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	495199	A. BUILDING ______ B. WING ______	09/13/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey Inspection was conducted 9/11/2017 through 9/13/2027. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 65 certified bed facility was 62 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through # 14) and 5 closed record reviews (Residents # 14 through #18).	F 000	PLEASE ALLOW MY PLAN OF CORRECTION TO CONSTITUTE AS MY ALLEGATION OF COMPLIANCE	
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164	a. As resident #10 stated to surveyor her curtain and resident #1 (roommates) privacy curtains were replaced immediately with appropriate privacy curtains that provide full privacy for both residents. b. The facility has identified all residents as having the potential to be affected by this alleged deficient practice . RECEIVED SEP 27 2017 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/25/17

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

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regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, Resident interview and clinical record review, the facility staff failed to ensure personal privacy for one Resident (Resident # 10) in a survey sample of 18 Residents.

Resident # 10, a 71 year old female, was admitted to the facility 6/12/2017. Her diagnoses included but were not limited to: End Stage Renal Disease, Anemia in Chronic Kidney Disease, Dialysis, Diabetes, Dysphagia and Atherosclerotic Heart Disease.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/30/2017 was coded as a 30 day assessment. Resident #10 was coded as having a BIMS (Brief

F 164

c. Measures put in place to ensure this alleged deficient practice does not recur include the reeducation for all staff members of the facility privacy policy on Thursday 9/21 by Risk Manager. (Resident dignity and privacy.) Daily care rounds by the nursing staff and documented weekly Angel rounds by the Administrative staff are conducted with the focus of maintaining the residents' dignity and privacy; any deviations being addressed immediately. Angel rounds are given to the Administrator for review. The DON/designee are conducting audit reviews weekly X4 weeks, then monthly X 3 months. The results are presented to the QA committee monthly.

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Interview for Memory Status) Score of 4 out of 15 indicating severe cognitive impairment. She was coded as needing limited to extensive assistance of one staff member to perform her activities of daily living.

The Director of Nursing, RN Supervisor/Assistant Director of Nursing (Employee C) and Risk Management Nurse (Employee D) and surveyor proceeded to the Resident # 10's bedroom to perform a skin assessment of the roommate, (Resident # 1) residing in the bed by the window. The door to Resident # 10's bedroom was observed to be open and the privacy curtain was pulled around Resident #10's bed. The privacy curtain between the two beds was pulled halfway between the beds. Resident # 1 was lying in her bed facing the pulled privacy curtain.

As the nurses (Employee C and Employee D) walked into the room past Resident # 10's bed, one pulled Resident # 10's privacy curtain on the right side that was adjacent to the roommate's curtain while the other pulled the other privacy curtain around Resident #1's bed.. When Resident # 10's curtain was pulled toward the right of her bed, Resident # 10 stated loudly, "Now it's not closed over here!" The Director of Nursing and surveyor were following into the room and observed that Resident # 10 could be seen from the left side of the curtain. The Director of Nursing pulled the privacy curtain to the left of the bed and then noted the curtain did not completely cover the right side of the bed. Simultaneously, Employee C and Employee D were pulling the privacy curtains around Resident # 1's bed. Resident # 10 could be observed from the right side of the curtain sitting on the side of the bed and wearing a blouse and an

d. Reports of the findings from the audits, along with any disciplinary action, if applicable, will be reported by the Director of Nursing and Administrator to the Quality Assurance Committee consisting of the Director of Nursing, Medical Director, NHA, MDS, Assistant Director of Nursing, Risk Manager, MDS Coordinator.

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incontinence brief. Resident # 10 stated she was getting dressed. The Director of Nursing stated she did not realize it but the curtain was "too short" and that she was going to have housekeeping replace the curtain. The Director of Nursing closed the door, pulled the privacy curtain and held it to the left to cover Resident # 10's bed and stood by the door to make sure privacy would be maintained if someone walked into the room. The Assistant Director of Nursing (Employee C) used her name badge to clip the right side of Resident # 10's curtain to the roommate's (Resident #1's) privacy curtain. Employee C and Employee D stated they also did not realize the privacy curtain was too short.

On 9/12/2017 at 1:55 PM, an interview was conducted with the Housekeeping Supervisor (Employee G) who stated she did not know why a yellow privacy curtain was in that room. She stated "the curtain is too short." Employee G also stated the curtain would be replaced immediately, as soon as the nursing staff was finished providing care in the room.

On 9/12/2017 at 2:00 PM, an interview was conducted with the Director of Housekeeping (Employee H) who stated that particular privacy curtain was an oversight on his part. He also stated new privacy curtains were ordered by housekeeping over 3 months prior to survey and he thought all curtains had been replaced.

On 9/12/2017 at 4:05 PM, Resident # 10 was observed wheeling herself in the hallway near the nurses station. An interview was conducted with Resident #10 who stated she recalled the above incident. Resident #10 stated she was changing into her clothes at the time. Resident # 10 stated

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she had been a nurse for many years and had noticed the curtain was not wide enough to completely cover the bed. Resident # 10 stated the privacy curtain had been changed already and stated she was glad it was changed.

On 9/12/2017 at 4:15 PM, observed the privacy curtain had been replaced with a larger curtain that could completely surround the bed of Resident # 10.

Guidance is also provided in "Fundamentals of Nursing, 7th Edition, Potter-Perry, page. 331, The tort of invasion of privacy protects the client's right to be free from unwanted intrusion into his or her private affairs. HIPPAA Privacy Standards have raised awareness of the need for health care professionals to provide confidentiality and privacy...HIPPAA (Health Insurance Portability and Accountability Act) and sets forth standards indicating that clients are entitled to confidential health care."

Also, same source:

""Fundamentals of Nursing, 7 th Edition, Potter-Perry, p. 475," provides guidance, "A sense of dignity includes a person's positive self-regard, an ability to invest in and gain strength from one's own meaning in life, feeling valued by others, and how one is treated by caregivers. Nurses promote a client's self esteem and dignity by respecting him or her as a whole person with feelings, accomplishments, and passions independent of the illness experience...When caring for a client's bodily functions, show patience and respect, especially after the client becomes dependent."

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F 164	Continued From page 5 During the End of Day Debriefing on 9/12/2017 at 4:35 PM, the DON (director of nursing) and Administrator were made aware of the failure of the staff to provide personal privacy..	F 164		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,	F 225	a. C.N.A. A. (Certified Nursing Assistant) and Employee D, RN (Risk Manager) have a current verified license on file. b. A 100% audit of all employees hired in the past 2 years was conducted with no issues. Human Resources inservice received by Administrator and Abuse Policy Education was provided to all staff on 9/21/17, which included license verification requirement. c. All new hires will be entered on a log verifying licensure verification completion. Administrator will verify weekly, and initial log. d. All new hires will be entered on a log verifying licensure verification completion. Administrator will verify weekly, and initial log.	9/21/17

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including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility documentation review, the facility staff failed to verify licensure/certification with the Department of Healthcare Professions (DHP) prior to hire for two employees, CNA (Certified Nursing Assistant) A and Employee D, RN (Registered Nurse) Risk Manager.

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F 225	Continued From page 7 1. CNA A was hired on 6/9/2017 and her certification was not verified with DHP until 9/8/2017, and Employee D, RN Risk Manager, was hired on 6/28/2017 and her license was not verified with DHP until 7/11/2017. Findings included: During a routine review of employee records, the two employees were discovered without licensure/certification verification prior to their hire date. On 9/13/2017 at 2:00 PM Employee E, Human Resources Manager, and Employee A, Facility Administrator, after reviewing the files, stated that it was true that both employees did not have licensure/certification verification prior to their respective dates of hire. At this time Employee B, Director of Nursing, verified that Employee B began working in the facility on 6/28/2017, and that CNA A began working in the facility on 6/9/2017. Administration was informed of the findings on 9/13/2017 at 3:00 PM	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to	F 226	a. C.N.A. A. (Certified Nursing Assistant) and Employee D, RN (Risk Manager) have a current verified license on file.	

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investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95
(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility documentation review, the facility staff failed to implement their abuse prevention policy.

1. Contrary to the facility abuse prevention policy, CNA (Certified Nursing Assistant) A was hired on 6/9/2017 and her certification was not verified with The Department of Healthcare Professions (DHP) until 9/8/2017, and Employee D, RN (Registered Nurse) Risk Manager, was hired on 6/28/2017 and her license was not verified with DHP until 7/11/2017.

Findings included:

F 226

b. A 100% audit of all employees hired in the past 2 years was conducted with no issues. Human Resources inservice received by Administrator and Abuse Policy Education was provided to all staff on 9/21/17, which included license verification requirement.

c. All new hires will be entered on a log verifying licensure verification completion. Administrator will verify weekly, and initial log.

d. All new hires will be entered on a log verifying licensure verification completion. Administrator will verify weekly, and initial log.

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During a routine review of employee records, the two employees were discovered without licensure/certification verification prior to their hire date. On 9/13/2017 at 2:00 PM Employee E, Human Resources Manager, and Employee A, Facility Administrator, after reviewing the files, stated that it was true that both employees did not have licensure/certification verification prior to their respective dates of hire.

At this time, Employee B, Director of Nursing, verified that Employee B began working in the facility on 6/28/2017, and that CNA A began working in the facility on 6/9/2017.

A review of the facility's Abuse Prevention Policy stated "State licensure and certification agencies, and applicable registries, will be contacted prior to hire to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the registry."

Administration was informed of the findings on 9/13/2017 at 3:00 PM.

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