State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

(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) COMPLETE DATE
F 000	Initial Comments	F 000		

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APR 16 2018
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An unannounced biennial State Licensure Inspection was conducted 03/27/2018 through 03/29/2018. Significant corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. Three complaints were investigated. The Life Safety Code survey/report will follow.

The census in this 117 certified bed facility was 105 at the time of the inspection. The survey sample consisted of 21 current Resident reviews and three (3) closed record reviews.

F 001 Non Compliance F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:

12VAC5-371-250(I). Please cross reference to F-657.

12VAC5-371-220(D). Please cross reference to F-677.

12VAC5-371-220(B). Please cross reference to F-684.

12VAC5-371-220(A). Please cross reference to F-689.

12VAC5-371-220(A)&(B). Please cross reference to F-692.

Janice R Onodena — LNHA — 4-13-2018

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

State of Virginia

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F 001	Continued From Page 1 12VAC5-371-300(A). Please cross reference to F-755. 12VAC5-371-340(I). Please cross reference to F-809.	F 001		

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

PRINTED: 04/06/2018
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/27/2018 through 03/29/2018. 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/Medicaid standard survey was conducted on 03/27/2018 through 03/29/2018. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Three complaints were investigated. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 105 at the time of the survey. The survey sample consisted of 21 current Resident reviews and three (3) closed record reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657	**F 657 Deficiency has been corrected.** **1.** 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #108. On 3/28/18 MDS Coordinator met with resident and offered alternative date and time for care plan meeting. A care plan meeting was scheduled for 3/30/18 at 1:00p.m., the meeting was held in resident room.	4/24/18

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Sandra R Ouvider	LNHA	4-13-2018

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

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F 657 Continued From page 1

An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and medical record review, the facility staff failed to invite and document resident attendance to care plan meetings for one of 24 residents, Resident #108 (R 108).

The facility could not show evidence for non participation in the development of an individual care plan for Resident #108 (R 108).

Findings include:

R 108 was admitted to the facility originally on 01/21/16 with a readmission on 2/11/18. The most current MDS (minimum data set) was a quarterly assessment dated 3/13/18. R 108 was assessed with a cognitive score of 15, indicating cognitively intact.

On 03/27/18 03:14 PM during an interview with R 108, R 108 verbalized that she does not go to care plan meetings because they are always on a Thursday and she (R 18) has dialysis on Thursday, but would be willing to go if it was on another day.

F 657

2.
1. Residents were notified in Resident Council Meeting on 4/10/18 that care plan meetings could be scheduled for any date/time that is convenient for resident or family.
2. A copy of Resident council minutes from meeting on 4/10/18 has been provided to each resident.
3.
1. The MDS Coordinators have been educated regarding offering alternative dates and times for care plan meetings.
2. Measures put into place to ensure the alleged practice does not recur include: The care plan letter that is given/sent to residents, family members or Responsible party has been revised to include the option of rescheduling care plan for alternative dates or times for meeting scheduled after 4/19/18.

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F 657	Continued From page 2	F 657		
	During an end of day meeting conducted with the staff on 3/28/18 the above information was presented to the director of nursing (DON). The DON verified that care plan meetings were conducted on Thursday's, but would be willing to accommodate a resident if another day would work better for them. An interview was conducted with the MDS coordinator (registered nurse, RN #1) on 3/29/18 at 8:30 AM regarding documentation of why resident did not or could not attend care plan meetings. RN #1 verbalized that the facility does not document why a resident does not participate in care plan meetings. 03/29/18 09:29 AM the above information was presented to DON verbalized understanding that documentation needs to be put in place. No other information was presented prior to exit conference on 3/29/18		**4.** The MDS personnel will report on the number of meeting rescheduled to the QA committee on a monthly basis for review or recommendation and follow up for 3 months then randomly for review and recommendations as necessary.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		
	§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review and staff interview, the facility staff failed to ensure two of 24 residents were provided with necessary care and services to carry out activities of daily living (ADL's), Resident # 42 (R42) and Resident # 97 (R97).			

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F 677 Continued From page 3

1. The facility staff failed to ensure effective communication for R42 and failed to maintain good nutrition for R42.

2. The facility staff failed to prevent weight loss and maintain good nutrition for R97.

Findings include:

1. The facility failed to ensure an effective means of communication for R42 and failed to ensure good nutrition.

R42 was admitted to the facility originally on 9/23/17, with the most current readmission on 12/31/17. Diagnoses for R42 included, but were not limited to: dementia, CAD (coronary artery disease), HTN (high blood pressure), and history of stroke.

The most current full MDS (minimum data set) was a significant change assessment dated 01/23/18. This MDS assessed the resident as having a cognitive score of '5', indicating the resident had severe impairment in daily decision making skills. This MDS also assessed the resident in Section B0600. Speech clarity, as no speech-absence of spoken words and the resident can sometimes understand. The resident was additionally assessed as requiring limited assistance for eating (resident highly motivated), with support/assistance from at least one staff person. This MDS also identified that the resident had a 5% or greater weight loss and was not physician prescribed.

R42 was observed multiple times throughout the

F 677

F 677 Deficiency has been corrected. 4/24/18

1.

1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #42. On 3/27/18 a Food and Beverage Preference List was completed on resident #42 with changes made to diet order as needed. On 4/10/18 an order was added for double portions to be served. On 4/11/18 resident #42 was evaluated by Occupational Therapy to develop an appropriate communication device.
2. Corrective action has been accomplished for the alleged deficient practice in regards to resident #97. On 4/10/18 staff education provided and care plan revised for resident to be offered and encouraged to be out of bed for all meals and to be provided assistance by staff for meals. Staff to also offer clothing protector at meals.

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survey process on 03/27/18 through 03/29/18. The resident was interviewed on several occasion and did have an ability to communicate with words. The resident's speech was broken and weak, and was very difficult to understand. The resident would answer yes/no questions appropriately and nod his head appropriately to questions being asked. The resident was also observed eating in his room on several occasions, the resident was served in bowls and the resident's food was pureed. The resident was very tall and very thin.

R42's clinical record was reviewed for information and/or documentation regarding the resident's ability to speak/communicate and to determine if ST (speech therapy) was seeing the resident.

03/28/18 01:52 PM The resident's record did not evidence that the resident was currently on ST.

03/29/18 09:28 AM An interview with DON (director of nursing) was conducted. The DON stated that the R42 was started on hospice after readmission and then that was d/c'd (discontinued) on 01/16/18 so that the resident could start receiving ST again. The DON presented information from ST and revealed that the resident received ST from 01/19/18 through 02/02/18.

ST notes documented that the resident had expressive aphasia (the person knows what he/she wants to say, yet has difficulty communicating it to others) and to utilize objects and picture board to increase communication. ST additionally addressed the resident's diet as being pureed.

F 677

2.

1. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of current residents that may require a communication device or assistance has been completed with referral to therapy as needed. A 100% audit of all current residents Food and Beverage Preferences has been completed by the Dietary Manager or Designee.
2. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of all current residents needing assistance with meals has been completed and care plans revised as needed.

3.

1. Measures put into place to ensure the alleged practice does not recur include Inservice initiated for Licensed nursing staff regarding set up of meal trays, offering assistance if needed, obtaining alternate food choices as requested and offering clothing protectors as requested.

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F 677 Continued From page 5

R42's CCP was then reviewed and documented, "...allow adequate time to respond...repeat as necessary...use simple, brief, consistent words/cues...use alternative communication tools as needed and to continue with pureed foods.

On 03/28/18 at approximately 7:30 a.m., R42 was observed eating in his room. The resident had three bowls of pureed food (oatmeal, grits, and bacon) and a carton of 2% milk, the resident had eaten all of the oatmeal and was eating the grits at that time. The resident communicated that he did not like the pureed bacon.

On 03/29/18 at approximately 8:00 a.m. R42 was observed eating in his room. The resident has three bowls of pureed food (oatmeal, grits, and bacon) and a carton of 2% milk, the resident had eaten all of the oatmeal and grits, the bowl of bacon was not touched. The resident again communicated that he did not like the pureed bacon. The resident communicated that he did like oatmeal and would like more, this surveyor asked the resident if he had asked for more. The resident stated that he had not. This surveyor then went to the kitchen and asked for more oatmeal for the resident and it was provided and taken to the resident by CNA #2.

Approximately 15 minutes later the resident was observed coming into the dining room in his w/c attempting to communicate to CNA #1 (certified nursing assistant). CNA #1 went with the resident to his room and shortly returned. CNA #1 stated that the resident had forgotten that he had just ate that oatmeal. CNA # 1 was asked if the resident wanted more oatmeal, the CNA stated, "No, he doesn't want anymore."

F 677

4.
The Administrative nursing staff and/or designee will observe dining room and resident room during meal times 3 to 5 times per week for 4 weeks to ensure compliance with resident needs regarding communication, food preferences, feeding assistance and clothing protection. The Director of Nursing (DON) or designee will report on the findings of the Dining observations to the QA committee on a monthly basis for recommendation and follow up for 3 months then randomly for review and recommendations as necessary.

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Approximately 5 minutes later, this surveyor went to the resident's room. The resident was still asking for more oatmeal. This surveyor returned to the kitchen and informed CNA #1 that the resident did in fact, want more oatmeal. The CNA then took the resident another bowl of oatmeal.

Approximately 10 to 15 minutes went by and the resident was observed again. The resident was eating the oatmeal. The resident was asked if he was full and the resident nodded his head no. The resident was asked if he wanted more and the resident stated, "If I can get it."

On 03/29/18 at approximately 10:00 a.m., the DON and the RD (Registered Dietitian) were made aware of concerns regarding R42's lack of ability to communicate effectively with staff to express his needs. The DON and RD were made aware of the observations and informed of concerns with communication and with the resident's weight loss.

The DON stated that, they (the facility) could be using some type of board with words or pictures to help the resident communicate effectively with staff. The DON did not provide a reason why this wasn't implemented, per the resident's CCP and per ST.

The RD stated that the resident had a stroke in late December and that could be contributing to his weight loss and his communication issues. The RD was made aware that the issue was that there were not interventions being implemented to assist the resident with effective communication and there were no interventions implemented to assist the resident from

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continued weight loss. The RD stated that the resident was not happy about the pureed diet and had been noncompliant. The RD was made aware that the resident was observed to eat what he likes (as evidence this morning with oatmeal) and it misunderstanding was expressed as to why these foods for the resident were not being fortified and why was the resident not served whole milk, instead of 2%. The RD stated that, there is a lot we (facility) can do with pureed foods and he should be getting whole milk. The DON and RD were made aware of the amount the resident was given and that the resident ate 3 bowls of oatmeal and one bowl of grits. The RD stated we could give him double portions. The RD and DON were asked why was this implemented prior, no response was given.

The DON stated that the resident was getting supplement drinks (which the resident had been refusing according to the clinical record) and was getting tube feedings, which are now discontinued because the resident peg tube was discontinued on 03/15/18.

The DON, administrator, and corporate nurse were made aware of the above concerns with R42 in a meeting with the survey team on 03/29/18 at approximately 2:45 p.m.

No further information and/or documentation was provided prior to the exit conference to evidence that R42 was provided care and services for effective communication and provided care and services for the prevention of weight loss.

2. The facility staff failed to ensure that R97 received care and services for the prevention of

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F 677	Continued From page 8 weight loss and proper nutrition. R97 was admitted to the facility on 2/10/18. Diagnoses for R97 included, but were not limited to: Diabetes, stroke with aphasia and right side paralysis. A 14 day MDS (minimum data set) was reviewed dated 02/24/18. This MDS assessed the resident with a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. This MDS also assessed the resident as requiring extensive assistance for most ADL's (activities of daily living). The resident was assessed as requiring extensive assistance with on person physical assistance for how the resident consumes food/nutrition. 03/28/18 08:43 AM Resident # 97 was observed laying in her bed. The resident was at approximately a 45 degree angle, with a pillow under her left back/arm. The bedside table was in front of her with the breakfast tray. The breakfast consisted of three separate bowls with pureed food. The resident could barely reach the food from that angle/position and the resident was not attempting to feed herself. One bowl had a small amount of food out of it. The resident did not have a clothing protector of any kind and had a moderate amount of spilled pureed food on the front of her shirt. The resident was spoke to, but did not respond. The resident's roommate then spoke up and stated that the resident cannot speak, and went on to say that she had a stroke and she is paralyzed on the right side. The resident was observed with her right arm laying beside her without movement.	F 677		

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03/28/18 02:00 PM R97 admitting weight was 159.0, current weight of 150. The resident has had a weight loss of 9 lbs (pounds) and 5.66 % loss in just over one month's time.

03/29/18 07:53 AM Resident # 97 observed in the dining room sitting at a table with one other female resident. The resident has a small gray tray attached to the resident's w/c (the resident is paralyzed on her right side). The resident's arm was observed dangling/hanging down beside of the w/c (not on the tray). CNA #1 (certified nursing aide) came over the resident within a few minutes and put the resident's right arm up on the tray. The resident has cranberry juice in front of her and coffee. CNA #2 brought the resident's breakfast and placed the food in front of the resident. CNA #2 placed three bowls of food in front of the resident and placed a regular spoon in one bowl. CNA #2 left the resident.

03/29/18 7:57 AM R97 picked up the bowl with the spoon in it with her left hand and just looked at it. The resident then raised the bowl up toward her mouth (end of spoon pointing toward her mouth), the resident looking around. The resident then took the bowl and put it up to her mouth, trying to pour her food from the bowl with the spoon into her mouth. The resident then began sticking out her tongue and trying to get the food from the bowl into her mouth.

03/29/18 08:01 AM Resident is still trying to eat and put her bowl up to her mouth, no assistance.

03/29/18 08:02 AM CNA #1 was feeding another resident and called for CNA #2 to come and help R97. CNA # 1 stated that she would be right

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F 677	Continued From page 10 there. 03/29/18 08:03 AM (Other Staff) OS #4 entered the dining room at that time and she would assist R97. The resident had pureed eggs, pureed sausage and pureed oatmeal in separate bowls. The resident consumed all of the oatmeal and all of the sausage. OS # 4 stated that the resident doesn't like the pureed eggs. On 03/29/18 at approximately 10:30 a.m., the DON (director of nursing) and the RD (Registered Dietitian) were interviewed and asked about R97. The DON was unaware of the resident's weight loss. The resident's CCP was then reviewed and documented, "...Up in w/c for all meals for safe feeding. Divided plate for meals..." The DON and RD were made aware that the resident is supposed to be up for meals and have assistance provided at meals, per a nutritional assessment dated 02/10/18. The administrator, DON, and corporate nurse were made aware in a meeting with the survey team on 03/29/18 at approximately 2:45 p.m. No further information and/or documentation was presented to the exit conference on 03/29/18 to evidence that the facility staff assisted R97 with the care and services for meal consumption, which resulted in a 9 lb weight loss in just over one months time.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		

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	495146		C 03/29/2018

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F 684	Continued From page 11 § 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 resident interview, clinical record review and staff interview, the facility staff failed to ensure that one of 24 resident's R83 (Resident # 83) followed physician's order for a bone stimulator. The facility staff failed to follow a physician's order for R83, for the use of a bone stimulator, twenty minutes per day; the bone stimulator was discontinued without a physician's order and the resident did not receive the bone stimulator for approximately 3 weeks. Findings include: R83 was admitted to the facility on 08/24/17. Diagnoses for R83 included, but were not limited to: High blood pressure, muscle weakness, osteoarthritis, anxiety, depression, and left femur fracture. The most recent MDS (minimum data set) was a quarterly assessment dated 02/27/18. This MDS assessed the resident with a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills.	F 684	**F 684 Deficiency has been corrected.** **1.** 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #83. On 3/27/18 the Bone Stimulator was started per physician order. **2.** 1. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of all current residents with current physician order for bone stimulators has been completed. Orders and care plans revised as needed. **3.** 1. Measures put into place to ensure the alleged practice does not recur include: Inservice initiated for Licensed Nurses regarding checking for new orders when residents return from outside appointments. Appointment schedule and daily orders will be reviewed in clinical morning meeting for follow up as needed.	4/24/18

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F 684 Continued From page 12

During an interview with R83 on 03/28/18 09:07 AM the resident stated that she is supposed to have a bone stimulator applied daily by the nurse and that she has not been getting it. The resident stated that when she asked the nurse about why she was not getting the bone stimulator the nurse really didn't give her an explanation why it was stopped.

R83 stated that it is to be done for 20 minutes per day everyday and they (staff) haven't been doing it. R83 stated that the staff never gave her an explanation, and stated that one nurse told her they weren't going to do it anymore, but when I went to the orthopedic doctor he said they should keep doing it. I went for a bone scan last week, the day it snowed (Tuesday) for the bone/knee scan because the bone is not healing right, but it did show that it was starting to heal, so I am not sure why they didn't keep doing the bone stimulator.

R83's clinical record was reviewed and revealed an orthopedic consult dated 01/19/18 that documented, "...left distal femur fracture...Bone Stimulator daily where marked for 6 weeks..."

The resident's physician's orders were reviewed and revealed an order for, "...Apply bone stimulator to left leg break for 20 minutes daily every day shift for bone healing for 6 weeks...Order date: 01/24/18...Start date: 01/25/18...End date: 03/08/18..."

An orthopedic consult dated 03/02/18 documented, "...left distal femur fracture delayed healing cont. [continue] bone stimulator f/u [follow up] will call after ct scan..."

F 684

4.
The Administrative nursing staff and/or designee will audit residents with physician orders for specialized equipment 3 to 5 times per week for 4 weeks. The Director of Nursing (DON) or designee will report on the findings to the QA committee on a monthly basis for recommendation and follow up for 3 months then randomly for review and recommendations as necessary.

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F 684 Continued From page 13

R83's MARs/TARs (medication administration records/treatment administration records) revealed that the bone stimulator was discontinued on 03/08/18 and was not continued, per the orthopedic consult dated 03/02/18.

The resident's physician's orders revealed that the orthopedic physician wrote an order on 03/26/18 that documented, "...This is to confirm that [name of resident] will need to resume the use of the bone stimulator daily and indefinitely..." This order was noted by facility staff on 03/27/18 and 03/28/18.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...Left hip fracture...Apply bone stimulator to left leg break for 20 minutes daily for bone healing [date initiated: 11/14/17] [created on: 11/14/17]..."

On 03/29/18 at approximately 2:45 p.m., the DON (director of nursing), administrator, and corporate nurse were made aware in a meeting with the survey team. The corporate nurse stated that she had seen that the bone stimulator had been discontinued, but wasn't sure why.

No further information and/or documentation was presented prior to the exit conference on 03/29/18 to evidence why the bone stimulator for R83 was discontinued, when the orthopedic physician ordered for the continuation of the bone stimulator on 03/02/18.

F 684

F 689 SS=G Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -

F 689

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NAME OF PROVIDER OR SUPPLIER: AVANTE AT HARRISONBURG

STREET ADDRESS, CITY, STATE, ZIP CODE: 94 SOUTH AVENUE, HARRISONBURG, VA 22801

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F 689	Continued From page 14 §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 staff interview, clinical record review and in the course of a complaint investigation, facility staff failed to prevent one of 24 residents from an accident, resulting in harm for Resident #360. Facility staff failed to put appropriate fall precautions in place for Resident #360, resulting in this resident falling, fracturing her pelvis in multiple places and rupturing her bladder. Findings included: Resident #360 was originally admitted to the facility on 10/19/16 and readmitted on 12/13/16 with diagnoses including, but not limited to: Dementia, Difficulty in Walking, Alzheimer's, Encephalopathy, Multiple Fractures of the Pelvis, and a Ruptured Bladder. Resident #360 was not in the facility at the time of survey. The most recent MDS (minimum data set) was a Re-entry (5-day assessment) with an ARD (assessment reference date) of 11/20/16. Resident #360 was assessed as severely impaired in her cognitive status with a total cognitive score of seven (7) out of 15. Resident #360's closed record was reviewed on 03/29/18 at 9:00 a.m. During this review seven "Fall Risk" assessments were completed on	F 689	**F 689 Deficiency has been corrected.** **1.** 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #360. Resident expired on 12/23/16 **2.** 1. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of all current residents for which bed alarms are in use has been completed to ensure that the alarms are in place. The MDS Coordinators validated with the Interdisciplinary team (IDT) regarding the continued effectiveness of bed pressure alarms. Effectiveness for all were validated.	4/24/18

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F 689	Continued From page 15 Resident #360. Every "Fall Risk" assessment indicated Resident #360 was "High Risk for Falls" except the assessment dated 10/27/16. The "High Risk for Falls" assessments were dated 10/19/16, 11/03/16, 11/10/16, 11/13/16, 12/13/16, and 12/20/16. Section G - Functional Status of the MDS dated 10/26/16 included Resident #360 required, "Extensive assistance, One person physical assist," in "Bed mobility, Transfer, Walk in room, Walk in corridor, Locomotion on unit, Locomotion off unit." Section G - Functional Status of the MDS dated 11/20/16 included Resident #360 required, "Limited assistance, One person physical assist," in "Bed mobility, Walk in room, Walk in corridor" and required "Extensive assistance, One person physical assist," in "Transfer, Locomotion on unit, Locomotion off unit." Progress notes were reviewed on 03/29/18 at approximately 10:00 a.m. and revealed the following documentation: LPN (licensed practical nurse) note dated 10/20/16, "pt [sic] is pleasantly confused, and is not alert enough to observe fall precautions. she [sic] is a great fall risk and continues to be in and out of bed and walking around with the support of staff or assistive devices..." LPN note dated 11/4/16, "pt [sic] continues on skilled services PT/OT [physical therapy/occupational therapy]..." LPN note dated 11/5/16, "...Participated with therapy this shift. 1 assist, ambulatory with w/c [wheelchair]..."	F 689	3. 1. Measures put into place to ensure the alleged practice does not recur include: Inservice initiated for current Licensed Nursing staff regarding the fall interventions and validation that interventions are in place as documented in the resident care plan. 2. All readmissions to facility will have fall interventions reviewed for continued effectiveness. Changes will be made as needed with care plan revisions as needed. 3. Department managers will validate that interventions are in place up to 5 times per week during assigned rounds utilizing Focus Rounds forms. Unit managers as well will validate interventions are in place during routine rounds utilizing the Focus Rounds Form. The Director of Nursing and or nursing administration team will review 5 residents weekly for 4 weeks then 10 residents monthly for 3 months to validate that fall interventions are in place and effective.	

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LPN note dated 11/6/16, "pt [sic] continues to participate with therapy services...ambulates with a wheelchair for unsteady gait..."

LPN note dated 11/9/16, "Day two post witnessed fall without c/o [complaints of] pain..."

LPN note dated 11/11/16, "...impulsive and needs ques and redirection...mobile with self propelled wheelchair..."

LPN note dated 11/17/16, "...unstedy [sic] gait, self propels wheelchair with direction..."

Wound Care Nurse note dated 11/21/16, "...extensive assist for...transfers, and bed mobility...propels self in w/c on and off the unit..."

LPN note dated 11/23/16, "...confused a lot and needs redirection..."

LPN note dated 11/24/16, "...alert but confused most of the time. needs [sic] prompting to voice needs and use call light...self propels wheelchair. needs [sic] ques and prompting for safety..."

Incident/Accident Note dated 12/10/16 at 7:21 a.m., "CNA [certified nursing assistant] heard a "thud" and when she went into the room resident was on the floor. On her back and c/o pain in her pelvic bone region...Resident's roommate stated she told her not to get up but she was already getting up at that time...Will ask day shift to notify POA [power of attorney] and MD [medical doctor]. We have initiated to monitor resident q30min [every 30 minutes]."

LPN note dated 12/10/16 at 1:00 p.m., "Received

F 689

4.
The Director of Nursing (DON) or designee will report on the findings to the QA committee on a monthly basis for recommendation and follow up for 3 months then randomly for review and recommendations as necessary.

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the resident this morning and was informed that she had a fall at 06:40 hours [6:40 a.m.] on 12/10/16. Resident received all morning medication from me but complained of left hip pain ad lef [sic] leg pain while having her morning care. Resident was medicated this morning with 650mg [milligrams] OTC [over the counter] Tylenol per listed PRN [as needed] order. Resident had no relief and physician was contacted for appropriate steps. Per Dr. [doctor] [Name] resident needs to be sent out and have f/u [follow/up] xray and full work up for left leg pain, left hip pain and check forpossible [sic] fracture. Resident also has some vaginal spotting and nurse has been informed to keep a watchful eye on the area as it may subside. If vaginal bleeding increases or gets worse resident will need GYN [gynecology] appointment..."

LPN note dated 12/12/16, "Resident was admitted to [hospital initials] for pelvic fx [fracture] and ruptured bladder."

LPN note dated 12/18/16, "Resident roommate called for help, CNA's entered room to find resident lying on L [left] side on the floor beside her bed. Bed pillow was partially out of place..."

LPN note dated 12/23/16, "Resident's CNA notified this nurse to come to resident's room. The nurse observed that resident had no respirations and there is no radial or carotid pulse noted..."

A "Physical Therapy Screening" note dated 11/08/16 included the following: "1. Type of Screen c. Fall/Occurrence Review...17. Comments: pt fell yesterday, 11/7/16, taking herself to the bathroom. pt. reported, along with

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F 689 Continued From page 18
nrsg. no injuries. [sic]"

Resident #360's CCP (comprehensive care plan) was reviewed and included the following regarding mobility and falls: "...Transfer: requires assistance by (1) staff to move between surfaces. Created on: 11/07/2016...At risk for falls r/t poor safety awareness. Fall on: 11/8/16, 12/10/16, 12/18/16...Bed pressure alarm to decrease fall risk. Created on: 11/08/2016...Low bed with fall mat to decrease fall risk. Created on: 12/20/2016..Be sure The [sic] resident's call light is within reach and encourage the resident to use it for assistance if needed. The resident needs prompt response to all requests for assistance. Created on: 10/23/2016...Ensure that [Name] is wearing appropriate footwear when ambulating or mobilizing in w/c as needed..."

Resident #360 c/o chest pain on 11/12/16 and was sent out to the ER. She returned to the facility on 11/13/16. Readmission orders were obtained from the physician and her CCP was updated. Upon her readmission Resident #360's bed alarm and low bed with fall mat was not reordered and was not included on her CCP. No fall precautions were in place at the time of Resident #360's fall on 12/10/16 resulting in multiple pelvic fractures and a ruptured bladder. Again Resident #360 was readmitted to the facility from the hospital and no fall precautions were put in place until she managed to roll out of bed on 12/18/16. Fall precautions were still not added until 12/20/16.

Incident reports for the three falls were reviewed on 03/29/18 at approximately 11:00 a.m. The incident report for the fall on 11/7/16 included Resident #360 was up in her room, unassisted,

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was wearing regular socks, was not using an assistive device and no alarms were present. The use of a bed alarm was initiated.

The incident report for the fall on 12/10/16 included Resident #360 complained of pubic pain, was up in her room unassisted, was wearing regular socks, was not using an assistive device and no alarms were in use. Every 30 minute checks were initiated.

The incident report for the fall on 12/18/16 included Resident #360 slid out of bed after displacing her bolster pillow with her legs. A low bed and floor mat were initiated.

An Admission H&P (history and physical) dated 12/10/2016 from the local hospital included: "...2. Multiple pelvic fractures - pain control 3. Hematuria with bladder rupture...Chief Complaint: Fall Patient sent in from [nursing home name] after fall this morning and pain with minimal movement..."

"CT Pelvis w/o Contrast [Cat Scan of pelvis without contrast]...dated 12/10/2016...Impression:
1. Evidence of combined intraperitoneal and extraperitoneal bladder rupture.
2. Multiple pelvic fractures including a parasymphyseal left superior pubic ramus fracture, comminuted left inferior pubic ramus fracture, left sacral ala fracture, and intra-articular fracture of the left posterior ilium extending to the SI joint..."

The Administrator and Interim DON (director of nursing) were informed of the above findings during a meeting with the survey team on 03/29/18 at approximately 2:30 p.m. The DON

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F 689

was asked about no alarm sounding after the fall on 12/10/16, why no fall precautions were in place on the CCP and why the resident was not sent out until 1:00 p.m. The DON stated, "I will need to look at her record and I will get back with you."

At approximately 3:30 p.m. the DON entered the conference room and stated, "We did education to the nurses on updating the care plans when needed awhile ago. I am not sure why she wasn't sent out until later in the day. I know they called the physician when she fell and he told them to watch her every 30 minutes. I also know after the Tylenol did not relieve her pain. The day shift nurse called the doctor and received an order to send the resident to the ER [emergency room]."

No further information was received by the survey team prior to the exit conference on 03/29/18.

F 692 Nutrition/Hydration Status Maintenance
SS=D CFR(s): 483.25(g)(1)-(3)

F 692

§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 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

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F 692	Continued From page 21 §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, resident interview, staff interview and clinical record review, the facility staff failed to ensure nutritional parameters for two of 24 resident's in the survey sample, Resident's # 42 (R42) and 97 (R97). 1. The facility staff failed to maintain and ensure appropriate nutritional parameters for R42, the resident lost a total of 19 lbs (pounds) in a 6 month period. 2. The facility staff failed to maintain nutritional parameters and prevent weight loss for R97; R97 was admitted on 2/10/18 and weighed 159, on 03/22/18 the resident was weighed and had lost 9 lbs since admission. Findings include: 1. The facility staff failed to maintain and ensure appropriate nutritional parameters for R42, the resident lost a total of 19 lbs (pounds) in a 6 month period. R42 was admitted to the facility originally on 9/23/17, with the most current readmission on 12/31/17. Diagnoses for R42 included, but were not limited to: dementia, CAD (coronary artery disease), HTN (high blood pressure), and history of stroke.	F 692	**F 692 Deficiency has been corrected.** **1.** 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #42 On 3/27/18 a Food and Beverage Preference List was completed on resident #42 with changes made to diet order as needed. On 4/10/18 an order was added for double portions to be served. 2. Corrective action has been accomplished for the alleged deficient practice in regards to resident #97. On 4/10/18 staff education provided and care plan revised for resident to be offered and encouraged to be out of bed for meals and to receive assistance by staff for meals.	4/24/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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The most current full MDS (minimum data set) was a significant change assessment dated 01/23/18. This MDS assessed the resident as having a cognitive score of '5', indicating the resident had severe impairment in daily decision making skills. This MDS also assessed the resident in Section B0600. Speech clarity, as no speech-absence of spoken words and the resident can sometimes understand. The resident was additionally assessed as requiring limited assistance for eating (resident highly motivated), with support/assistance from at least one staff person. This MDS also identified that the resident had a 5% or greater weight loss that was not physician prescribed.

R42 clinical record was reviewed and revealed in summary that the resident was admitted to the facility on 09/23/17, the resident weighed 163 lbs on admission. The resident was weighed weekly and on 12/04/18 the resident had gained 5lbs weighing 168 lbs. On 12/24/18 the resident had a stroke and was hospitalized for 5 days and readmitted to the facility on 12/31/17, during this hospitalization the resident lost 11lbs and returned to the facility with a peg tube to supplement the resident's PO (by mouth) intake. According to the clinical record the resident did not want the peg tube and often refused the feedings via the peg tube and often refused the supplemental drinks PO drinks. The resident wanted to eat food by mouth and had difficulty communicating with staff due to effects of the stoke, which impaired the resident's ability to swallow and speak.

During the survey process from 03/27/18 through 03/29/18, R42 was observed multiple times. The

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2.
1. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of all current residents Food and Beverage Preferences has been completed by the Dietary Manager or Designee.
2. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of all current residents needing assistance with meals has been completed and care plans revised.
3.
1. Measures put into place to ensure the alleged practice does not recur include inservice initiated for Licensed nursing staff regarding set up of meal trays, offering assistance if needed, obtaining alternate food choices as requested.

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resident was interviewed on several occasions and exhibited great difficulty communicating with words. The resident's speech was broken and weak. The resident would answer yes/no questions appropriately and nod his head appropriately to questions being asked. The resident was also observed eating in his room on several occasions, the resident was served pureed food in bowls. The resident was very tall and very thin.

R42's clinical record was reviewed for information and/or documentation regarding the resident's ability to speak/communicate and to determine if ST (speech therapy) had evaluated the resident.

03/28/18 01:52 PM The resident's record did not evidence that the resident was currently on ST.

03/29/18 09:28 AM An interview with DON (director of nursing) was conducted. The DON stated that the R42 was started on hospice after readmission and that was d/c'd (discontinued) on 01/16/18 so that the resident could start receiving ST again. The DON presented information from ST and revealed that the resident received ST from 01/19/18 through 02/02/18.

ST notes documented that the resident had expressive aphasia (the person knows what he/she wants to say, yet has difficulty communicating it to others) and to utilize objects and/or picture boards to increase communication. ST additionally addressed the resident's diet as being pureed.

R42's CCP was then reviewed and documented, "...allow adequate time to respond...repeat as necessary...use simple, brief, consistent

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4.
The Administrative nursing staff and/or designee will observe dining room and resident room during meal times 3 to 5 times per week for 4 weeks to ensure compliance with resident needs regarding food preferences, feeding assistance and use of clothing protectors. The Director of Nursing (DON) or designee will report on the findings of the Dining room and resident room observations to the QA committee on a monthly basis for recommendation and follow up for 3 months then randomly for review and recommendations as necessary.

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words/cues...use alternative communication tools as needed and to continue with pureed foods.

On 03/28/18 at approximately 7:30 a.m., R42 was observed eating in his room. The resident had three bowls of pureed food (oatmeal, grits, and bacon) and a carton of 2% milk, the resident had eaten all of the oatmeal and was eating the grits at that time. The resident communicated that he did not like the pureed bacon. The resident ate everything that was provided except for the pureed bacon.

On 03/29/18 at approximately 8:00 a.m. R42 was observed eating in his room. The resident has three bowls of pureed food (oatmeal, grits, and bacon) and a carton of 2% milk, the resident had eaten all of the oatmeal and grits, the bowl of bacon was not touched. The resident again communicated that he did not like the pureed bacon. The resident communicated that he did like oatmeal and would like more, this surveyor asked the resident if he had asked for more. The resident communicated that he had not. This surveyor then went to the kitchen and asked for more oatmeal for the resident and it was provided and taken to the resident by CNA #2.

Approximately 15 minutes later the resident was observed coming into the dining room in his w/c attempting to communicate with CNA #1 (certified nursing assistant) about more oatmeal. CNA #2 stated to CNA # 1 that she had given him oatmeal shortly ago. CNA # 2 stated that she would check on it and the CNA and the resident went up the hall to R42's room. A few minutes later CNA #1 returned. CNA #1 stated that the resident had forgotten that he had just ate that oatmeal. CNA # 1 was asked if the resident wanted more

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oatmeal, the CNA stated, "No, he doesn't want anymore."

Approximately 5 minutes later, this surveyor went to the resident's room. The resident was asking for more oatmeal. This surveyor returned to the kitchen and informed CNA #1 that the resident did in fact, want more oatmeal. CNA #1 then took the resident another bowl of oatmeal.

Approximately 10 later, the resident was again observed in his room and was finishing up the third bowl of oatmeal. The resident was asked if he was full and the resident nodded his head no. The resident was asked if he wanted more and the resident strained verbally and spoke several times and finally stated, "If I can get it."

This surveyor went to the kitchen as informed CNA # 1 that the resident was requesting another bowl of oatmeal. The CNA stated that she would get the resident more oatmeal.

On 03/29/18 at approximately 10:00 a.m., the DON and the RD (Registered Dietitian) were made aware of concerns regarding R42's lack of ability to communicate effectively with staff to express his needs and wants and concerns over the resident's weight loss. The DON and RD were made aware of the observations above with the oatmeal and the breakfast observations. The RD was asked if the facility served fortified foods and the RD stated, "No." The RD stated that she is not the RRD (Regular RD). The RRD is out on leave and she is just filling in until she returns. The RD was asked why would this resident not be given fortified food, double portions, and/or whole milk. The RD stated that she was not sure and stated, 'We can do a lot with pureed foods.' The

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F 692	Continued From page 26 RD stated that the resident was getting tube feedings and two cal with medications and that had actually been increased. The RD was made aware that the resident's clinical record revealed that the resident now no longer has a peg tube due to the resident not wanting it and that the resident often refuses the two cal or consumes very little. The RD was made aware that according to the documentation and observations that the resident want to eat and appears to be having difficulty communicating with staff. The DON stated that, they (the facility) could be using some type of board with words or pictures to help the resident communicate effectively with staff what he may want or need and to express his desire for food and/or drink. The DON was made aware that ST had recommended that in January and that information was on the resident's CCP. The DON was asked why was this not being done for resident. The DON did not provide a reason why these interventions were not being implemented for R42, per the resident's CCP and per ST. The RD stated that the resident had a stroke in late December and that could be contributing to his weight loss and his communication issues. The RD was made aware that the issues with R42 related to no interventions being implemented to assist the resident with effective communication for food and no interventions by dietary/RRD to prevent the from continued weight loss. The RD was made aware that the resident's breakfast ticket did not have any dislikes and the resident clearly indicated two days in a row that he does not like pureed bacon. The RD stated that dietary is supposed to check with resident every so often to determine their likes and	F 692		

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dislikes. The RD stated that the resident was not happy about the pureed diet and had been noncompliant in the past. The RD was again made aware of the observations and that the resident was eating now and wanting more. The RD was made aware that the bacon served to the resident was taking away from what the resident wanted and/or liked.

The DON stated that the resident was getting supplement drinks and was getting tube feedings. The DON was made aware that according to documentation the resident was refusing the tube feedings and the supplement drinks or consuming very little. The DON stated, 'we can give him ice cream and whole milk.'

The DON, administrator, and corporate nurse were again made aware of the above concerns with R42 in a meeting with the survey team on 03/29/18 at approximately 2:45 p.m.

No further information and/or documentation was provided prior to the exit conference to evidence that R42 was provided care and services for effective communication and provided care and services for the prevention of weight loss.

2. The facility staff failed to maintain nutritional parameters and prevent weight loss for R97; R97 was admitted on 2/10/18 (weight of 159), on 03/22/18 the resident's weight was 150. The resident had a 9 lb weight loss since admission to the facility.

R97 was admitted to the facility on 2/10/18. Diagnoses for R97 included, but were not limited to: Diabetes, stroke with aphasia and right side

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F 692	Continued From page 28 paralysis. A 14 day MDS (minimum data set) was reviewed dated 02/24/18. This MDS assessed the resident with a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. This MDS also assessed the resident as requiring extensive assistance for most ADL's (activities of daily living). The resident was assessed as requiring extensive assistance with one person physical assistance for meal consumption. R97's clinical record was reviewed and revealed in summary that the resident was admitted to the facility on 02/10/18 for a severe stroke, which left the resident aphasic (unable to speak) and with right side paralysis (the resident had not control over the right side of her body). On 03/28/18 08:43 AM Resident # 97 was observed laying in her bed. The resident was at approximately a 45 degree angle, with a pillow under her left back/side/arm. The bedside table was in front of her with a breakfast tray. The breakfast consisted of three separate bowls with pureed food. The resident could barely reach the food from the angle/position the resident was in. The resident was not attempting to feed herself. The resident's right arm was laying down by her right side without movement. The resident was asked if she was going to eat and the resident shook her head, in a no manner. One of the bowls of food had some food taken out of it. The resident did not speak and was observed to have a moderate amount of pureed food on the front of her shirt. The resident did not have a clothing protector or any type of special utensils. The resident was again spoke to, but did not respond.	F 692		

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The resident's roommate then spoke up and stated that the resident cannot speak, and went on to say that she had a stroke and she is paralyzed on the right side. The resident was observed with her right arm laying beside her without movement.

R97 clinical record was reviewed and revealed the an admitting weight was 159.0, current weight of 150. The resident has had a weight loss of 9 lbs (pounds)/5.66 % loss in just over one month's time.

03/29/18 07:53 AM R97 was observed in the dining room sitting at a table with one other female resident. The resident has a small gray tray attached to the resident's w/c (the resident is paralyzed on her right side). The resident's arm was observed dangling/hanging down beside of the w/c (not on the tray) without support.

03/29/18 07:55 AM CNA #1 (certified nursing aide) came over the resident and lifted the resident's right arm up and laid it on the tray. The resident had cranberry juice in front of her and coffee. The resident was not observed to attempt to drink either.

03/29/18 07:56 AM CNA #2 brought the resident's breakfast, which consisted of three separate bowls of food and sat them in front of the resident. The CNA placed a regular spoon in one bowl. CNA #2 left the resident.

03/29/18 7:57 AM R97 picked up the bowl with the spoon in it with her left hand and just looked at it. The resident then raised the bowl up toward her mouth (end of spoon pointing toward her

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mouth), the resident was looking around. The resident then took the bowl and put it up to her mouth, trying to pour the food from the bowl with the spoon into her mouth. The resident then began sticking out her tongue and trying to get the food from the bowl into her mouth.

03/29/18 08:01 AM Resident was observed still trying to eat and put her bowl up to her mouth, no assistance was provided by staff.

03/29/18 08:02 AM CNA #1 was feeding another resident and called for CNA #2 to come and help R97. CNA # 1 stated that she would be right there.

03/29/18 08:03 AM (Other Staff) OS #4 entered the dining room at that time and she would assist R97. The resident had pureed eggs, pureed sausage and pureed oatmeal in separate bowls.

The resident consumed all of the oatmeal and all of the sausage. OS # 4 stated that the resident doesn't like the pureed eggs.

The resident's CCP (comprehensive care plan) documented, "...ask yes/no questions...anticipate and meet needs...observe for dysphagia [difficulty swallowing]...Up in w/c for all meals for safe feeding. Divided plate for meals..."

A Nutritional Data collection document dated 02/10/18 by the RRD documented that the resident needs assistance with meals and has a low protein status related to low albumin.

A Nutritional Data collection document dated 02/15/18 by the dietary manager was reviewed and documented that the resident was to eat all

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F 692	Continued From page 31 meals in her room and that the resident required no adaptive equipment and was independent for feeding self. On 03/29/18 at approximately 10:30 a.m., the DON (director of nursing) and the RD (Registered Dietitian) were interviewed and asked about R97. The DON was unaware of the resident's weight loss. The RD did not comment. The RD and DON were made aware of the observations above with lack of assistance at meals and the concern with the resident's weight loss. On 03/29/18 at approximately 2:45 p.m. the administrator, DON, and corporate nurse were made aware of the above concerns. No information and/or documentation was presented prior to the exit conference on 03/29/18.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	**F 755 Deficiency has been corrected.** **1.** 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #108. On 3/28/18 the medication Reglan was removed from medication cart.	4/24/18

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§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to ensure the disposition of a medication that was no longer being prescribed for one of 24 resident's, Resident #108 (R 108).

R 108's Reglan (Metoclopramide) was no longer being prescribed, but continued to be accessible in the nurses medication cart.

The Finding include:

R 108 was admitted to the facility originally on 01/21/16 with a readmission on 2/11/18. The most current MDS (minimum data set) was a quarterly assessment dated 3/13/18. R 108 was assessed with a cognitive score of 15, indicating cognitively intact.

On 03/28/18 at 7:40 AM a medication pass observation was conducted. License practical

F 755

2.
1. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of all current residents medication administration record to cart audit has been completed. All discontinued medications have been removed.

3.
1. Measures put into place to ensure the alleged practice does not reoccur include: Inservice initiated for Licensed Nurses staff regarding the removal of discontinued medications from the medication cart.
2. Nursing management or designee will audit discontinued medication orders to ensure medications have been removed from medication cart 3-5 times per week.

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F 755	Continued From page 33 nurse (LPN #1) pulled all of R 108's medications from the medication cart and handed the medications to the surveyor for documentation. Reglan 10 milligrams (MG) was handed to this surveyor and documented and handed back to LPN #1. The surveyor did not see LPN #1 pop the medication (in question) into a cup for disbursement. After medication pass was completed this surveyor then reconciled the medications with physician's orders, Reglan 10 Mg was not an active prescribed medication. On 3/28/18 at 11:50 AM an interview with LPN #1 was conducted concerning the above information. The nurse reviewed the medication, reviewed the MAR and reviewed the physician's orders and was not able to evidence that the Reglan 10 MG was a current order and understood that it was in the cart and available for distribution. The above information was presented to the director of nursing (DON) on 3/28/18 and a policy was asked for regarding medications that were no longer prescribed. The DON presented a policy titled Disposal/destruction of Expired or Discontinued Medications. Under the procedure of the policy it was documented "Once an order to discontinue a medication is received, Facility staff should remove this medication from the resident's medication supply." The DON also presented a discontinuation order for R 108 for Reglan 10 Mg dated 1/3/18. No other information was presented prior to exit conference on 3/29/18.	F 755	4. The Director of Nursing (DON) or designee will report on the findings to the QA committee on a monthly basis for recommendation and follow up for 3 months then randomly for review and recommendations as necessary.	
F 809	Frequency of Meals/Snacks at Bedtime	F 809		

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STREET ADDRESS, CITY, STATE, ZIP CODE: 94 SOUTH AVENUE, HARRISONBURG, VA 22801

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F 809 SS=D	Continued From page 34 CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on group interview and staff interview, the facility staff failed to ensure snacks were provided. Findings include: A group meeting was conducted on 03/28/18 at 11:00 a.m., eight residents from both units were represented. The group was asked about snack availability in the facility. The group agreed that snacks are not given out to residents on a regular basis. The group stated that if you are a diabetic and ask for a snack that you may get one, but that is not	F 809	**F 809 Deficiency has been corrected.** **1.** 1. Corrective action has been accomplished for the alleged deficient practice in regards to multiple residents. Dietary staff were educated to provide a variety of HS snacks. **2.** 1. Current facility residents that have potential to be affected by the alleged deficient practice. A 100% audit of all current residents Food and Beverage Preference audit has been completed. **3.** 1. Measures put into place to ensure the alleged practice does not recur include: Inservice initiated for Licensed Nursing staff regarding passing out HS snacks and documentation in Point of Care (POC) computer system. 2. Nursing management or designee will audit documentation in POC during morning clinical meeting for compliance.	4/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495146		C 03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

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F 809 Continued From page 35

always a guarantee and that they are usually never passed out and offered on a regular basis. One resident stated that they have never been offered, and it is a standard for residents to have ask and they may or may not get one. The resident stated that depends on if they have snacks and also depends on the staff who are working.

The group stated that sometimes they will ask for a snack and the staff will go to get snacks and come back to tell them that there isn't any. The group additionally stated that they feel snacks should be passed out nightly and they should have the opportunity to turn down the snack instead of having to ask for it. One resident in the group stated that if a resident has dementia, how do they know if they want a snack unless they see it.

The administrator, DON and corporate nurse were made aware in a meeting with the survey team on 03/29/18 and stated that they have snacks available in the resident frig, but staff have to get them and pass them out. The DON was asked if they keep par levels on snacks or if there is a system in place to account for food items being used or disposed of and to ensure distribution. The DON stated that they did not have any type of system or tracking.

No further information and/or documentation was provided prior to the exit conference on 03/29/18 to evidence that residents are offered snacks between meals or that snacks are actually being provided.

F 809

4.
The Director of Nursing (DON) or designee will report on the findings to the QA committee on a monthly basis for recommendation and follow up for 3 months then randomly for review and recommendations as necessary.