STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495383	A. BUILDING _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS N SANDERS NURSING HOME, INC	7385 WALKER AVE GLOUCESTER, VA 23061

(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 4/17/18 through 4/19/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare standard was conducted 4/17/18 through 4/19/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 55 certified bed facility was 52 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #5, #29, #8, #27, #7, #28, #17, #139, #189, #23, #26, #25, #19) and 3 closed record reviews (Residents #39, #40 and #38).	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on Observation, Clinical Record Review, and Staff Interview, facility staff failed to assess one resident (Resident #25) in a survey sample of 16 residents for self-administration of medication. Resident #25 was not assessed for self-administration of Biotene mouth rinse kept at	F 554	1. The Provider and the responsible party were notified that resident #25 was assessed for self-administration of medications on 4/18/2018 and determined that he could safely administer the self-administer medications. The resident was discharged from the facility on	5/19/18

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

Electronically Signed | 05/07/2018

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F 554	Continued From page 1 the resident's bedside. The findings included: Resident #25 was admitted to the facility on 2/13/2018. Resident #25's most recent Minimum Data Set (MDS) Assessment was a Medicare 30 Day Assessment with an Assessment Reference Date (ARD) of 4/10/2018. Resident #25's Brief Interview for Mental Status (BIMS) assessed him with a score of 15, indicating no impairment. Resident #25 required extensive assistance of two or more staff for bed mobility, transfers, and toileting; extensive assistance of one person for dressing and bathing; limited assistance of one person for dressing; and supervision and setup assistance for eating. On 4/18/2018 at 8:46 a.m., Resident #25 was observed napping in his room. Biotene oral rinse was noted to be sitting on the Resident's windowsill next to the bed. A review of Resident #25's current Care Plan, effective 2/22/2018, did not reveal documentation of self-administration of medications. Resident #25's Electronic Medical Record did not include any assessment of the Resident's ability to safely self-administer medications. Resident #25's current Physician Orders dated March 2018 did not include any provision for self-administration of medications. The Administrator and Director of Nursing (DON) were notified at 11:10 a.m. on 4/19/18 that Biotene was observed at the bedside. They were asked to provide documentation that Resident	F 554	4/19/2018. 2. All current residents will be reviewed by nursing staff for the need for self-administration assessment by 5/19/18 3. The DON or designee will provide in-service to the nursing staff of the facility policy for the resident self-administration of medication by 5/19/2018 4. The DON or designee will audit 3 charts per week for 4 weeks then 3 charts per month for 2 months to ensure that an assessment and order is completed on any resident who request to self-administer medications to determine safety prior to them doing so. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed 5/19/2018.	

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F 554	Continued From page 2 #25 had been assessed to self-administer medications. On 4/19/18 at 1:05 p.m., the DON stated Res #25 had not been assessed. No further information was provided.	F 554		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		5/19/18

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F 565	Continued From page 3 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility staff failed to provide the Resident Council group with a private space for their meetings on the Heron Cove 2 unit. The facility Resident Council group conducted their meetings in the Dining area, which is open without space for privacy. The findings included: 04/18/18 02:03 PM, the Resident Council met for a group meeting. Resident # 24, Resident # 13, Resident # 10, Resident # 28, and Resident # 1 were congregated in the Dining Room on Heron Cove 2. There were no doors on the Dining Room, but was open to all staff and other residents coming and going through the area. The Resident Council was moved to meet on the porch, which was cold, for privacy. Residents were provided blankets, but were visibly shivering. The group was told by Nurse Consultant there is "no private area" so the meeting kept as short as possible due to chilly environment. On 4/18/18 at approximately 2:10 PM: The Household Mentor (other A), stated "We usually meet in the dining room. There is no private area."	F 565	1. The meeting was moved to private area on porch to provide privacy. 2. All residents are at risk for failure to be provided a private space for the resident council meetings to occur. 3. The resident council meeting will be scheduled for the parlor, empty resident room, garage or patio provided weather permitting. Resident council location will documented in the minutes each month. 4. The location of the occurrence of resident council will be audited for three months to ensure compliance. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed by May 19, 2018.	

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F 565	Continued From page 4 On 4/19/18 at 11:15 AM, the facility Administrator, DON (director of nursing) and two nurse consultants were notified of above findings.	F 565		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and facility documentation review, the facility failed for one resident, Resident #8, in a survey sample of 16 residents, to implement their policies and procedures for reporting abuse. The facility failed to report an allegation of verbal abuse by the resident's son. The findings included: Resident #8 was most recently admitted to the facility on 1/21/15. Diagnoses included atrial fibrillation, stroke and dementia. Resident #8's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/6/18. She was	F 607	1. The facility failed to implement policy and procedure for reporting abuse for resident #8. A facility reportable incident was filed for resident #8 during the survey on 4/18/2018. The physician and responsible representative were notified on 4/18/2018. 2. All residents are at risk for failure to implement policies and procedures for reporting abuse. 3. The DON or designee will educate the facility staff on the proper procedure for reporting incidents of abuse by 5/19/2018. 4. House hold mentors to survey 10% of Staff re: residents with allegations of abuse monthly x 2 months and then quarterly. The DON or designee will ensure that all instances of abuse are	5/19/18

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F 607	Continued From page 5 coded with a Brief Interview of Mental status score of "3" out of a possible 15 or severe cognitive impairment. She required assistance with her activities of daily living. Review of the nurse's note dated 3/3/18 revealed an incident where Resident #8's son was "verbally abusive to her yelling because she had spilled her drink. Asked him to leave the door open." On 4/19/18 at 9:35 AM, the DON (director of nursing) was asked if there was an investigation about the incident. The DON stated, "We did not do a FRI (facility reported incident). We just read the nurse's note." She went on to state that the staff would be educated on reporting incidents of abuse. She went on to stat that the resident was kept safe by staff leaving the resident's door open and visiting to be done in the dining area. Review of the facility's policy and procedure on Abuse Prevention and Management revealed: "Abuse includes verbal abuse" and "Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member." On 4/19/18 at 11:15 AM, the Administrator and DON were notified of the above findings.	F 607	reported. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed by May 19, 2018.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		5/19/18

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F 609	Continued From page 6 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and facility documentation review, the facility staff failed for one resident, Resident #8, in a survey sample of 16 residents, to report an incident of verbal abuse to the state agency. 1. Resident #8's incident of verbal abuse was not reported to the State Agency (Office of Licensure and Certification (OLC)) The findings included: Resident #8 was most recently admitted to the	F 609	1. The facility failed to implement policy and procedure for reporting abuse for resident #8. A facility reportable incident was filed for resident #8 during the survey 4/18/2018. The physician and responsible representative were notified during the survey 4/18/2018. 2. All residents are at risk for failure to implement policies and procedures for reporting abuse. 3. The DON or designee will educate the facility staff on the proper procedure for reporting incidents of abuse by 5/19/2018.	

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F 609	Continued From page 7 facility on 1/21/15. Diagnoses included atrial fibrillation, stroke and dementia. Resident #8's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/6/18. She was coded with a Brief Interview of Mental status score of "3" out of a possible 15 or severe cognitive impairment. She required assistance with her activities of daily living. Review of the nurse's note dated 3/3/18 revealed an incident where Resident #8's son was "verbally abusive to her yelling because she had spilled her drink. Asked him to leave the door open." On 4/19/18 at 9:35 AM, the DON (director of nursing) was asked if there was an investigation about the incident. The DON stated, "We did not do a FRI (facility reported incident). We just read the nurse's note." She went on to state that the staff would be educated on reporting incidents of abuse. She went on to stat that the resident was kept safe by staff leaving the resident's door open and visiting to be done in the dining area. Review of the facility's policy and procedure on Abuse Prevention and Management revealed: "Abuse includes verbal abuse" and "Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member." On 4/19/18 at 11:15 AM, the Administrator and DON were notified of the above findings.	F 609	4. The House hold mentors to survey 20% of residents re: process to report concerns of abuse and mistreatment monthly x 2 months and then quarterly. The DON or designee will ensure that all instances of abuse are reported. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed by May 19, 2018.	
F 610	Investigate/Prevent/Correct Alleged Violation	F 610		5/19/18

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F 610 SS=D	Continued From page 8 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and facility documentation review, the facility failed for one resident, Resident #8, in a survey sample of 16 residents, to investigate an allegation of verbal abuse. The facility failed to investigate an allegation of verbal by the resident's son. The findings included: Resident #8 was most recently admitted to the facility on 1/21/15. Diagnoses included atrial fibrillation, stroke and dementia. Resident #8's most recent Minimum Data Set assessment was a quarterly assessment with an	F 610	1. The facility failed to investigate an allegation of verbal abuse for resident #8. An investigation was performed during the survey and a facility reported incident was filed for resident #8 on 4/18/2018. The physician and responsible representative were notified on 4/18/2018. 2. All residents are at risk for failure to implement policies and procedures for investigation an allegation of abuse. 3. The Corporate QA support or designee will educate the facility staff on the proper procedure for investigating allegations of abuse by 5/19/2018 4. The Administrator or designee will ensure that all allegations of abuse are investigated and reported. The results of	

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F 610	Continued From page 9 assessment reference date of 2/6/18. She was coded with a Brief Interview of Mental status score of "3" out of a possible 15 or severe cognitive impairment. She required assistance with her activities of daily living. Review of the nurse's note dated 3/3/18 revealed an incident where Resident #8's son was "verbally abusive to her yelling because she had spilled her drink. Asked him to leave the door open." On 4/19/18 at 9:35 AM, the DON (director of nursing) was asked if there was an investigation about the incident. The DON stated, "We did not do a FRI (facility reported incident). We just read the nurse's note." She went on to state that the staff would be educated on reporting incidents of abuse. She went on to stat that the resident was kept safe by staff leaving the resident's door open and visiting to be done in the dining area. Review of the facility's policy and procedure on Abuse Prevention and Management revealed: "Abuse includes verbal abuse" and "Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member." On 4/19/18 at 11:15 AM, the Administrator and DON were notified of the above findings.	F 610	the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed by May 19, 2018.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		5/19/18

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F 645	Continued From page 10 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under	F 645		

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F 645	Continued From page 11 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed for 1 resident (Resident #17) of 16 residents in the survey sample to ensure a Preadmission Screening and Resident Review (PASARR) screening was conducted prior to admission to the nursing facility. 1. For Resident #17, the PASARR was not completed. The findings included: Resident #17, a 79 year old, was admitted to the	F 645	1. The facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) was conducted prior to the admission of resident 17 to the facility. The PASARR was completed for resident #17 on date May 7, 2018. 2. The Administrator or designee will perform an audit of 100% of residents that are currently admitted to the facility to ensure a PASSAR form is present. All residents without PASARR's will have them completed by facility staff by 5/19/2018. Any needing Level 2 recommendations will be referred to	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS N SANDERS NURSING HOME, INC	7385 WALKER AVE GLOUCESTER, VA 23061

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F 645	Continued From page 12 facility on 8/30/16. Diagnoses included dementia, depression, atrial fibrillation, hypertension, kidney disease, psychosis, and chronic pain. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/28/18. Resident #17 was coded with a Brief Interview of Mental Status score of 4 indicating severe cognitive impairment ad required limited assistance with activities of daily living. Upon review of the clinical record, Resident #17's PASARR could not be located. During a meeting held with the Administrator and Director of Nursing (DON) on 4/19/18 at 11:10 a.m., the DON was asked if she could assist in locating the PASARR. At 1:05 p.m., the DON stated that she could not find the PASARR. No further information was provided.	F 645	Ascend for assessment. 3. The Administrator or designee will educate the Admission Department and the Social Service department on the PASSAR requirement for all admissions by 5/19/2018 4. All new admissions will be audited by Household Mentors for the presence of a PASSAR for four weeks, then 10 % of admissions for four weeks will be audited for the presence of a PASSAR. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed by May 19, 2018.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and 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	F 656		5/19/18

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F 656	Continued From page 13 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on Clinical Record Review and Staff Interview, facility staff failed to develop a comprehensive person-centered care plan for one resident (Resident #25) in a survey sample of 16 residents. Resident #25's Care Plan did not contain goals or interventions for risks related to use of psychotropic medications. The findings included:	F 656	1. Resident # 25 care plan was updated on 4/18/2018 to reflect a comprehensive person-centered care plan for the resident's use of psychotropic medications. 2. A 100% review of all residents on psychotropic medication will have care plans updated to ensure completion by 5/19/18. 3. The DON or designee will provide an in-service to the licensed nurses on the policy and procedures of Resident	

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F 656	Continued From page 14 Resident #25 was admitted to the facility on 2/13/2018. Resident #25's most recent Minimum Data Set (MDS) Assessment was a Medicare 30 Day Assessment with an Assessment Reference Date (ARD) of 4/10/2018. Resident #25's Brief Interview for Mental Status (BIMS) assessed him with a score of 15, indicating no impairment. Resident #25 required extensive assistance of two or more staff for bed mobility, transfers, and toileting; extensive assistance of one person for dressing and bathing; limited assistance of one person for dressing; and supervision and setup assistance for eating. On 4/18/2018, a review of Resident #25's clinical record was conducted. The following was found in the "Problem" tab of Resident #25's current Care Plan dated 2/22/2018: "[Resident] is at risk for side effects related to use of psychoactive medication: X Antidepressants Psychoactive medications are being used to treat/manage following[sic] behaviors/symptoms [Identify]:" No behaviors or symptoms were listed. The tabs of the Care Plan labeled "Goals", "Interventions", "Disciplines", and "Frequency" contained no text. The Administrator and Director of Nursing (DON) were notified at 11:10 a.m. on 4/19/18 that the Care Plan for psychoactive medications was incomplete. On 4/19/18 at 1:05 p.m., the DON stated that the section of the Care Plan had not been completed.	F 656	Centered Care Plan related to psychotropic medications by 5/19/2018. 4. DON or designee will audit 10% of the resident psychotropic medication care plans monthly for three months. The results of the audits will be reported at the QA meeting by the DON or designee for evaluation of compliance and ongoing monitoring for the continuous improvement analysis. 5. The corrective action will be completed by 5/19/ 2018.	

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F 656	Continued From page 15 No further information was provided.	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 observation, staff interview, clinical record review and facility documentation review the facility staff failed for 1 resident (Resident #7) of 16 residents in the survey sample to ensure the bowel protocol was implemented. Resident #7 did not have a bowel movement for 7 days. The facility bowel protocol was not implemented. The findings included: Resident #7, a 91 year old, was admitted to the facility on 2/10/15. Diagnoses included dementia, hypertension, restless leg syndrome, delusions, anxiety, depression, hyperthyroidism and constipation. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/2/18. Resident #7 was coded with a Brief Interview of Mental Status score of 11	F 684	1. The facility failed to ensure the bowel process was implemented for resident # 7. Resident #7 had no negative outcomes from failure to ensure implementation of the bowel process. The resident had a bowel movement on December 7, 2018 and the physician implemented a bowel regime for resident # 7. The resident representative was aware of the absence of bowel movements during this time period. 2. All residents with in the facility are at potential risk for failure to ensure the bowel process is implemented as appropriate. The DON/designee will complete a 100% review of all residents for current BM status with treatment as necessary by 5/7/2018 3. The DON or designee will in-service the licensed nurses regarding to the facility bowel process and daily evaluation of EMR reports compliance by 5/19/2018.	5/19/18

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F 684	Continued From page 16 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. The following nursing notes were documented in Resident #7's clinical record: - 12/4/17, 7:39 a.m. "PRN (as needed) suppository administered due to constipation x 3 days." - 12/7/17, 3:33 p.m. "Resident proceed a small hard BM (bowel movement) on 6-2 shift. Warm prune juice given throughout shift." - 12/8/17, 2:01 a.m. "Spoke with NP (nurse practitioner) on call due to resident constipation. Resident has not had a large BM (bowel movement) since 12/1/17, Noted CNA (certified nursing assistant) did document resident had a large BM on 12/5/17 however she states it was a mistake and resident did not have BM. Noted Am (morning) nurse gave MOM (milk of magnesia) on day shift and got a few small hard fecal pieces the size of pebbles. NP recommended resident to be NPO (nothing by mouth) expect (sic) fluids until an x-ray of abdomen is completed. Resident stomach is distended and slightly hard, active bowel sounds x 4 quads. Vitals are WNL (within normal limits). Resident denies pain. X-ray scheduled for AM. Will continue to monitor." - 12/8/17, 1:31 p.m. 'X-ray of Abdomen, KUB (Kidney, ureter, bladder xray) single obtained at 1050. Resident has been NPO (nothing by mouth) through out shift and all medication held. Results faxed to (doctor) after reporting findings to (doctor's) nurse (name). (Nurse Practitioner) is coming to facility to assess resident. Continue NPO until resident is evaluated by (Nurse Practitioner). Resident is active with no c/o (complaint of) pain or discomfort." - 12/8/17, 7:2 p.m. "MD (doctor) in to visit new	F 684	All residents will be monitored by Nurse Mentor or designee for proper implementation of bowel monitoring with implementation of appropriate treatment per bowel process. An audit of the bowel movement process will be performed on 6 residents a week for four weeks, 3 residents weekly for four weeks, and then 6 residents monthly for 3 months. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 4. The corrective action will be completed by May 19, 2018.	

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F 684	Continued From page 17	F 684		

orders Dok plus 86 mg (milligram)- 50 ours sleep; also ordered Lactulose 10 mg (milligram)/ 15 ml (milliliter) x 2 days. Few hours resident up to bathroom x 2 assist large bowel movement."

The abdominal x-ray report was reviewed. The report read "IMPRESSIONS: Nonspecific study"

The December 2017 bowel movement record was provided. Bowel movements were documented as follows:
12/1/17-12/4/17: No bowel movement
12/5/17, 5:55 p.m.: soft, small
12/7/17, 2:05 p.m.: hard, small
12/9/17, 1:29 a.m.: soft, small
12/9/17, 1:09 p.m.: soft, extra large
12/10/17, 1:06 p.m.: hard, large

According to the 12/8/17, 2:01 a.m. nursing note above, the bowel movement documented on 12/5/17 was documented in error. According to facility documentation, Resident #7 did not have a bowel movement from 12/1/17 until 12/7/17.

On 4/19/18 at 10:30 a.m., the DON provided a blank bowel protocol form. She stated that the bowel movement report was reviewed in the morning meeting to identify residents that had not had a bowel movement. The bowel protocol form was used along with the bowel movement report. The DON stated that the form was reviewed in the morning meeting. She stated that the forms that had been completed to include resident names were not kept.

The "Bowel Protocol" form included a line for the date. The form read:
"11-7 fill in names for 7-3 if no BM in 6 shifts. 7-3 gives prune juice at 0800."

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"7-3 fill in names for 3-11. If no BM by 1400 after receiving prune juice, place name here for 3-11 to give laxative at 2000"
"If no BM from PO laxative by 1800 11-7 to give suppository at 0600. List names here"
"If no results from suppository by 0630, place names of patients who will need fleets enema to be given by 7-3 shift by 0900"

Resident #7's December 2017 Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed. It was documented on the TAR that a bisacodyl suppository was administered on 12/4/17 at 7:38 a.m. At 8:38 a.m., the results were documented as "Not effective as of 0853 (8:53 a.m.)".

According to the bowel protocol, if the suppository was not effective, a fleets enema was supposed to be administered.

According to Resident #7's MAR and TAR, after the laxative was administered on 12/4/17 with no result, no further treatment was provided until Milk of Magnesia was administered on 12/7/17 at 10:23 p.m.. The results were documented as "No Effect."

The Nurse Practitioner (NP) note from 12/8/17 read "(Resident) is seen today for constipation. Nursing reports no significant BM (bowel movement) since 12/5/17 despite suppository, prune juice, milk of magnesia, and fleets enema administered. KUB completed this AM (morning) with no acute findings." The "Assessment/ Plan" read "Recurrent constipation to be managed with laxatives x2 and scheduled stool softener to be added to daily medication regime."

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F 684	Continued From page 19 The NP note documented that a fleets enema was administered. According to the MAR and TAR, no fleets enema was administered. On 4/19/18 at 3:40 p.m. the DON stated that she did not see that a fleets enema was administered. She stated that Resident # 7 did not have an order for fleets enema. Resident #7's care plan was reviewed. The care plan was not dated. The care plan read "Resident is at risk of constipation related to (check all that apply)" with "inadequate fluid & fiber in diet", "Reduced physical mobility" and "history of constipation" checked. The interventions included consult with dietitian, provide fiber supplements and preventative medications per order, encourage fluids, monitor bowel elimination, encourage resident to report need for toileting, provide incontinence care, administer medications per bowel protocol. On 4/19/18 at 11:10 a.m., it was reviewed with the Administrator and DON that the bowel protocol had not been initiated for Resident #7. No further information was provided.	F 684		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		5/19/18

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F 812	Continued From page 20 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed to ensure food temperatures were documented. The facility staff did not measure the temperature of hot coffee prior to service. The findings included: On 4/18/18 at 4:30 p.m., two carafes of coffee were observed on the counter. The coffee was available to staff and residents to serve themselves. Employee C, homemaker, was preparing the dinner meal in Heron Cove 1. Employee C was asked if she took the temperature of the coffee prior to service. Employee C stated no, the Lead Homemaker was supposed to take the coffee temperature. Employee C was asked to provide the coffee temperature log. The "Hot Coffee Serving Temperature Log" was last completed on 4/10/18. No coffee temperatures had been documented for the past eight days. The facility policy "Hot Liquids Procedure" dated 7/2017 read "1. Record temperatures of hot liquids prior to delivery to resident care areas"	F 812	1. The dietary staff were immediately educated on date 4/18/2018 by the corporate quality team of the hot liquids policy and the documentation of the temperature of the liquid and recording it on the log. 2. All residents are at potential risk for being served coffee where staff failed to ensure temperature is documented and recorded prior to service. 3. The Food Service Director or designee will in-service all dietary staff of the hot liquids policy and procedures and the measurement of the coffee temperature and proper documentation prior to service to residents by 5/19/2018. 4. An audit of the completion of the measurement logs will be completed by the Food Services Director or designee 5 times per week for four weeks than 3 times a week for four weeks then weekly for four weeks. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation 5. The corrective action will be	

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F 812	Continued From page 21 and "3. Record the temperature of the hot beverage dispensing machines daily to ensure temperatures equal to or less than 155 degrees". On 4/19/18 at 11:10 a.m., the Administrator and Director of Nursing were notified of the issue with the hot coffee temperature log.	F 812	completed by May 19, 2018.	