STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING _____ B. WING _____	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(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 4/24/18 through 4/26/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 5 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/24/18 through 4/26/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey. The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 5 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		6/8/18

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

Electronically Signed | 05/14/2018

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F 580	Continued From page 1	F 580		

deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:

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F 580	Continued From page 2 Based on clinical record review and staff interview, the facility staff failed to notify the physician of a change in condition for one of 28 residents, Resident #39. The physician was not notified of decreased blood sugar readings for Resident #39. Findings were: Resident #39 was initially admitted to the facility on 03/03/2018 and was readmitted on 04/13/2018. Her diagnoses included but were not limited to: Diabetes mellitus, dry gangrene of toes with subsequent amputation of her right leg below the knee, peripheral vascular disease, femur fracture, hypothyroidism and hypotension. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 04/15/2018. Resident #39 was assessed as cognitively intact with summary score of "15". The clinical record was reviewed on 04/25/2018 at approximately 11:00 a.m. The following nurse's note written 03/25/2018 at 14:48 (2:48 p.m.) by LPN (licensed practical nurse) #3 was observed: "When this nurse went in to check patient's BS [blood sugar] this morning around 0800 it was only noted to be 70. This nurse told her that she needed to eat breakfast and she said that she was going to. At 1208 this nurse went in to help the CNA [certified nursing assistant] get patient up to her WC [wheel chair]. The back of the patient's gown was noted to be sweaty and she said, "I am not feeling well." Patient's BS at this	F 580	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 580 1) Resident #39□s MD is now made aware of low blood sugar on 3/25/2018, patient has since returned to center with no further untoward event. 2) All residents that receive blood glucose checks are at risk. 3) Staff Development Coordinator or designee will education all licensed nurses on notifying the MD of blood glucose readings per ordered parameters, or if the patient is symptomatic. 4) DON or designee will audit 100% of residents receiving blood glucose checks for parameters of notification, then will audit 50% of residents 5x per week for 2 weeks, then 20% of residents 5x per week for 2 weeks. Then review findings at next QA meeting	

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F 580	Continued From page 3	F 580		

time was noted to be 50. This nurse went to get some OJ [orange juice] for patient. This nurse asked the patient if she had ate anything and she said she did not eat her breakfast. This nurse told the patient that she did need to eat and asked her what she would eat if this nurse could get her something. Patient said that she would eat some French fries. This nurse asked if she would like some French fries form McDonalds. The patient said she would love it. This nurse had the other nurse come over and be with the patient along with the CNA while I went to get her some fries. They made sure she drank the rest of her OJ. When this nurse arrived back patient had drank the OJ, but her BS was still noted to be 53. The other nurse gave her a glucagon injection and I had her eating some of the fries. Her BS did get up to 63. Then she said her stomach was upset was she needed to go to the bathroom. The other nurse said that she had a dark stool. The patient said that she didn't really feel well. The patient was asked if she wanted to go to the hospital since she is her own RP [responsible party] and she said she did. This nurse went up to start getting paperwork ready and the CNA went in to check vitals. CNA said VS [vital signs] were noted to be 98.7 [temperature], 157/68 [blood pressure], 106 [pulse], 22 [respirations] and 82 [oxygen saturation] on RA [room air]. This nurse called 911 and they were here in a few minutes. Dr. [Name] was notified at 1220 and [Name] was notified at 1215, because this nurse could not get ahold (sic) of any other contacts."

Per the note, Resident #39 was not feeling well, and was sent to the hospital via 911. The physician was not notified of the events until 12:20 p.m., when Resident #39 was being transported out.

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F 580	Continued From page 4 The above information was discussed with the DON (director of nursing) and the nurse consultant on 04/25/2018 at approximately 11:45 a.m. They were asked if the facility had standing orders for diabetics, blood sugar levels and/or the treatment of hypoglycemia. The nurse consultant stated the facility did not have standing orders for diabetic management. The nurse consultant stated the physician should have been notified of the decreased blood sugar when it was found to be 50 and prior to administering glucagon. The above information was discussed with the DON and the corporate nurse consultants during an end of the day meeting on 04/26/2018. No further information was obtained prior to the exit conference on 04/26/2018.	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		6/8/18

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F 655	Continued From page 5 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to complete and implement a baseline care plan for one of 28 residents in the survey sample, Resident #35. Facility staff failed to develop a baseline care plan for contact isolation, droplet isolation, care and maintenance of an indwelling catheter, care and maintenance of a tracheostomy, and use of oxygen for Resident #35.	F 655	F 655 1) Resident # 35 is no longer in the center. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all licensed nurses on development of the baseline care plan to include as indicated by resident care needs: a. Contact isolation b. Droplet isolation	

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F 655	Continued From page 6 Findings included: Resident #35 was originally admitted on 01/09/18 and readmitted on 04/09/18 with diagnoses including, but not limited to: Bacterial Pneumonia, Chronic Respiratory Failure, Cancer of his Oral Cavity, Tracheostomy, PEG Tube, Ileostomy, RSV (Respiratory Syncytial Virus) and MRSA (Methiciliin Resistant Staphylococcus Aureus). The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 03/20/18. Resident #35 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 04/24/18 at 3:30 p.m., Resident #35 was observed in his room. He was sitting up in his wheelchair [w/c] alert, with flow-by oxygen via mask at 4L/min over his tracheostomy, IV abx [antibiotics] infusing through a left upper arm PICC (peripherally inserted central catheter) line and an indwelling catheter in place. There were droplet and contact isolation signs posted on his door and an isolation cart just outside of his doorway. Resident #35's clinical record was reviewed on 04/25/18 at approximately 11:30. During this review, the initial care plan was noted. This care plan did not include any information for contact and droplet isolation, care and maintenance of an indwelling catheter, care and maintenance of a tracheostomy, or use of supplemental oxygen. The Corporate Nurse (CP) was interviewed on 04/26/18 at 9:00 a.m. regarding who is responsible for developing the initial care plan.	F 655	c. Care and maintenance of an indwelling catheter d. Care and maintenance of a tracheostomy e. Use of Oxygen 4) DON or designee will audit 100% of current resident□s care plans for inclusion as indicated: a. Contact isolation b. Droplet isolation c. Care and maintenance of an indwelling catheter d. Care and maintenance of a tracheostomy e. Use of Oxygen Then, 50% of resident□s care plans 5x per week for 2 weeks, then 20% of resident□s care plans 5x per week for 2 weeks, then review findings in the next QA meeting.	

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F 655	Continued From page 7 The CP stated, "The admission nurse is responsible for developing the initial care plan." The Administrator and DON (director of nursing) were informed of the above finding during a meeting with the survey team on 04/26/18 at approximately 4:00 p.m. The DON and CP both concurred they would expect all of the above mentioned care areas in the initial care plan. No further information was received by the survey team prior to the exit conference on 04/26/18.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not 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	F 656		6/8/18

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F 656	Continued From page 8 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for seven of 28 Residents: Resident #86, Resident #53, Resident #303, Resident #62, Resident #39, Resident #35, and Resident #12. 1. Resident #86 did not have a care plan for a dialysis shunt. 2. Resident #53 did not have a care plan for profore wraps to his legs. 3. Resident #303 was not care planned for contact isolation. 4. Resident #62 was not care planned for smoking. 5. Resident #39 did not have a care plan for	F 656	F 656 1) All resident□s care plans were updated to include: a. Resident #86-location of dialysis shunt b. Resident #53-Profore wraps to legs c. Resident #303-no longer on isolation-Care plan current d. Resident #62-smoking with use of vape/e-cig e. Resident #39-no longer on isolation-Care plan current f. Resident #35-is no longer in the center g. Resident #12-self-care/treatment of his tracheostomy 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all license nurses	

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F 656	Continued From page 9 contact isolation. 6. Resident #35 did not have a care plan for isolation, foley catheter care and maintenance, tracheostomy care and maintenance, or oxygen use. 7. Resident #12 did not have a care plan for self treatment of a tracheostomy. Findings were: 1. Resident #86 was admitted to the facility on 06/16/2017 with the following diagnoses, but not limited to: hypertension, diabetes mellitus, dementia and ends stage renal disease. The most recent MDS (minimum data set) was a significant change with an ARD (assessment reference date) of 04/09/2018. Resident #86 was assessed as cognitively intact with a summary score of "15". The clinical record was reviewed on 04/25/2018. Orders on the current POS (physician order sheet) included: " HEMODIALYSIS: Mon-Wed-Fri: [Name] Dialysis Center..." The care plan was reviewed. A focus area "The resident needs hemodialysis r/t [related to] renal failure." Interventions included but not limited to: "Check and change dressing as ordered at access site; Do not draw blood or take B/P in arm with graft; Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of infection to access site: Redness, Swelling, warmth or drainage." There was no mention of where the dialysis shunt was or which arm was effected.	F 656	on completing comprehensive care plans including as indicated by resident care needs: a. Site of dialysis shunt b. Type isolation and location of isolated organism c. Smoking and type of device d. Care and maintenance of an indwelling catheter e. Care and maintenance of a tracheostomy f. Oxygen dose and route of administration g. Self-care/administration 4) DON or designee will audit 100% of current resident□s care plans for inclusion as indicated: a. Site of dialysis shunt b. Type isolation and location of isolated organism c. Smoking and type of device d. Care and maintenance of an indwelling catheter e. Care and maintenance of a tracheostomy f. Oxygen dose and route of administration g. Self-care/administration Then, 50% of resident□s care plans 5x per week for 2 weeks, then 20% of resident□s care plans 5x per week for 2 weeks, then review findings in the next QA meeting	

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F 656	Continued From page 10	F 656		

During an end of the day meeting with facility staff on 04/25/2018, the above information was discussed. Per the corporate nurse consultant, the care plan should include information regarding the location and care of the dialysis shunt.

On 04/26/2018 at approximately 8:00 a.m., the corporate nurse consultant was asked who was responsible for developing/updating the resident care plans. He stated that the admitting nurse started the care plans, but all nurses were responsible for adding to and updating them.

No further information was obtained prior to the exit conference on 04/26/2018.

2. Resident #53 was admitted to the facility on 03/02/2018 with the following diagnoses, but not limited to: Chronic kidney disease, prostate cancer, pantocytopenia, hypertension and chronic obstructive pulmonary disease.

The most recent MDS was an admission assessment with an ARD (assessment reference date) of 03/08/2018. Resident #53 was assessed as moderately impaired in his cognitive status intact with a summary score of "09".

The clinical record was reviewed on 04/25/2018 at approximately 2:00 p.m. The current POS (physician's order sheet) contained the following order: "Profore wraps to BLE [bilateral lower extremities] change Q (every) Wednesday and Sunday."

The care plan was reviewed, there were no interventions for the use of the Profore wraps.

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F 656	Continued From page 11	F 656		

During an end of the day meeting with facility staff on 04/25/2018, the above information was discussed. Per the corporate nurse consultant, the care plan should include information regarding the Profore Wraps for Resident #53.

On 04/26/2018 at approximately 8:00 a.m., the corporate nurse consultant was asked who was responsible for developing/updating the resident care plans. He stated that the admitting nurse started the care plans, but all nurses were responsible for adding to and updating them.

No further information was obtained prior to the exit conference on 04/26/2018.

3. Resident #303 was admitted to the facility on 03/26/2018. His diagnoses included but were not limited to: Hypertension, liver disease, Pseudomonas Pneumonia, polycystic kidney disease (s/p [status post] kidney transplant in 1998), and and acute respiratory failure.

The most recent MDS was an "Admission in Progress" assessment with an ARD of 04/18/2018. Resident #303 was assessed as cognitively intact with a summary score of "13".

During initial tour of the facility on 04/24/2018, Resident #303 was observed in his room. An isolation cart was outside his door and a sign on his door read "Contact Precautions."

The clinical record was reviewed on 04/25/2018 at approximately 9:00 a.m. The following order was observed: "Contact Precautions for VRE [vancomycin resistant enterococcus]." The care plan was then reviewed. There were no interventions or focus areas regarding contact

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precautions.

During an end of the day meeting with facility staff on 04/25/2018, the above information was discussed. Per the corporate nurse consultant, the care plan should include information regarding contact precautions.

On 04/26/2018 at approximately 8:00 a.m., the corporate nurse consultant was asked who was responsible for developing/updating the resident care plans. He stated that the admitting nurse started the care plans, but all nurses were responsible for adding to and updating them.

No further information was obtained prior to the exit conference on 04/26/2018.

4. Resident #62 was admitted to the facility on 11/13/2017 with the following diagnoses, but not limited to: Gastroperesis, hypertension, chronic obstructive pulmonary disease, and diabetes mellitus.

The most recent MDS was a quarterly assessment with an ARD of 04/02/2018, assessed Resident # 62 was cognitively intact with a summary score of "15".

The clinical record was reviewed on 04/26/2018 at approximately 9:30 a.m. A smoking assessment was completed on Resident on 04/18/2018. The assessment determined that Resident #62 used a vape (Vapor) pen. She was assessed as cognitively intact and safe to smoke without supervision.

On 04/26/2018 at approximately 11:30 a.m., Resident #62 was interviewed regarding her

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smoking. She showed this surveyor her electronic cigarette. She stated, "I only smoke this outside, there is no flame, and no smoke...it comes all ready to go...I change the cartridge on it when the light on the top blinks white."

The care plan was reviewed. There were no interventions listed for smoking.

The above information was discussed during an end survey meeting on 04/26/2018 with the DON (director of nursing), the administrator and the corporate nurse consultants. The DON stated, "That should be on the care plan."

No further information was obtained prior to the exit conference on 04/26/2018.

5. Resident #39 was initially admitted to the facility on 03/03/2018 and was readmitted on 04/13/2018. Her diagnoses included but were not limited to: Diabetes mellitus, dry gangrene of toes with subsequent amputation of her right leg below the knee, peripheral vascular disease, femur fracture, hypothyroidisim and hypotension.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 04/15/2018. Resident #39 was assessed as cognitively intact with summary score of "15".

During initial tour of the facility on 04/24/2018, Resident #39 was observed in her room. An isolation cart was outside her door and a sign on the door read "Contact Precautions".

The clinical record was reviewed on 04/25/2018 at approximately 11:00 a.m. The care plan was

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reviewed. There were not a focus area or interventions regarding contact precautions.

During an end of the day meeting with facility staff on 04/25/2018, the above information was discussed. Per the corporate nurse consultant, the care plan should include information regarding contact precautions.

On 04/26/2018 at approximately 8:00 a.m., the corporate nurse consultant was asked who was responsible for developing/updating the resident care plans. He stated that the admitting nurse started the care plans, but all nurses were responsible for adding to and updating them.

No further information was obtained prior to the exit conference on 04/26/2018.

6. Resident #35 was originally admitted on 01/09/18 and readmitted on 04/09/18 with diagnoses including, but not limited to: Bacterial Pneumonia, Chronic Respiratory Failure, Cancer of his Oral Cavity, Tracheostomy, PEG (percutaneous endoscopic gastrostomy) Tube, Ileostomy, RSV (Respiratory Syncytial Virus) and MRSA (Methiciliin Resistant Staphylococcus Aureus).

The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 03/20/18. Resident #35 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

On 04/24/18 at 3:30 p.m., Resident #35 was observed in his room. He was sitting up in his wheelchair [w/c] alert, with flow-by oxygen via mask at 4L/min over his tracheostomy, IV abx [antibiotics] infusing through a left upper arm

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PICC (peripherally inserted central catheter) line and an indwelling catheter in place. There were droplet and contact isolation signs posted on his door and an isolation cart just outside of his doorway.

Resident #35's clinical record was reviewed on 04/25/18 at approximately 11:30. During this review, the comprehensive care plan was noted. This care plan did not include any information for contact and droplet isolation, care and maintenance of an indwelling catheter, care and maintenance of a tracheostomy or use of supplemental oxygen.

The Corporate Nurse (CP) was interviewed on 04/26/18 at 9:00 a.m. regarding who is responsible for developing the comprehensive care plan. The CP stated, "The admission nurse is responsible for developing the initial/comprehensive care plan and then the nursing staff is responsible for updating the care plan with any changes or updates."

The Administrator and DON (director of nursing) were informed of the above finding during a meeting with the survey team on 04/26/18 at approximately 4:00 p.m. The DON and CP both concurred they would expect all of the above mentioned care areas in the initial and comprehensive care plan.

No further information was received by the survey team prior to the exit conference on 04/26/18.
7. Resident #12 was admitted to the facility on 02/17/16. Diagnoses for Resident #12 included: Cancer of the larynx, and tracheostomy (trach).

The most current MDS (minimum data set) was

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an annual with an ARD (assessment reference date) of 2/20/18. R 12 was assessed with a cognitive score of 8, indicating moderately cognitively intact.

On 04/24/18 01:08 PM Resident #12 was interviewed. When asked about the care and treatment of Resident #12's tracheostomy, Resident #12 verbalized that he cleans his own trach three times a day. When asked how it is cleaned, Resident #12 demonstrated by pulling out the inner cannula, and verbalized that he (Resident #12) washes it in the sink. Resident #12 was then asked how did he learn to take care of his trach, Resident #12 verbalized he (Resident #12) taught himself.

On 4/26/18 Resident #12's care plan was reviewed and did not evidence that a care plan was put in place for self treatment of tracheostomy care.

Resident #12's residence assessment forms were then reviewed and did not evidence that Resident #12 was assessed for self care of a tracheostomy.

On 04/26/18 10:12 AM, registered nurse (RN #1, nurse consultant) was interviewed regarding assessment of self care for a tracheostomy. RN #1 reviewed the resident's chart and verbalized that Resident #12 did not have a assessment for self treatment of tracheostomy care and one should be done prior to allowing a resident to perform care on a tracheostomy. RN #1 also agreed that a care plan should be in place for self care of a tracheostomy if the Resident performing self care.

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F 656	Continued From page 17 On 04/26/18 04:30 PM the above information was provided to the director of nursing and administrator. No other information was provided prior to exit conference on 4/26/18.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to provide treatment and care in accordance with professional standards of practice for one of 28 residents, Resident #39. Resident #39 did not receive proper assessment or treatment for decreased blood sugar readings. Findings were: Resident #39 was initially admitted to the facility on 03/03/2018 and was readmitted on 04/13/2018. Her diagnoses included but were not limited to: Diabetes mellitus, dry gangrene of toes with subsequent amputation of her right leg below the knee, peripheral vascular disease, femur fracture, hypothyroidism and hypotension.	F 684	F 684 1) Resident #39□s MD has been notified and orders in place for glucagon. MD also ordered a new sliding scale to include notification if blood glucose is less than 60. 2) All residents with diabetes and blood glucose monitoring are at risk. 3) Staff Development Coordinator or designee will educate all licensed nursing staff on obtaining orders prior to administration of medication, and entering sliding scales to include MD notification 4) DON or designee will audit 100% of current patients with diabetes and blood glucose monitoring for glucagon orders and MD notification parameters on all	6/8/18

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F 684	Continued From page 18 The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 04/15/2018. Resident #39 was assessed as cognitively intact with summary score of "15". The clinical record was reviewed on 04/25/2018 at approximately 11:00 a.m. The following nurse's note written 03/25/2018 at 14:48 (2:48 p.m.) by LPN (licensed practical nurse) #3 was observed: "When this nurse went in to check patient's BS [blood sugar] this morning around 0800 it was only noted to be 70. This nurse told her that she needed to eat breakfast and she said that she was going to. At 1208 this nurse went in to help the CNA [certified nursing assistant] get patient up to her WC [wheel chair]. The back of the patient's gown was noted to be sweaty and she said, "I am not feeling well." Patient's BS at this time was noted to be 50. This nurse went to get some OJ [orange juice] for patient. This nurse asked the patient if she had ate anything and she said she did not eat her breakfast. This nurse told the patient that she did need to eat and asked her what she would eat if this nurse could get her something. Patient said that she would eat some French fries. This nurse asked if she would like some French fries form McDonalds. The patient said she would love it. This nurse had the other nurse come over and be with the patient along with the CNA while I went to get her some fries. They made sure she drank the rest of her OJ. When this nurse arrived back patient had drank the OJ, but her BS was still noted to be 53. The other nurse gave her a glucagon injection and I had her eating some of the fries.	F 684	Sliding Scale orders, then 50% of patients with diabetes and blood glucose monitoring 5x per week for 2 weeks, then 25% of patients 5x per week for 2 weeks, the review findings in next QA meeting.	

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Her BS did get up to 63. Then she said her stomach was upset was she needed to go to the bathroom. The other nurse said that she had a dark stool. The patient said that she didn't really feel well. The patient was asked if she wanted to go to the hospital since she is her own RP [responsible party] and she said she did. This nurse went up to start getting paperwork ready and the CNA went in to check vitals. CNA said VS [vital signs] were noted to be 98.7 [temperature], 157/68 [blood pressure], 106 [pulse], 22 [respirations] and 82 [oxygen saturation] on RA [room air]. This nurse called 911 and they were here in a few minutes. Dr. [Name] was notified at 1220 and [Name] was notified at 1215, because this nurse could not get ahold [sic] of any other contacts."

The physician orders and MAR (medication administration record) that were in place on the above date were reviewed. Resident #39 had orders for: "Humalog Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151-225 = 3; 226-300 = 5; 301-350 = 8; 351-400 = 10; 401-450 = 12; 451-500 = 14 Greater than 450 administer 14 units and notify MD' subcutaneously before meals and at bedtime related to DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH FOOT ULCER." There were no low parameters for blood sugar readings in place.

On 03/26/2018, Resident #39's blood sugar obtained by LPN #3, was listed on the MAR as "70" with no insulin given. There was no documentation in the clinical record that LPN #3 returned to check on or assess Resident #39 to see if she had eaten breakfast or the status of her blood sugar until she returned to the room at

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12:08 (4 hours later) to assist a CNA in getting Resident #39 up to her wheelchair. At that time Resident #39 was assessed as not feeling well, her gown was sweaty and her blood sugar was noted to be "50". LPN #3 got Resident #39 some orange juice and learned that she had not eaten breakfast. LPN #3 then left the facility to go to McDonald's to obtain french fries for Resident #39. LPN #3 had another nurse stay with Resident #39 while she (LPN #3) was out of the facility. After LPN #3 returned, Resident #39 "had drank the OJ, but her BS was still noted to be 53." Per the note the other nurse gave Resident #39 a glucagon injection and after eating some of the french fries, Resident #39's blood sugar went up to "63".

Review of the physician orders indicated that there was no order obtained for the glucagon injection that was given, nor was it documented on the MAR.

Per the note, Resident #39 was not feeling well, and was sent to the hospital via 911. The physician was not notified of the events until 12:20 p.m., when Resident #39 was being transported out.

The above information was discussed with the DON (director of nursing) and the nurse consultant on 04/25/2018 at approximately 11:45 a.m. They were asked if the facility had standing orders for diabetics, blood sugar levels and/or the treatment of hypoglycemia. The nurse consultant stated the facility did not have standing orders for diabetic management. They were asked if the nurse leaving the facility to go to McDonald's was acceptable. The nurse consultant stated, "No." They stated the physician should have been

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notified of the decreased blood sugar and an order should have been obtained prior to the administration of the glucagon, they also stated that the nurse should have gone back into the room to check on the resident to see if she had actually eaten breakfast.

On 04/26/2018 at approximately 3:30 p.m., LPN #3 was contacted via telephone regarding the events on 03/25/2018 with Resident #39. She stated, "[Resident name] wasn't eating...she really hadn't been eating for a couple of days...when I went in there at lunch time her blood sugar was down in the 50's. I got her some orange juice and then I left her with another nurse...I think her name is (name), but I don't know her last name. I left and went to McDonald's to get her some french fries, because that's what she wanted...when I got back I was behind on my meds and stuff so she [other nurse] helped me...she gave her glucagon...then [Resident name] went to the bathroom, she had a bowel movement, I think it was dark and then all of a sudden she got short of breath. She wanted to go to the hospital so we sent her...." LPN #3 was asked where McDonald's was in relation to the facility. She stated, "About a 5 minute drive each way."

The above information was discussed with the DON and the corporate nurse consultants during an end of the day meeting on 04/26/2018. The DON stated, "That note that was written is her [LPN #3] note for the entire shift...the timeline is off and there is no way to tell when she did what."

Potter and Perry Fundamentals of Nursing, 6th edition, page 846 states the following: "A

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F 684	Continued From page 22 medication order is required for any medications to be administered by a nurse." Potter and Perry. Fundamentals of Nursing, 6th Edition. 2005 Mosby Incorporated. St Louis Missouri No further information was obtained prior to the exit conference on 04/26/2018.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure brake extenders were in place for one of 28 Residents, Resident # 86. Resident #86's care plan contained an intervention for brake extenders due to a fall with major injury, the brake extenders were not in place on her wheelchair. Findings were: Resident #86 was admitted to the facility on 06/16/2017 with the following diagnoses, but not limited to: hypertension, diabetes mellitus, dementia and ends stage renal disease.	F 689	F 689 1) Resident #86□s wheelchair has been adjusted to include brake extenders. Resident #86□s care plan now includes all assistive devices utilized in the care of the resident. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all licensed nursing staff on ensuring assistive devices needed to inact the plan of care are in place for resident use. 4) DON or designee will audit 100% of current residents for care planned assistive devices, and verify devices are in place for resident use, then 20% of	6/8/18

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The most recent MDS (minimum data set) was a significant change with an ARD (assessment reference date) of 04/09/2018. Resident #86 was assessed as cognitively intact with a summary score of "15".

The care plan was reviewed on 04/25/2018 at approximately 11:00 a.m.. A focus area was "The resident has had an actual fall with serious injury..." An updated intervention (04/17/2018) included: "Assistive devices: Assist bars, Low Bed, Brake Extenders."

On 04/24/2018 and 04/25/2018, this surveyor spoke with Resident #86. The brakes on the wheelchair were adjacent to the wheels and wrapped with pink duct tape. There were no brake extenders observed on her wheelchair during either conversation.

On 04/25/2018 the DON (director of nursing) was interviewed regarding the care plan for brake extenders. She stated that brake extenders were handles that were attached to the brakes and were higher for the resident to use to lock the wheelchair. She was told that they were not observed on the wheelchair during this surveyors observations.

On 04/25/2018 at 4:45 p.m., the nurse consultant spoke with this surveyor. He stated that the extenders had been put into place as care planned on 04/17/2018; however, Resident #86's wheelchair was traded out on on Friday, 04/20/2018 for a better fit. The extenders were not moved from one chair to the other.

During an end of the day meeting with facility staff on 04/25/2018, the above information was

residents 4x weekly for 2 weeks, then 20% of residents 2x weekly for 2 weeks, and review findings during next QA meeting.

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F 689	Continued From page 24 discussed. No further information was obtained prior to the exit conference on 04/26/2018.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		6/8/18

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F 690	Continued From page 25 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document interview, and clinical record review, facility staff failed to obtain physician orders for one of 28 residents in the survey sample, Resident #35, for care and maintenance of an indwelling catheter; and failed to properly assess one of 28 residents, Resident #28, for self catheterization. 1. Facility staff failed to obtain physician orders for the care and maintenance of an indwelling catheter for Resident #35. 2. Facility staff failed to properly assess Resident #28 for self catheterization. Findings included: 1. Resident #35 was originally admitted on 01/09/18 and readmitted on 04/09/18 with diagnoses including, but not limited to: Bacterial Pneumonia, Chronic Respiratory Failure, Cancer of his Oral Cavity, Tracheostomy, PEG Tube, Ileostomy, RSV (Respiratory Syncytial Virus) and MRSA (Methiciliin Resistant Staphylococcus Aureus). The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 03/20/18. Resident #35 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 04/24/18 at 3:30 p.m., Resident #35 was	F 690	F 690 1) Resident #35 and #28 are no longer in the center. 2) All residents with indwelling catheter or perform self-catheterizations are at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff on: a. Obtaining orders for care of indwelling catheters b. How to assess patients ability to perform self-catheterization. 4) DON or Designee will audit 100% of current residents with indwelling catheters for appropriate care orders and audit 100% of current residents requesting to self-catheterize for assessment completion. Then 50% of residents with indwelling catheters 5x weekly for 2 weeks and 50% of residents requesting to self-catheterize 5x weekly for 2 weeks. Then 20% of residents with indwelling catheters 5x weekly for 2 weeks and 20% of residents requesting to self-catheterize 5x weekly for 2 weeks. Then review all findings in the next QA meeting.	

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F 690	Continued From page 26	F 690		

observed in his room. He was sitting up in his wheelchair [w/c] alert, with flow-by oxygen via mask at 4L/min over his tracheostomy, IV abx [antibiotics] infusing through a left upper arm PICC line and an indwelling catheter in place.

Resident #35's clinical record was reviewed on 04/25/18 at approximately 11:30. The current POS (physician order sheet), dated April 2018 did not include any orders for the care and maintenance of an indwelling catheter.

RN #2 (registered nurse) was interviewed on 04/25/18 at 2:00 p.m. regarding Resident #35. RN #2 stated, "Yes, he does have a Foley catheter. I clean his catheter with Betadine wipes around the insertion site and down the tubing. That is what I do. I don't know about the other shifts. The catheter should be cleaned every shift with betadine. The catheter should be changed every 30 days. Empty the catheter bag every shift and record the amount."

At approximately 2:30 p.m., the DON (director of nursing) was asked for a policy on the use, care and maintenance of indwelling catheters. At approximately 4:00 p.m., the Corporate Nurse (CP) entered the conference room and stated, "We do not have a policy for catheters. We use "Mosby's" as our standard of practice. The standards of practice included the following for "Giving Catheter Care...17. Apply soap to a clean, wet washcloth. 18. Hold the catheter near the meatus. 19. Clean the catheter from the meatus down the catheter about 4 inches...Clean downward, away from the meatus with 1 stroke. Do not pull on the catheter. Repeat a needed with a clean area of the washcloth. Use a clean washcloth if needed. 20. Rinse the catheter with

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F 690	Continued From page 27	F 690		

a clean washcloth. Rinse from the meatus down the catheter about 4 inches. Rinse downward away from the meatus with 1 stroke. Do not tug or pull on the catheter. Repeat as needed with a clean area of the washcloth. Use a clean washcloth if needed. 21. Dry the catheter with a towel. Dry from the meatus down the catheter about 4 inches..." (1)

The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 04/25/18 at approximately 6:00 p.m. The DON stated, "There should definitely be orders for his catheter and the care of his catheter."

No further information was received by the survey team prior to the exit conference on 04/26/18.

(1). Kostelnick, Clare, RN, BSN; Mosby's Textbook for Long-Term Care Nursing Assistants , Seventh Edition, Page 364, Elsevier, St. Louis, MO, 2015.

2. Resident #28 was originally admitted to the facility on 11/16/17 and readmitted on 03/06/18 with diagnoses including, but not limited to: Paraplegia, and Neurogenic Bladder.

The most recent MDS (minimum data set) was a fourteen day assessment with an ARD (assessment reference date) of 02/13/18. Resident #28 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

On 04/24/18 at 4:06 p.m. Resident #28's door was closed. This surveyor knocked on the door and the resident responded, "Who is it? I am cathing myself right now." This surveyor did not

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F 690	Continued From page 28 enter. Resident #28's clinical record was reviewed on 04/25/18 at 3:25 p.m. Included on his April 2018 POS (physician order sheet) was an order for Resident #28 to "...self cath every 4 hours." Included in his Comprehensive care plan (CCP) was: "Resident is able to do in and out self cath every 4 hours. Created On: 11/16/17. Revision on 03/29/2018..." No assessment for self catheterization by Resident #28 was located in the clinical record. The DON (director of nursing) was asked to find an assessment if one was available on 04/25/18 at approximately 4:30 p.m. During a meeting with the survey team on 04/25/18 at approximately 6:00 p.m., the DON stated, "No assessment was completed for Resident #28 performing his own self catheterizations." No further information was received by the survey team prior to the exit conference on 04/26/18.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		6/8/18

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F 692	Continued From page 29 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to maintain acceptable parameters of nutrition for one of 28 resident's, Resident #18. The facility failed to thoroughly assess Resident #18, who experienced an unplanned significant weight loss, for the ability to chew. Resident #18 had broken bottom teeth and no top teeth; however, was not assessed by the Registered Dietitian or Speech Therapy for her ability to chew. The Findings Include: Resident #18 was admitted to the facility on 02/18/16. Diagnoses for Resident #18 included: Dementia, and diabetes. The most current MDS (minimum data set) was a quarterly with an ARD (assessment reference date) of 2/20/18. Resident #18 was assessed with a cognitive score of 3, indicating severely cognitively impaired. Section "K" of the most current MDS triggered a weight loss that was not intended.	F 692	F 692 1) Resident #28 has now been seen by speech therapist and appropriate diet ordered for resident. Dentist consult initiated and appointment scheduled for May 16, 2018 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all licensed staff on inclusion of oral assessment with ability to chew on patients with unexplained weight loss. 4) DON or Designee will audit 100% of current residents with unexplained weight loss for appropriate assessment including ability to chew, then 50% of residents with unexplained weight loss weekly for 2 weeks, then 25% of residents with unexplained weight loss weekly for 2 weeks, then review findings in following QA meeting.	

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On 4/24/18 12:15 PM. Resident #18 was observed during lunch. Resident #18 was in the dinning room and able to feed herself. Resident #18 was served a regular diet as ordered that consisted of meatloaf, red skin potatoes, and broccoli/cauliflower blend. Resident #18 was observed putting the meatloaf into her mouth, chewing then taking the meat out of her mouth and putting it back onto the plate. Resident #18 repeated this action with other pieces of meat and some potatoes. Resident #18 was able to swallow some of the potatoes.

During the time of the observation, this surveyor asked a certified nursing assistant (CNA #1) to sit down and observe Resident #18. CNA #1 verbalized that Resident #18 had complained of pain when eating and that it had been reported to the nurses. CNA #1 also verbalized that Resident #18 doesn't have very many teeth and the meat was too tough.

During the observation while sitting with CNA #1, another CNA approached Resident #18 and asked Resident #18 why she was taking food out of her mouth. Resident #18 replied "I can't eat no more, I ain't got no teeth." The CNA then offered Resident #18 some ice cream. Resident #18 ate 100 % of the ice cream without difficulty.

On 4/25/18 Resident #18's clinical record was reviewed. The clinical record indicated that speech therapy had done an assessment on the afternoon of 4/24/18 after this surveyor had brought the concern to the facility's attention. The speech therapist evaluation also indicated that Resident #18 was having trouble chewing because of not having any teeth.

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Dietary progress notes were also reviewed and evidenced that the facility was aware of the significant weight loss and had attributed some of the weight loss to stomach problems and loose stools. Resident #18 was on supplements (MED PASS) twice daily that had been increased to three times a day in March 2018. Dietary progress notes did not evidence that Resident #18 had been fully assessed including the ability to chew foods.

On 04/26/18 08:09 AM the dietary manager (OS #2) along with the registered dietitian (RD) were interviewed concerning Resident #18's weight loss. The RD verbalized that the facility staff was aware of a weight loss for Resident #18, had increased Resident #18's supplements and over the past couple of months and had stabilized in weight with very little fluctuation. RD verbalized that Resident #18 had dementia that could contribute to weight loss, was within her (Resident #18) ideal body weight, and felt that her needs were being met because the supplements kept Resident #18's weights stable.

When asked if anyone had ever observed Resident #18 actually eating, the RD verbalized that she (RD) had not. The RD was asked if a full assessment would include watching a resident eat to indicate any problems with chewing. The RD verbalized that a full assessment would include observing a resident while eating. The RD was asked if mouth pain or the lack of teeth could be a contributing factor for loss of weight. The RD agreed that mouth concerns could be a contributing factor to weight loss.

At this time OS #2 verbalized that she had

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observed Resident #18 eat in October 2017 and did not have a concern at that time. There was no documentation found in Resident #18's clinical record evidencing an assessment for chewing and or swallowing ability.

On 04/26/18 08:42 AM Speech Therapist (OS #1) was interviewed. OS #1 verbalized that she tried Resident #18 on deli thin sliced roast beef during the assessment on 4/24/18. Resident #18 was unable to chew the meat although she was willing to try to eat the meat, so OS #1 recommended mechanical soft diet. OS #1 verbalized that Resident #18 does not seem to have a problem with appetite and was willing to eat and can self feed. OS #1 also stated that she felt that Resident #18 had some broken off lower teeth, and no upper teeth, which could be sharp and should probably be seen by a dentist.

On 04/26/18 09:04 AM, CNA #2 was interviewed regarding Resident #18's mechanical soft diet that was served for breakfast. CNA #2 verbalized Resident #18 was eating pretty good now on softer diet but still having trouble with meat.

On 4/26/18 at 10:40 AM, CNA #1 was again interviewed concerning the reporting of Resident #18's chewing concerns. CNA #1 verbalized that the nurses and other staff are aware of Resident #18's chewing problems and the problems have been reported several times. CNA #1 was not specific on the names of the staff the concern was reported too.

On 04/26/18 10:54 AM license practical nurse (LPN #2) was interviewed. LPN #2 verbalized she was aware of Resident #18 not eating meats and had asked the Resident #18 why was she not

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F 692	Continued From page 33 eating the meats. LPN #2 verbalized that Resident #18's response was because she didn't have any teeth. LPN #2 also verbalized that Resident #18 only had some lower teeth and they were not in good shape. On 4/26/18 4:30 PM the above information was provided to the director of nursing and administrator. No other information was provided prior to exit conference on 4/26/18.	F 692		
F 693 SS=D	Cross Reference F 791 Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic	F 693		6/8/18

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F 693	Continued From page 34 abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff failed to obtain physician orders for one of 28 residents in the survey sample, Resident #35, on care of a PEG tube. Facility staff failed to obtain orders for the care of a PEG tube, to include flushes with medication administration for Resident #35. Findings included: Resident #35 was originally admitted on 01/09/18 and readmitted on 04/09/18 with diagnoses including, but not limited to: Bacterial Pneumonia, Chronic Respiratory Failure, Cancer of his Oral Cavity, Tracheostomy, PEG Tube, Ileostomy, RSV (Respiratory Syncytial Virus) and MRSA (Methiciliin Resistant Staphylococcus Aureus). The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 03/20/18. Resident #35 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 04/24/18 at 3:30 p.m., Resident #35 was observed in his room. He was sitting up in his wheelchair [w/c] alert, with flow-by oxygen via mask at 4L/min over his tracheostomy, IV abx [antibiotics] infusing through a left upper arm PICC line and an indwelling catheter in place. Resident #35's clinical record was reviewed on 04/25/18 at approximately 11:30. The current	F 693	F 693 1) Resident #35 is no longer in the center. 2) All residents with PEG tubes at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff on obtaining orders for the care of a PEG tube and include flushes with every medication administration. 4) DON or Designee will audit 100% of current residents with PEG tubes for care orders that include flushes with medication administration, then 50% of residents with PEG tubes 3x weekly for 2 weeks, then 25% of residents with PEG tubes 3x weekly for 2 weeks, then review findings in following QA meeting.	

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POS (physician order sheet), dated April 2018 included: "...Enteral Feed Order five times a day Flush feeding tube with 100mL [milliliters] of water before and after TF [tube feeding] bolus administration. Enteral Feed Order five times a day for nutrition...Enteral Nutrition via Bolus: Osmolite 1.5, 1 can (237mL) five times daily. [Enteral] Elevate HOB [head of bed] 30 to 45 degrees at all times during feeding and for at least 1 hour after the feeding is stopped four times a day [Enteral] Elevate HOB 30 to 45 degrees at all times during feeding and for at elast [sic] 30 to 40 minutes after the feeding is stopped..." No orders were included for the care of the PEG insertion site or for flushing the PEG before and after medication administration.

A policy for the care of a PEG tube was requested from the DON (director of nursing) on 04/25/18 at approximately 1:00 p.m. The policy "Care of the Patient with a Feeding Tube...Effective Date: 02/01/15. Policy: The patient will receive the necessary skills and services necessary to maintain skin integrity related to the stoma site...assess for placement and residual amounts...Procedure: Stoma Care: ...1. Gastrointestinal stoma site care will be cleaned and a dressing applied as indicated by a licensed nurse in accordance with physician orders. a. Cleanse peristomal area with soap and water using spiral pattern; moving from the proximal stoma area outward. b. Apply moisture barrier if indicated. c. Apply non-sterile dressing and topical ointment if ordered...Procedure: General Principles related to Enteral Feedings: ...5. Verify placement of feeding tube PRIOR to infusion of formula. DO NOT GIVE FEEDING IF UNABLE TO VERIFY PLACEMENT. If residual gastric content measures

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F 693	Continued From page 36 > [greater than] 200cc [cubic centimeters], hold the feeding and notify the physician for direction to decrease risk of aspiration...Procedure: Medication Administration: ...4. Verify tube placement and residual amounts...6. Connect the tip of the 60cc syringe to the end of the tube and flush via gravity using 30cc-60cc of water, or as prescribed by physician PRIOR to instillation of medications...follow with 15 cc water flush, or as prescribed by physician..." The Administrator and DON were informed of the above findings during a meeting with the survey team on 04/25/18 at approximately 6:00 p.m. The DON stated, "There should be orders for the site care of his PEG tube and for flushes with medications. We will correct his orders for feedings five times per day and the amount of time to remain elevated after feedings are administered." No further information was received by the survey team prior to the exit conference on 04/26/18.	F 693		
F 694 SS=E	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff failed to obtain physician orders for care and maintenance of a PICC (peripherally inserted	F 694	F 694 1) Resident #35 is no longer in the center.	6/8/18

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F 694	Continued From page 37 central catheter) line, for one of 28 residents in the survey sample, Resident #35. Facility staff failed to obtain physician orders for the care and maintenance of a dual lumen PICC line for Resident #35. Findings included: Resident #35 was originally admitted on 01/09/18 and readmitted on 04/09/18 with diagnoses including, but not limited to: Bacterial Pneumonia, Chronic Respiratory Failure, Cancer of his Oral Cavity, Tracheostomy, PEG (percutaneous endoscopic gastrostomy) Tube, Ileostomy, RSV (Respiratory Syncytial Virus) and MRSA (Methiciliin Resistant Staphylococcus Aureus). The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 03/20/18. Resident #35 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 04/24/18 at 3:30 p.m., Resident #35 was observed in his room. He was sitting up in his wheelchair [w/c] alert, with flow-by oxygen via mask at 4L/min over his tracheostomy, IV abx [antibiotics] infusing through a left upper arm PICC line and an indwelling catheter in place. Resident #35's clinical record was reviewed on 04/25/18 at approximately 11:30. The current POS (physician order sheet), dated April 2018 included: "...PICC line-flush with 10mL [milliliters] NS [normal saline], then 5mL 10 units/mL heparin (non-valved). PICC line dressing change on	F 694	2) All residents with PICC lines are at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff on obtaining orders for the care and maintenance of PICC lines. 4) DON or Designee will audit 100% of current residents with PICC lines for orders regarding the care and maintenance of the intervention, then 50% of residents with PICC lines 5x weekly for 2 weeks, then 25% of residents 5x weekly for 2 weeks, then review findings in the following QA meeting.	

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F 694	Continued From page 38	F 694		

admission, then Q [every] week and PRN [as needed]...Heparin Lock Flush Solution 100 unit/ml. Use 2 ml intravenously one time a day...Sodium Chloride Flush Solution. Use 10ml/hr intravenously one time a day...Infuse 10 mL into vein every day to flush PICC...Piperacillin-Tazobactam in Dex Solution 4-0.5 GM/100ML [Grams per milliliter]. Use 100 ml intravenously every 6 hours...for 136 Administrations until finished. Infuse 100 mL into vein via PICC every 6 hours for 34 days...Vancomycin HCl in Dextrose Solution 750-5 MG/150ML-% [milligrams per milliters]. Use 150 ml intravenously every 18 hours...until 05/10/2018 08:59 Infuse 150 mL into vein via PICC every 18 hours for 30 days @ [at] 100mL/hour [milliliters per hour]..."

RN #2 (registered nurse) was interviewed on 04/25/18 at 2:00 p.m. regarding Resident #35's PICC line care and IV abx (antibiotic) administration and flushes. RN #2 stated, "We have MD [physician] orders for care of his PICC line and meds. His PICC line has two lumens. The red port, blood draw port is flushed daily. The purple port, med administration port is flushed as used." RN #2 and this surveyor reviewed Resident #35's physician orders on his MAR (medication administration sheet). RN #2 stated, "Oh, I see what you are saying about the blood draw port. There are no flushing orders for the purple port. I was following what I thought was standard procedure."

A central line policy was requested from the DON (director of nursing) on 04/25/18 at 3:00 p.m. Included on the "Infusion Maintenance Table...Flush Protocols...Verify Patency: The nurse should aspirate the catheter for blood

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F 694	Continued From page 39 return prior to administration of medications and solutions...PICC-Intermittent-Non-Valved 10 mL NS infuse medication then 10 mL NS follow with 5 mL 10 units/mL heparin...Non-Valved: Non-valved catheters require heparin flushing after med administration..." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 04/25/18 at approximately 6:00 p.m. The DON stated, "We will get and write corrected orders for the Heparin and Saline flushes and also for the correct concentration of the Heparin flushes being used." No further information was received by the survey team prior to the exit conference on 04/26/18.	F 694		
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 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 staff interview, facility document review, and clinical record review, facility staff failed to obtain physician orders for the care and maintenance of a tracheostomy (trach) and use of supplemental oxygen for one of 28 residents in the survey sample, Resident #35; and failed to provide specialized care needs for the provision	F 695	F 695 1) Resident #12 has now been assessed for ability to provide self-care to tracheostomy and orders obtained accordingly. Resident #35 is no longer in the center.	6/8/18

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F 695	Continued From page 40 of a tracheostomy for one of 28 resident's, Resident #12. 1. Facility staff failed to obtain physician orders for care and maintenance of a trach and use of supplemental oxygen for Resident #35. 2. Resident #12 was not being provided treacheostomy care by licensed staff. Findings included: 1. Resident #35 was originally admitted on 01/09/18 and readmitted on 04/09/18 with diagnoses including, but not limited to: Bacterial Pneumonia, Chronic Respiratory Failure, Cancer of his Oral Cavity, Tracheostomy, PEG (percutaneous endoscopic gastrostomy) Tube, Ileostomy, RSV (Respiratory Syncytial Virus) and MRSA (Methiciliin Resistant Staphylococcus Aureus). The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 03/20/18. Resident #35 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 04/24/18 at 3:30 p.m., Resident #35 was observed in his room. He was sitting up in his wheelchair [w/c] alert, with flow-by oxygen via mask at 4L/min over his tracheostomy, IV abx [antibiotics] infusing through a left upper arm PICC line and an indwelling catheter in place. Resident #35's clinical record was reviewed on 04/25/18 at approximately 11:30. The current POS (physician order sheet), dated April 2018 included: "...Deep	F 695	2) All residents with tracheostomy care are at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff on: a. Obtaining orders for the care of a tracheostomy b. Appropriate orders for supplemental oxygen use with tracheostomy c. Appropriately documenting when care is provided by nurse 4) DON or Designee will audit 100% of current residents with tracheostomy tubes for: a. Appropriate care orders b. Need for supplemental oxygen orders c. Appropriate documentation based on the care provided Then 50% of residents with tracheostomy 5x weekly for 2 weeks, then 25% of residents with tracheostomy 5x weekly for 2 weeks, then review findings in the following QA meeting.	

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suction tracheostomy as needed...Oxygen Therapy-Oxygen at (specify) liters per minute via nasal cannula..." No further orders regarding Resident #35's trach were included. No specific amount of oxygen was ordered and Resident #35 received his oxygen via a mask over his trach, not by nasal cannula.

RN #2 (registered nurse) was interviewed on 04/25/18 at 2:00 p.m. regarding trach care. RN #2 stated, "You use a sterile trach care kit and use sterile water and peroxide. Clean around the outer cannula with betadine, check the trach ties and suction as needed. His trach is not new. He flags us down when it needs cleaned or he needs suctioned. There is a Yankeur at the bedside he uses to suction his mouth."

A trach care policy was requested from the DON (director of nursing) on 04/25/18 at 3:00 p.m. The policy, "Tracheostomy Care...Effective Date: 02/01/15" included the following: "Policy: Tracheostomy care will be provided by licensed nurses in accordance with the physician's orders. Procedure: 1. Assemble equipment and prepare dressing tray. a. Remove sterile drape and place it on a table. b. Place all items on the sterile drape, maintaining sterility. c. Prepare a solution of 1/2 hydrogen peroxide and 1/2 sterile normal saline into the largest compartment of the trach care tray. d. Pour sterile normal saline into one of the smaller compartments. 2. If inner cannula is non-disposable: a. Remove inner cannula from trach tube. b. Immerse in a solution of 1/2 hydrogen peroxide and 1/2 sterile normal saline. c. Use a pipe cleaner/brush to clean inside the inner cannula and remove all secretions. d. Rinse the inside and outside of the inner cannula with sterile normal saline. Shake cannula to

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remove any excess sterile saline. e. Reinsert inner cannula, secure in place...4. Remove the used trach sponge and assess the secretions for color and character. Assess site for redness, excoriations and weeping. 5. Clean tracheostomy site with sterile Q-tips and normal saline;apply new trach sponge. 6. Change trach tube tie-holder if soiled and PRN [as needed]..."

The Administrator and DON were informed of the above findings during a meeting with the survey team on 04/25/18 at approximately 6:00 p.m. The DON stated, "We will get complete trach care orders from the physician and make sure his care is being done. We will also get an order for his Yankeur suction he uses at the bedside."

No further information was received by the survey team prior to the exit conference on 04/26/18.
2. Resident #12 was admitted to the facility on 02/17/16. Diagnoses for Resident #12 included: Cancer of the larynx, and tracheostomy (trach).

The most current MDS (minimum data set) was an annual with an ARD (assessment reference date) of 2/20/18. Resident #12 was assessed with a cognitive score of 8, indicating moderately cognitively intact.

On 04/24/18 01:08 PM, Resident #12 was interviewed. When asked about the care and treatment of Resident #12's tracheostomy, Resident #12 verbalized that he cleans his own trach three times a day. When asked how it is cleaned, Resident #12 demonstrated by pulling out the inner cannula, and verbalized that he washes it in the sink. Resident #12 was then asked how did he learn to take care of his trach. Resident #12 verbalized he taught himself.

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04/26/18 07:57 AM, license practical nurse (LPN #1) was interviewed regarding trach care for Resident #1 and said that Resident #12 does do own trach care three times a day and nurses sign off that it has been done.

On 4/26/18 R 12's care plan was reviewed and did not evidence that a care plan was put in place for self treatment of trach care.

Resident #12's resident assessment forms were then reviewed and did not evidence that Resident #12 was assessed for self care of a trach.

R 12's treatment administration record (TAR) for the month of April 2018 was then reviewed and evidenced treatment instructions "Remove inner cannula, clean per policy, return to trachea. q 8 hours trach care every shift related to MALIGNANT NEOPLASM OF LARYNX, UNSPECIFIED (C32.9) -Order Date-06/16/2016 0943." The TAR was signed of by nurses as having been completed tree times a day from the first of April through 4/25/18.

A facility policy titled "Tracheostomy Care" was obtained and documented that tracheostomy care is done using sterile technique and also gave step by step instruction how to clean the trach.

On 04/26/18 10:12 AM, registered nurse (RN #1 , nurse consultant) was interviewed regarding assessment of self care for a trach. RN #1 reviewed the resident's chart and verbalized that resident did not have a assessment for self treatment of trach care and one should be done prior to allowing a resident to perform care on a

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F 695	Continued From page 44 trach. On 04/26/18 4:30 PM the above information was provided to the director of nursing and administrator. No other information was provided prior to exit conference on 4/26/18.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, complaint investigation, and staff interview, the facility failed for one of 28 residents in the survey sample (Resident # 147) to implement a comprehensive pain management program. Resident # 147 was administered as needed pain medications 68 times without being offered non-pharmacological pain interventions. The findings were: Resident # 147 in the survey sample, an 88 year-old female, was admitted to the facility on 11/4/16 with diagnoses that included dementia without behavioral disturbance, delirium, altered mental status, major depression disorder, generalized muscle weakness, encephalopathy, and rash and other non-specific skin eruption.	F 697	F 697 1) Resident #147 is no longer in the center. 2) All residents receiving as needed pain medication are at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff providing and documenting non-pharmacological intervention usage prior to as needed pain medication administration. 4) DON or Designee will audit 50% of current residents receiving as needed pain medication 5x weekly for 2 weeks, then 25% of residents receiving as needed pain medication 5x weekly for 2 weeks, then review findings in the following QA meeting.	6/8/18

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According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 11/11/16, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills.

Under Section G (Functional Status), the resident was assessed as not walking in her room or in the unit corridor; as needing extensive assistance with one person physical assist for eating; as needing extensive assistance with two persons physical assist for transfer, dressing, and hygiene; and as totally dependent with one person physical assist for locomotion on and off the nursing unit, and bathing.

On 1/28/17, the resident was discharged to another nursing facility. At the time of discharge, her assessment parameters under Sections C and G were unchanged.

Resident # 147 had the following orders, dated as noted, for as needed pain medications:

11/4/16 - Oxycodone HCl Tablet 5 mg (milligrams). Give 0.5 (1/2) tablet by mouth every 6 hours as needed for pain.

11/4/17 - Tramadol HCl Tablet 50 mg. Give 1 tablet by mouth every 6 hours as needed for pain.

Review of the Electronic - Medication Administration Records (EMAR) for the months of November and December 2016, and January 2017 revealed the number of times Resident # 147 received as needed Oxycodone and Tramadol.

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Oxycodone:
November 2016 - 3 times
December 2016 - 32 times
January 2017 - 20 times

Tramadol:
November 2016 - 1 time
December 2016 - 8 times
January 2017 - 4 times

Resident # 147's care plan, dated 11/7/16, included the following problem, "Pain." The goal for the problem of pain was, "Resident will have no/decreased complaints of pain through next review."

The interventions for the stated problem were, "Encourage relaxation techniques and provide diversional alternatives, example enjoys hand lotion, watches TV. May use lavender oil for relaxation if requested; Medicate as ordered; Notify MD for pain not relieved with medication or with new complaints of pain; Position resident for comfort; Premedicate in anticipation of painful procedures."

Review of the Progress (Nurses) Notes in Resident # 147's Electronic Health Record (EHR) revealed entries for each administration of as needed Oxycodone and Tramadol. Examples of the entries include the following:

11/26/16 - 9:48 a.m. "Oxycodone HCl Tablet 5 mg. Give 0.5 tablet by mouth every 6 hours as needed for pain. Leg pain 5/10 (pain level of 5 on a scale of 10)."

12/11/16 -12:03 p.m. "Tramadol HCl Tablet 50

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F 697	Continued From page 47 mg. Give 1 tablet every 6 hours as needed for pain. C/O (Complained of) hip pain 4/10." 12/19/16 - 8:04 a.m. "Tramadol HCl Tablet 50 mg. Give 1 tablet every 6 hours as needed for pain. Back pain 4/10." 1/2/17 - 8:54 a.m. "Oxycodone HCl Tablet 5 mg. Give 0.5 tablet by mouth every 6 hours as needed for pain. Rt (right) hip pain 5/10." There was no documentation to indicate non-pharmacological pain interventions were offered or used prior to the administration of as needed pain medication to the resident. The findings were discussed with the administrative staff during a meeting with the survey team at 3:30 p.m. on 4/26/18. This is a COMPLAINT DEFICIENCY.	F 697		
F 756 SS=E	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	F 756		6/8/18

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F 756	Continued From page 48 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to act on a pharmacy recommendation for one of 28 residents in the survey sample: Resident #9. Resident #9's pharmacy recommendation to decrease Metformin (a diabetic medication) and have a BMP (basic metabolic panel) done on the next convenient lab day was not acted upon by the resident's physician. Findings include: Resident #9 was admitted to the facility 5/8/17	F 756	F 756 1) Resident #9 has now had pharmacy recommendations reviewed by MD, Metformin has been reduced to recommended dosage and BMP has been obtained and reviewed by MD. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff, practitioners, and medical director on the process for addressing pharmacy recommendations. 4) DON or Designee will audit 100% of	

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F 756	Continued From page 49 with a readmission date of 6/9/17. Diagnoses for Resident #9 included, but was not limited to: diabetes, depression, history of stroke, heart failure, and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) was a quarterly review dated 2/8/18 and had Resident #9 coded as cognitively intact with a total summary score of 15 out of 15. On 4/25/18 at approximately 11:48 a.m. during clinical record review, a progress note by the facility's pharmacy consultant dated 12/19/17, directed the reader to refer to a consultation report for details of the monthly medication review. The report was not located in the clinical record, and the DON (director of nursing) was asked for assistance in locating the report. On 4/25/18 at 4:00 p.m. the DON provided a copy of the consultation report to this surveyor. The report documented "Comment: (name of resident) receives metformin 1000 mg with meals, but does not have a recent creatinine evaluation (a lab value for kidney function) documented in the resident record...Recommendation: Please consider decreasing metformin to 850 mg with meals and monitoring a BMP on the next convenient lab day and repeat in 3 months." The consultation was dated 12/19/17, and had no action by the physician documented on the physician response section. The current April 2018 POS (physician order summary) documented "Metformin HCL Tablet 1000 mg -Give 1 tablet by mouth with meals." There were no orders located for Resident #9 to have a BMP	F 756	current residents with pharmacy recommendations from April for completion, then 50% of residents with pharmacy recommendations 4x weekly for 2 weeks, then 25% of residents with pharmacy recommendations 4x weekly for 2 weeks, then review findings in following QA meeting.	

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F 756	Continued From page 50 drawn. The DON was asked why the physician did not act upon the recommendation. The DON stated "There were several recommendations during that time (December 2017 and January 2018) that were not seen by the physician; the former DON had left around November 2017, and an interim DON from the company was here for a couple of months. During that time the recommendations were not handled until I took over in March 2018 and found they had not been done and I have been trying to get them caught up." The DON and two regional consultants were informed of the above findings during a meeting with facility staff 4/25/18 beginning at 6:00 p.m. No further information was provided prior to the exit conference.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		6/8/18

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F 757	Continued From page 51 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure two of 28 residents in the survey sample, Resident #9 and Resident #14, were free from unnecessary medications. 1. Resident #9's pharmacy recommendation to decrease Paxil (an anti-depressant) was not done. 2. Resident #14's pharmacy recommendation to decrease Cymbalta (an anti-depressant) was not done. Findings include: 1. Resident #9 was admitted to the facility 5/8/17 with a readmission date of 6/9/17. Diagnoses for Resident #9 included, but not limited to: diabetes, depression, history of stroke, heart failure, and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) was a quarterly review dated 2/8/18 and had Resident #9 coded as cognitively intact with a total summary score of 15 out of 15. On 4/25/18 at approximately 11:48 a.m. during clinical record review, a progress note by the	F 757	F 757 1) Resident #9□s Paxil decrease has now been reviewed by the MD and reduced. Resident # 14□s Cymbalta decrease has now been reviewed by the MD and reduced. No other current recommendations for these two residents. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff, practitioners, and medical director on the process for addressing pharmacy recommendations and ensuring orders are carried out. 4) DON or Designee will audit 100% of current residents with pharmacy recommendations from April for completion of recommendations, then 50% of residents with pharmacy recommendations 4x weekly for 2 weeks, then 25% of residents with pharmacy recommendations 4x weekly for 2 weeks, then review findings in following QA meeting	

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F 757	Continued From page 52	F 757		

facility's pharmacy consultant dated 1/24/18, directed the reader to refer to a consultation report for details of the monthly medication review. The report was not located in the clinical record, and the DON (director of nursing) was asked for assistance in locating the report.

On 4/25/18 at 4:00 p.m. the DON gave a copy of the consultation report to this surveyor. The report documented "Comment: (name of resident) has received Paxil 30 mg every day for management of depressive symptoms since 5/2/17. Recommendation: Please consider a gradual dose reduction, perhaps decreasing Paxil to 20 mg every day, if clinically appropriate." The physician responded to the recommendation to agree to decrease Paxil to 20 mg every day. (While the consultation form was dated 1/24/18, the physician did not date the form).

The current POS (physician order summary) for April 2018 was then reviewed and revealed an order carried forward from 6/11/17 for "Paxil Tablet 30 mg-Give 1 tablet by mouth in the morning for depressive disorder."

On 4/26/18 at approximately 3:00 p.m. the regional nurse consultant was asked about the Paxil not being decreased as ordered by the physician. The nurse consultant stated "Well, looks like the nurse did not take the order off the report and put it in the system to send to pharmacy to get the decreased dosage sent." The consultant stated that would be corrected immediately.

The DON and two regional consultants were informed of the above findings during a meeting with facility staff 4/25/18 beginning at 6:00 p.m.

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F 757	Continued From page 53	F 757		

No further information was provided prior to the exit conference.

2. Resident #14 was admitted to the facility 11/2/16 with a readmission date of 2/10/17. Diagnoses for Resident #14 included, but were not limited to: high blood pressure, diabetes, and depression.

The most recent MDS (minimum data set) was an annual review dated 12/19/17 and had Resident #14 coded as cognitively intact with a total summary score of 15 out of 15.

On 4/25/18 at approximately 9:00 a.m. during review of the clinical record a progress note by the facility's pharmacy consultant dated 1/24/18, directed the reader to refer to a consultation report for details of the monthly medication review. The report was not located in the clinical record, and the DON (director of nursing) was asked for assistance in locating the report.

On 4/25/18 at 4:00 p.m. the DON gave a copy of the consultation report to this surveyor. The consultation report documented "Comment: (name of resident) has received Cymbalta 60 mg every day (since 11/17) for management of depressive symptoms. Recommendation: Please consider a gradual dose reduction if clinically appropriate." The physician responded to the recommendation on 2/18/18, agreeing to decrease Cymbalta to 30 mg every day.

The April 2018 POS (physician order summary) was then reviewed and revealed the following order carried forward from 1/31/17 for "Cymbalta Delayed Release 60 mg- Give 1 capsule by

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F 757	Continued From page 54 mouth one time a day." On 4/26/18 at approximately 3:00 p.m. the regional nurse consultant was asked about the Cymbalta not being decreased as ordered by the physician. The nurse consultant stated "Well, looks like the nurse did not take the order off the report and put it in the system to send to pharmacy to get the decreased dosage sent." The consultant stated that would be corrected immediately. The DON and two regional consultants were informed of the above findings during a meeting with facility staff 4/25/18 beginning at 6:00 p.m. No further information was provided prior to the exit conference.	F 757		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident-	F 791		6/8/18

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F 791	Continued From page 55 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide or obtain an outside resource for routine dental services for one of 28 resident's, Resident #18. Resident #18's teeth were in poor condition, impacting chewing ability and she had not received dental care since admission. Resident #18 is a recipient of Medicaid services. The Findings Include: Resident #18 was admitted to the facility on	F 791	F 791 1) Resident #18 now has a scheduled dental appointment on May 16, 2018 2) All residents requiring dental services at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff and Social services department on the requirements of providing routine and emergent dental services. 4) DON or Designee will audit 100% of current residents for latest dental visit and	

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F 791	Continued From page 56 02/18/16. Diagnoses for Resident #18 included: Dementia, and diabetes. The most current MDS (minimum data set) was a quarterly with an ARD (assessment reference date) of 2/20/18. Resident #18 was assessed with a cognitive score of 3, indicating severely cognitively impaired. Section "K" of the most current MDS triggered a weight loss that was not intended. On 4/24/18 12:15 PM. Resident #18 was observed during lunch. Resident #18 was in the dinning room and able to feed herself. Resident #18 was served a regular diet as ordered that consisted of meatloaf, red skin potatoes, and broccoli/cauliflower blend. Resident #18 was observed putting the meatloaf into her mouth, chewing then taking the meat out of her mouth and putting it back onto the plate. Resident #18 repeated this action with other pieces of meat and some potatoes. Resident #18 was able to swallow some of the potatoes. During the time of the observation, this surveyor asked a certified nursing assistant (CNA #1) to sit down and observe Resident #18. CNA #1 verbalized that Resident #18 had complained of pain when eating and that it had been reported to the nurses. CNA #1 also verbalized that Resident #18 doesn't have very many teeth and the meat was too tough. During the observation while sitting with CNA #1, another CNA approached Resident #18 and asked Resident #18 why she was taking food out of her mouth. Resident #18 replied "I can't eat no more, I ain't got no teeth." The CNA then offered Resident #18 some ice cream. Resident #18 ate	F 791	for need to see a dentist emergently, then 50% of current patients 2x weekly for 2 weeks, then 25% of current patients 2x weekly for 2 weeks, then review in following QA meeting.	

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F 791	Continued From page 57 100 % of the ice cream without difficulty. On 4/25/18 Resident #18's clinical record was reviewed. The clinical record indicated that speech therapy had done an assessment on the afternoon of 4/24/18 after this surveyor had brought the concern to the facility's attention. The speech therapist evaluation also indicated that Resident #18 was having trouble chewing because of not having any teeth. Dietary progress notes were also reviewed, and did not evidence that Resident #18 had been fully assessed including the ability to chew foods or any concerns regarding dental issues. On 04/25/18 at 10:15 AM an attempt was made to interview Resident #18. Resident #18 seemed to understand the subject of a question, but would quickly start talking about things that did not pertain to the subject. This surveyor was able to observe Resident #18's teeth, which only included approximately 6 front lower teeth that looked about half the size/height of an average tooth, possibly being ground down or broken off. On 04/26/18 08:09 AM the dietary manager (OS #2) along with the registered dietitian (RD) were interviewed concerning Resident #18's weight loss in relationship to dental concerns. When asked (by the surveyor), if anyone has ever observed Resident #18 actually eating, the RD verbalized that she had not. The RD was asked if a full assessment would include watching a resident eat to indicate any problems with chewing. The RD verbalized that a full assessment would include observing a resident while eating. The RD was asked if mouth pain or the lack of teeth could be a contributing factor for	F 791		

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loss of weight. The RD agreed that mouth concerns could be a contributing factor to weight loss.

At this time OS #2 verbalized that she had observed Resident #18 eat in October 2017 and did not have a concern at that time. There was no documentation found in Resident #18's clinical record evidencing an assessment for chewing and or swallowing ability.

On 04/26/18 08:42 AM, Speech Therapist (OS #1) was interviewed. OS #1 verbalized that she tried Resident #18 on deli thin sliced roast beef during the assessment on 4/24/18. Resident #18 was unable to chew the meat although she was willing to try to eat the meat, so OS #1 recommended mechanical soft diet. OS #1 verbalized that Resident #18 does not seem to have a problem with appetite and was willing to eat and can self feed. OS #1 also stated that she felt that Resident #18 had some broken off lower teeth, and no upper teeth, which could be sharp and should probably be seen by a dentist.

On 04/26/18 09:04 AM, CNA #2 was interviewed regarding Resident #18's mechanical soft diet that was served for breakfast. CNA #2 verbalized Resident #18 was eating pretty good now on softer diet but still having trouble with meat.

On 4/26/18 at 10:40 AM, CNA #1 was again interviewed concerning the reporting of Resident #18's chewing concerns. CNA #1 verbalized that the nurses and other staff are aware of Resident #18's chewing problems and the problems have been reported several times. CNA #1 was not specific on the names of the staff the concern was reported too.

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F 791	Continued From page 59 On 04/26/18 10:54 AM license practical nurse (LPN #2) was interviewed. LPN #2 verbalized she was aware of Resident #18 not eating meats and had asked the Resident #18 why was she not eating the meats. LPN #2 verbalized that Resident #18's response was because she didn't have any teeth. LPN #2 also verbalized that Resident #18 only had some lower teeth and they were not in good shape. On 4/26/18 at 11:15 AM this surveyor asked registered nurse (RN #1, nurse consultant) to review Resident #18's medical records and provide any dental consults that Resdient #18 had during her admission to the facility. On 4/26/18 at 2:30 PM, RN #1 verbalized that there were no dental consults found in Resident #18's clinical record and was unable to evidence that Resdient #18 had been seen by dental services since admission (a 2 year period). On 4/26/18 4:30 PM the above information was provided to the director of nursing and administrator. No other information was provided prior to exit conference on 4/26/18.	F 791		
F 880 SS=D	Cross Reference to F 692 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	F 880		6/8/18

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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

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	495420	A. BUILDING _____ B. WING _____	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(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 880	Continued From page 61 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to follow proper infection control practices during medication pass. While preparing medications on the 300 Hall, RN (registered nurse) #4 donned gloves and then touched each pill with her gloved hands during medication pass. Findings were: On 04/25/2018 at approximately 8:00 a.m., a medication pass and pour observation was conducted on the 300 Hall with RN #4. After introducing herself, this surveyor explained the	F 880	F 880 1) RN #4 has been educated on the appropriate procedures to maintain proper infection control during medication administration. The resident□s receiving medication during the medication administration on 4/25/2018 experienced no untoward incident do to the medication administration.. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate licensed nursing staff on the procedures of maintaining proper infection control practices during medication administration.	

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F 880	Continued From page 62 observation process to RN #4. RN #4 asked, "Do you mind if I wear gloves? I've been told that this facility doesn't like us to wear gloves in the hallway." This surveyor stated, "I don't know what your facility's policies are, please proceed with your meds as you normally would." She stated, "Okay, well I wouldn't want someone touching my pills, so I'll wear the gloves." RN #4 donned a pair of nonsterile blue gloves, opened the medication cart and began preparing medications for the first resident. She picked up each medication card, compared it to the computer screen, popped the medication out of the card into her gloved hand, picked the pill up out of her hand with her other gloved hand and placed it in the medication cup. She prepared a total of 13 pills in this manner. She did not change gloves during the preparation. She touched the medication cards, the top of the medication cart, her computer, and other medications in the medication cart as she looked for other prescribed medications (Flonase, Miralax, and insulin) for the same resident. When RN #4 completed the medication preparation, this surveyor told her that we need to count the pills in the medication cup. She poured all of the medications into her gloved left hand and picked each one up with her right hand, placing them back into the medication cup as they were counted. After the medications were given, RN #4 was asked about touching each pill. She stated, "I have hand tremors so I feel like if I am wearing the gloves I am less likely to drop the pills." A copy of the medication administration policy	F 880	4) DON or Designee will audit 100% of nurses for infection control violations during medication administration, then will complete 5 medication administration observations per week for 2 weeks, then 3 medication administration observations per week for 2 weeks, then review findings in following QA meeting.	

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F 880	Continued From page 63 was requested and received. Per the facility policy "General Dose Preparation and Medication Administration" Item "3.4 Facility staff should not touch the medication when opening a bottle or unit dose package." On 04/25/2018 at approximately 6:00 p.m., a meeting was held with the DON (director of nursing), the administrator and the corporate nurse consultants. The above information was discussed. The DON and the corporate nurse consultants were asked if wearing gloves during medication pass and touching each pill individually was acceptable. The DON and the nurse consultants stated it was not. No further information was obtained prior to the exit conference on 04/26/2018.	F 880		