also	F 880	DON/UM/designee to conduct random wound care observation quality reviews with licensed nurses on current resident with a wound vac to ensure infection control practices are maintained per professional standards with clean dressing changes 3 times weekly x 2 weeks, twice weekly x 4 weeks, weekly and PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance 04/10/18	3 4/10/18

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F 880	Continued From page 72 placed the scissors that were used to remove the old dressing back into Resident # 180's sink and using her hands and the hand soap, washed the scissors and placed them in her pocket. The old dressing pad was picked up and placed in the trash bag but further observation revealed the used gloves remained on the bed. At this time a CNA (certified nursing assistant) # 2 knocked and entered Resident # 180's room. CNA # 2 stated she was checking on Resident # 180 and was not aware that LPN # 2 was finishing a dressing change. LPN # 2 then removed the bed pad/chuck that was in place under Resident # 180's knee during the removal of the old dressing, the saline rinse of the laceration and the application of the clean dressing. LPN # 2 replaced the bed pad/chuck with a clean pad while CNA # 2 straightened Resident # 180's bed sheet and blanket. LPN # 2 then removed the trash and supplies from Resident # 180's room. On 03/01/18 at 1:15 p.m. an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe the process for cleaning scissors before and after removing a dressing LPN # 2 stated, "You can use soap and water, bleach wipes or alcohol pads." When asked where she learned to clean scissors with soap and water LPN # 2 sated, "Another nurse." When asked when she received training for wound dressings, LPN # 2 was unable to recall how long it had been and when she received the training. LPN # 2 did state she had attended a conference about two or three years ago about wound care products. When asked if the bed pad/chuck should have been changed before applying the clean dressing to Resident # 180's knee, LPN # 2 stated, "Yes." When asked about the old dressing pad and used gloves falling and	F 880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 880	Continued From page 73 lying on Resident # 180's bed sheet, LPN # 2 sated, "I don't recall anything falling out of the trash bag." When asked if the bed sheet should have been changed after the old dressing pad and used gloves were lying on the bed sheets, LPN # 2 stated the sheets were changed and it was done by the CNA who was in Resident # 180's room. On 03/01/18 at 1:40 p.m. an interview was conducted with CNA # 2. When asked if she changed the bed sheets on Resident # 180's bed, CNA # 2 stated, "I didn't change the sheets or the blanket." On 03/01/18 at 9:10 a.m., an interview was conducted with ASM # 2. When asked what standards of practice the facility refers to and uses ASM # 2 stated, "We use a combination of Potter & Perry, Lippincott, state and federal regulations, CDC (Centers for Disease Control) guidelines and company policies." On 03/01/18 at 3:10 p.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When informed of the observation of LPN # 2 dressing change procedure for Resident # 180, ASM # 2 stated, "The contaminated field (bed pad/chuck) should have been replaced or removed before applying the clean dressing." When asked about the bed sheets ASM # 2 stated, "They should have been changed." When asked about the process of cleaning the scissors before and after removing a dressing, ASM # 2 stated, "Use bleach wipes. We follow the NPUAP (National Pressure Ulcer Advisory Panel) that states you can use soap and water." ASM # 2 was asked to provide a copy of the guidance from NPUAP for the cleaning of	F 880		

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F 880	Continued From page 74 equipment when preforming dressing changes. In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick. In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol. Reference: Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000. According to Fundamentals of Nursing, Potter and Perry, 6th Edition, 2005. Page 787, "Proper cleansing, disinfection, and sterilization of contaminated objects significantly reduce and often eliminate microorganisms....Reusable objects must be cleaned thoroughly before reuse...." On 03/01/18 at 5:25 p.m. ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, divisional nurse were made aware of the above findings. When asked for the guidance from NPUAP for the	F 880		

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F 880	Continued From page 75 cleaning of equipment when preforming dressing changes, ASM # 2 stated they were unable to locate it. No further information was provided prior to exit. References: (1) Disease that makes it difficult to breath that can lead to shortness of breath) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) A scarring of the liver and poor liver function. It is the last stage of chronic liver disease. Cirrhosis is the end result of chronic liver damage caused by chronic (long-term) liver disease. Common causes of chronic liver disease in the United States are: Hepatitis B or hepatitis C infection or alcohol abuse. This information was obtained from the website: https://medlineplus.gov/ency/article/000255.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 880		