STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. BUILDING _____ B. WING _____	C 01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/3/17 through 1/5/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 85 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents 1 through 14 and Resident 19) and 4 closed record reviews (Residents 15 through 18).	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and /or executed solely because required by the provisions of Health Code Section 1280 and 42 C.F.R. 405.1907.	
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164	1. Bedside Commode for Resident #12 was assessed and determined not to be needed, therefore it was removed on 1/3/17. 2. A 100% audit of all residents with bedside commodes was conducted by Director of Nursing (DON) on 1/6/17 to determine if Bedside Commodes are necessary and to ensure if privacy is provided. No issues identified.	2/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy M. Bender — TITLE: Administrator — (X6) DATE: 1/26/17

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

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F 164	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide privacy for 1 of 19 Residents, Resident #2. The findings included. Resident #2 was observed by the surveyor to be using a bedside commode. The Resident was unclothed from the waist to the thigh area and was visible from the open doorway of the room. There was a staff person present in this room The record review revealed that Resident #2 had been admitted to the facility on 12/03/15. Diagnoses included, but were not limited to, encephalopathy, hypertension, muscle weakness,	F 164	3. Inservices were initiated on 1/24/17 for all departmental staff by Administrator, DON or Designee on resident privacy. Routine room rounds will be conducted by Department Managers (Guardian Angel Rounds) to ensure privacy of residents is being maintained. 4. The results of the room rounds will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

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unsteadiness on feet, cognitive communication deficit, dementia, psoriasis, and paranoid schizophrenia.

Section C (cognitive patterns) of the Resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/21/16 included a BIMS (brief interview for mental status) score of 7 out of a possible 15. Section G (functional status) was coded to indicate the Resident required supervision of one person for transfers and toilet use and used a wheelchair for mobility. Section H (bladder and bowel) was coded to indicate the Resident was always continent in both of these areas.

The Residents CCP (comprehensive care plan) included the focus areas of falls, alert with confusion, memory loss, and ADL (activities of daily living) self-care deficit.

During initial tour of the facility on 01/03/17 at approximately 11:55 a.m. the surveyor and LPN (licensed practical nurse) #1 walked to the doorway of Resident #2's room. Upon reaching this doorway and without entering the room the surveyor was able to observe Resident #2 using the bedside commode. This bedside commode was in direct line of sight of the doorway, no curtain had been pulled, and the door had been left open. The Residents private area from below the waist and to their upper thighs was observed to be uncovered. There was a staff person as well as another Resident in this room and numerous other Residents of the facility and staff outside of the room in the hallway.

Upon observing the Resident on the bedside commode LPN #2 shut the Residents door and

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stated the door should have been closed. LPN #2 identified the staff person in the room as a SLP (speech language pathologist).

On 01/03/17 at approximately 3:30 p.m. the surveyor interviewed the SLP about the above incident. The SLP verbalized to the surveyor that she had not noticed that the Resident was on the commode.

On 01/04/17 at approximately 8:25 a.m. the surveyor attempted to interview Resident #2 concerning the incident. Resident #2 verbalized to the surveyor that she did not remember the incident.

On 01/04/17 at approximately 10:40 a.m. the surveyor interviewed CNA (certified nursing assistant) #1. CNA #1 verbalized to the surveyor that the Resident was able to go to the bathroom by herself.

The administrative staff were notified of the above in a meeting with the survey team on 01/04/17 at approximately 2:55 p.m.

The facility policy/procedure titled "Quality of Life-Dignity" read in part "Each Resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatments procedures..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 167 SS=C	Continued From page 4 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post the results of the most recent life safety code survey and failed to post a notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections.	F 167	1. Results of the most recent surveys to include the Life Safety Survey were made available and accessible to residents and families on 1/5/17. 2. A sign was placed above the current surveys on 1/5/17 stating "Most recent Survey Results posted below (please see Receptionist if you would like to see the previous 3 years.) A binder with the previous 3 years of surveys was placed in the Conference Room on 1/5/17. 3. A weekly audit will be conducted by the Administrator for four weeks and randomly thereafter to ensure survey history is available. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	2/17/17

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F 167	Continued From page 5 The findings included. On 01/03/17, during initial tour of the facility, the surveyor observed a sign on the wall in the front lobby informing staff, visitors, and Residents of the facility that the current survey results were available in a binder, also in the front lobby for review. However, upon checking this binder the surveyor was unable to locate the most current life safety code survey report. There was no posting or notification indicating the last three preceding year's survey results were available for review. On 01/04/17 at approximately 10:30 a.m. a group meeting was held with ten Residents of the facility. During this meeting the Residents verbalized to surveyor #2 that they were aware of where the current survey results were kept. The administrative staff were notified of the missing life safety code survey report and the missing notice of the availability of the three preceding year's reports during a meetings with the survey team on 01/04/17 at 2:55 p.m. and again on 01/05/17 at 11:05 a.m. During the meeting on 01/05/17 the administrator verbalized to the survey team that the sign had been updated to include the availability of the three preceding years of survey reports. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 167		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	F 203		

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F 203	Continued From page 6 (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of	F 203	1. Resident #12 was discharged to an apartment on 1/6/17. 2. A 100% audit of all residents discharged within the last 90 days was completed on 1/6/17. No issues identified. 3. Inservice to be completed by Administrator to Interdisciplinary Team, including Social Worker regarding Discharge process and required Discharge Notice. 4. Discharge Notices will be signed by the Administrator on future discharges.	2/3/17

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this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(c) (5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related

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disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, ombudsman interview, facility document review, and clinical record review, the facility staff failed to ensure the 30 day discharge notice was complete for 1 of 19 residents (Resident #12).

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The findings included:

The facility staff failed to ensure the 30 day discharge note for Resident #12 included the date the 30 day discharge notice was given to the resident, reason for discharge, a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests, information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman and the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

The clinical record of Resident #12 was reviewed 1/3/17 through 1/5/17. Resident #12 was admitted to the facility 12/8/16 with diagnoses that included but not limited to acute on chronic systolic congestive heart failure, bilateral pleural effusions, severe aortic stenosis, cardiomyopathy with ejection fraction 30-35%, severe peripheral arterial disease, myocardial infarction, pacemaker, cerebrovascular accident, transient ischemic attacks, hypertension, gastroesophageal reflux disease, PTSD (post-traumatic stress disorder), alcohol use, tobacco use, and chronic back and neck pain.

Resident #12's admission minimum data set (MDS) assessment with an assessment reference date (SRD) of 12/15/16 assessed the

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resident with a cognitive summary score of 15 and was assessed without signs of delirium, psychosis, or behaviors.

On 1/3/17, the ombudsman came to the facility and shared with the surveyor the discharge notice that was received in the local ombudsman's office on 1/3/17. The discharge notice read "Dear [Resident #12], This letter is to inform you that your discharge date from Avante at Roanoke will be January 3, 2017 to the Rescue Mission."

The discharge notice did not include the date the notice was given, the reason for the discharge, information about the appeal process, the state ombudsman phone number, or any agency responsible for the protection and advocacy of individuals with mental disorders.

The surveyor interviewed the social worker on 1/3/17 at 2:40 p.m. The social worker stated discharge planning with Resident #12 started on admission. The resident was admitted to hospice initially but was never here for hospice to assess him. The social worker stated "Resident #12 was non-compliant with care and treatment. Resident #12 would leave early in the morning and return late at night sometimes as late as 10:00 p.m. The facility didn't know where he would go. We're not a prison but we are still responsible for the resident. Every intervention I would offer for placement, the resident wasn't agreeable. Resident #12 didn't want people looking into his credit report. Resident #12 also was having behaviors. The resident was found smoking in his room (12/17/16) and an empty bottle of whiskey was found on Christmas day. Resident #12 stayed out overnight with a friend at the hospital 12/28/16." The social worker stated she

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offered Resident #12 numerous housing options but the resident doesn't want to pay the rent. The social worker stated she had informed the resident about getting a room in a hotel and had faxed applications to a local home for adults. The social worker stated with Resident #12 it was "a money thing. Resident #12 doesn't get much."

During the interview, the social worker stated she gave Resident #12 the discharge notice on 1/3/17. She stated hospice discharged the resident on 1/2/17 for non-compliance. Arrangements were made for the resident to go to the rescue mission because they have medical care. The social worker stated that the facility had only done two 30 day discharge notices and this was one of the two. The social worker stated she wasn't aware of the information that needed to be provided.

The surveyor reviewed the facility policy for discharges titled "Transfer and Discharge (including AMA) Policy" on 1/5/17. The policy read in part "Policy Explanation and Compliance Guidelines: 1. Non-Emergency Transfers or Discharges (complete a Discharge Summary). This portion of the policy applies to transfers or discharges that are initiated by the Facility, not by the resident or the resident's representative. The Social Service Designee or other designated staff member should handle all non-emergency transfers or discharges. Procedures should include: a. Notify the resident in writing, and if known, a family member, 30 days in advance, of the transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, and the reasons for the transfer or discharge, according to the above reasons for transfer or discharge.

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F 203	Continued From page 12 Exceptions to a 30-day requirement are if/when a resident is endangering the health or safety of themselves or others, when a resident's health has improved to allow a more immediate transfer or discharge, when a resident's urgent medical needs require more immediate transfer, and when a resident has not resided in the Facility for 30 days. B. record the reasons for, the effective date of transfer or discharge, and the location to which the resident is being transferred or discharged, in the medical record and on a discharge form or a letter. Give a copy of the discharge notice to the resident and his/her family/legal representative. D. provide the resident with a statement of the right to appeal the action to the state agency designated for such appeals, along with the name, address, phone number of the State long term care ombudsman. E. In the case of a mentally ill individual, the name address and phone number of the agency responsible for advocating for mentally ill individuals." The surveyor informed the administrator, the regional nurse consultant, and the social worker of the above concern with Resident #12's discharge planning on 1/5/17 at 11:10 a.m. No further information was provided prior to the exit conference on 1/5/17.	F 203		
F 242 SS=E	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions	F 242		

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	495156	A. BUILDING _____ B. WING _____	C 01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATE, ZIP CODE
AVANTE AT ROANOKE	324 KING GEORGE AVE SW ROANOKE, VA 24016

ID 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)
F 242	Continued From page 13 of this part.	F 242	

(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.
This REQUIREMENT is not met as evidenced by:
Based on group and staff interviews and facility document review, the facility staff failed to seek input and allow residents to make choices that are significant to the residents of the facility.

The findings included:

During the initial conversations on 1/3/17 at approximately 2 pm the administrator notified the survey team that the facility had implemented a plan on the resident's menu to make it a " Healthier Every Day Menu " which was started on December 1, 2016. The administrator explained that the residents no longer received Shasta sodas on regular bases but would receive them once a week.

The survey team, which consisted of 5 surveyors, asked the administrator who had approved the changes made in the " Healthier Every Day Menu " . The administrator stated that this recommendation was brought to the Quality Assurance committee and the committee had approved these changes. This surveyor asked the administrator how the residents and families were notified of the menu changes. The administrator stated " Iwrote a letter back in

1/13/17

1. Administrator met with regularly scheduled Resident Council Meeting on 1/9/17 to announce that Ginger Ales would be reinstated to be available every day on 1/11/17 due to resident request.
2. All residents are at risk for not participating in making choices related to dining options.
3. Resident food and drink choices to be monitored via monthly Resident Council meeting and monthly Dining Committee, a sub -committee of the Resident Council. Minutes of the Committees are to be provided to all residents of the facility.
4. Dining Committee minutes are reviewed at monthly Quality Assurance and Performance Improvement (QAPI) meeting for review.

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F 242	Continued From page 14	F 242		

October, 2016 to the residents and families of the facility to introduce the implementation of the new menu changes. The surveyor requested the administrator to provide a copy of this letter to the survey team.

The administrator provided a copy of the above letter, in which the administrator was referring to that in the above documented conversation. The following was noted in the letter dated October 20, 2016 which stated:

" Dear Residents, Families and Friends
...effective December 1, 2016, we will be making some changes to our Dining Program. Our Quality Assurance committee including _____ (name of), our Medical Director to include:
v Introduction of a Healthier Every Day Menu to include more salads, cottage cheese & fruit plates, and grilled chicken. Hamburgers and Hotdogs will be removed from the everyday menu.
v Shasta sodas will not be offered daily. We will offer a Soda day once a week with a variety of sodas.
v The Kitchen will be closed certain times of the day to allow staff to clean and prep for the next meal. "

A group interview was conducted with 10 residents participating in this discussion on 1/4/17 at 10:30 am in the training room. This surveyor asked the group of residents how the newly implemented " Healthier Every Day Menu " that began on December 1, 2016. It was the consensus of the group that they did not like that they were not able to have a soda when they wanted it. Resident #1 stated " I don't like it at all. We can only get soda on Fridays and then we

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F 242	Continued From page 15 have to remind the staff on that day to get it to us. " Resident #10 stated " If we have money in our accounts then we can get some out of it to get the sodas that we want other than on Fridays. But if you don't have any money or family then you can't have sodas until it is soda day. The surveyor reviewed the Resident Council Minutes from the December 12, 2016 meeting that was held. There were 9 residents present and discussed Dietary concerns. According to the minutes of this meeting the following statements were made by the residents: · " ...Drinks are water with food coloring in them-no taste of all. · 2nd alternate meal is still not good ... " The administrative team was notified of the above documented findings concerning the new " Healthier Every Day Menu " that began on December 1, 2016 by the surveyor on 1/4/16 at approximately 3 pm. The survey team again discussed that the residents that were interviewed during the survey process did not like having sodas one time a week. This discussion took place on 1/5/17 at 11:00 am in the conference room. No further information was provided to the surveyor prior to the exit conference on 1/5/17.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a	F 272		

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F 272	Continued From page 16 resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident,	F 272	1. CAA (Care Area Assessment) documentation has been corrected for Resident #1 and Resident #5 to reflect date and location of CAA information. 2. A 100% audit for all current residents was conducted and completed on 1/26/17 by MDS Coordinator to ensure CAA documentation is accurate. No other issues identified. 3. Interdisciplinary Team, DON, and Administrator inserviced on 1/19/17 by MDS Coordinator regarding completion and accuracy of CAA documentation. Weekly audit will be conducted by MDS Coordinator for 30 days and randomly thereafter to ensure CAA documentation is completed accurately. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	2/1/17

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F 272	Continued From page 17	F 272		

as well as communication with licensed and non-licensed direct care staff members on all shifts.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) for 2 of 19 Residents, Resident #1 and Resident #5.

The findings included:

1. For Resident #1 the facility staff failed to accurately name the date and location of CAA (care area assessment) documentation.

Resident #1 was admitted to the facility on 06/24/16 and readmitted on 08/17/16. Diagnoses included but not limited to neurogenic bladder, urinary tract infection, quadriplegia, malnutrition, anxiety, depression, respiratory failure, and dysphagia.

The most recent comprehensive MDS with an ARD (assessment reference date) of 08/25/16 coded the Resident as 15 of 15 in section C, cognitive patterns. Section V, care area assessment, was reviewed. The facility staff had not identified the date and location of the CAA information used to determine the psychosocial care plan. The only documentation was "see CAA worksheet". The CAA worksheet was reviewed and the information could not be located.

The surveyor spoke with the MDS coordinator on 01/04/17 at approximately 0910 regarding the

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missing documentation. MDS coordinator stated that she did not complete that area of the CAA, the activities director did. Surveyor spoke with the activities director on 01/04/17 at approximately 0915. Activities director stated "that's just how I've always done them " .

The concern of the missing CAA documentation was discussed with the administrative staff during a meeting on 01/04/17 at approximately 1455.

No further information was provided prior to exit.

2. For Resident #5, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/27/16.

The record review revealed that Resident #5 had been admitted to the facility 07/30/07. Diagnoses included, but were not limited to, paranoid schizophrenia, hypertension, drug induced tremor, major depressive disorder, klinefelter syndrome, peripheral autonomic neuropathy, dysphagia, and constipation.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD of 10/27/16 had a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be

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F 272	Continued From page 19 found..." Under the column labeled "Location and Date of CAA documentation" for the area of psychosocial well-being the facility staff had documented "CAA WS (worksheet) dated 10/31/2016." The actual location(s) regarding the documentation had not been documented. On 01/04/17 at approximately 9:15 a.m. the surveyor and other staff #2 reviewed the CAA worksheets. During this review other staff #2 was unable to find documentation to indicate where the information had been obtained or could be found. The administrative team was made aware of the missing MDS information during meetings with the survey team on 01/04/17 at 2:55 p.m. and again on 01/05/17 at 11:55 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 272		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff	F 281		

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F 281	Continued From page 20 failed to follow professional standards of nursing practice for 1 of 19 residents (Resident #8). The facility staff failed to write two telephone orders for laboratory testing that were obtained on Resident #8. The findings included: The facility staff failed to write physician orders after orders were obtained for laboratory testing for Resident #8. The clinical record of Resident #8 was reviewed 1/4/17. Resident #8 was admitted to the facility 8/1/16 with diagnoses that included but not limited to alcohol abuse, nicotine dependence, convulsions, gastroesophageal reflux disease (GERD), sepsis, urinary tract infection, toxic encephalopathy, bipolar disorder, and facial bone fractures. Resident #8's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/13/16 assessed the resident with a cognitive summary score of 15. Current comprehensive care plan dated 8/1/16 identified that Resident #8 had a focus area for liver disease related to cirrhosis and hepatitis. Interventions read in part "Obtain and monitor lab/diagnostic work as ordered by MD (medical doctor). Report results and follow up as indicated." The electronic clinical record had results of an ammonia level obtained 9/9/16. The surveyor was unable to locate the physician order for the laboratory test.	F 281	1. Physician orders were clarified for laboratory testing obtained on 9/9/16 & 10/2/16 for Resident #8. 2. A 100% audit of all labs ordered within the last 30 days will be conducted by the DON or designee to ensure physician orders are obtained for all lab testing. 3. Inservices were initiated on 1/24/17 for Licensed Nursing staff by the DON or designee regarding obtaining physician orders for laboratory testing. An audit will be conducted for 30 days and randomly thereafter to ensure physician orders are obtained for lab testing. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	2/17/17

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The electronic clinical record also had the results of an alcohol profile obtained 10/2/16. The surveyor was unable to locate the physician order for the laboratory test.

The surveyor informed the corporate registered nurse, licensed practical nurse #2, registered nurse #3, environmental service director and the administrator of the inability to locate the physician orders for the ammonia level and the alcohol level in the end of the day meeting on 1/4/17 at 2:55 p.m.

The surveyor received a progress notes from the administrator on 1/5/17 at 7:30 a.m. dated 9/9/16 15:41 (3:41 p.m.) that read "New orders: Resident seen by PA (physician assistant) on rounds this am (morning). Resident c/o (complains of) 'falling asleep during the day' at intervals. Med review completed by PA and orders received to decrease Namenda to 14 mg (milligrams) once a day and administer at bedtime, decrease Risperdal to 1 mg po (by mouth) daily, and obtain ammonia level for baseline due to liver hx (history). Resident aware of PA med review." The 10/2/16 23:26 (11:26 p.m.) progress note read in part "Resident's speech was slurred, unsteady gait observed. Registered Nurse #3 and administrator notified. STAT blood alcohol level ordered." The administrator stated she would expect nurses to write an order. The corporate registered nurse stated on 1/5/17 at 9:30 a.m. that writing a physician order when an order was received was "a company expectation."

The surveyor requested the facility policy on nursing standards for writing physician orders on 1/5/17 at 7:30 a.m. and was provided the policy

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F 281	Continued From page 22 titled "Physician Medication Orders." The policy read in part "4. Verbal orders must be recorded immediately in the resident's Medical Record by the person receiving the order and must include the date and time of the order." Basic Nursing, Essentials for Practice, 6th edition, Potter and Perry, 2007 page 58 was used as a reference on physician orders. The physician or health care provider is responsible for directing the medical treatment of a patient. You are responsible for carrying out that medical treatment unless the physician's or health care provider's order is in error, violates hospital policy, or is harmful to the patient. Basic Nursing, Essentials for Practice, 6th edition, Potter and Perry, 2007 pages 148-149 was used as a reference for telephone orders and verbal orders. · Clearly identify the patient ' s name, room number and diagnosis. · Read back all orders to the physician or health care provider. · Use clarification questions to avoid misunderstandings. · Write "TO" (telephone order) or "VO" (verbal order), including date and time, name of patient, complete order; sign the name of the physician or health care provider and nurse. · Follow agency policies; some institutions require documentation of the "read-back" or require two nurses to review and sign telephone (and verbal) orders. · The physician or health care provider co-signs the order within the time frame required by the institution (usually 24 hours, verify agency policy).	F 281		

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F 281	Continued From page 23 No further information was provided prior to the exit conference on 1/5/17.	F 281		
F 285 SS=E	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (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,	F 285	1. a. Copy of Preadmission Screening and Resident Review (PASRR) level one and level two screening is being obtained for Resident #7. b. Copy of PASSR is being obtained for Resident #5. c. Copy of PASSR is being obtained for Resident #1. d. Copy of PASSR is being obtained for Resident #3. e. Copy of PASSR is being obtained for Resident #6. f. Copy of PASSR is being obtained for Resident #9. 2. A 100% audit of all residents was conducted by Social Worker and completed on 1/26/17 to ensure PASSRs have been completed and copies of such obtained in medical records. Process will be initiated to obtain missing PASSRS.	2/17/17

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F 285	Continued From page 24 (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, (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 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	F 285	3. Social Worker, Admission Coordinator, Director of Sales & Marketing, and Business Office Manager will be inserviced by Administrator regarding PASSR requirements and need for copies to be obtained in resident records. A monthly audit will be conducted by Social Worker on all new admissions to ensure PASSR Level one and Level two if necessary are obtained. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

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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.

(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.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for both level one and level two screenings for 6 of 19 residents (#1, #3, #5, #6, #7, and #9).
The PASRR process requires that all applicants

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to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI (serious mental illness) or intellectually delayed (ID).
The findings included:
Resident #7 was admitted to the facility on 6/8/13 and readmitted on 4/10/15. Her diagnoses included, but were not limited to: anemia, heart failure, adrenocortical insufficiency, downs syndrome, rheumatic aortic stenosis, thyroid disease, and depression.

Resident #7's MDS (minimum data set) assessment, with an ARD (assessment reference date) of 3/10/16, was reviewed. The assessment scored the resident to be a 4 in section C for her cognitive pattern. She was also coded in section g to require assistance with activities of daily living. In section I, the staff coded her to have downs syndrome.

Resident #7 current comprehensive care plan revealed she was care planned to have downs syndrome. She was also care planned for activities of daily living.

A review of the Resident #7 clinical record failed to include a copy of the Level one or a level two screening for mental illness, mental retardation/intellectual disability, or related condition.

On 1/4/17, five surveyors asked the social worker if the form had been completed. She was also asked to show the surveyor where Resident #7's form was. She said she would look for the forms for all residents in question.

On 1/4/17 at 2:55pm, during a summary meeting

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with the facility administrator, director of nurses, and regional nurse consultant; the PASRR forms were discussed.

On 1/5/17, the social worker returned with forms from the business office stating she thought they obtained the PASRR's. The forms given to the surveyor were not the PASRR screenings for Resident #7.

On 1/5/17 at 9:20am, the administrator was asked if the PASRR's had been found. She stated, " We will not be getting them. " She informed the survey team they had not been obtained.

Prior to exit on 1/5/17 at 11:05am, the administrator, director of nurses, and regional nurse were again informed of the PASRR issues.

2. For Resident #5, the facility staff failed to ensure a PASRR (preadmission screening and Resident review) had been completed prior to the Resident being admitted to the facility.

A PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

Upon arrival to the facility (01/03/17 at approximately 11:45 a.m.) the facility provided the survey team with a copy of an 802 (roster/sample matrix). This 802 identified Resident #5 as having a mental illness.

The record review revealed that Resident #5 had been admitted to the facility 07/30/07. Diagnoses included, but were not limited to, paranoid schizophrenia, hypertension, drug induced

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tremor, major depressive disorder, klinefelter syndrome, peripheral autonomic neuropathy, dysphagia, and constipation. Section I (active diagnoses) had been coded under the heading "psychiatric/mood disorder" to include the following diagnoses anxiety disorder, depression, and schizophrenia.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/27/16 had a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

During the record review the surveyor was unable to locate the PASRR.

The administrative team of the facility was made aware of the missing PASRR on 01/04/17 at approximately 2:55 p.m. during a meeting with the survey team.

On 01/05/17 at approximately 9:20 a.m. the administrator verbalized to the survey team that they were unable to find the missing PASRR's.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #1 the facility staff failed to obtain a level 1 PASRR (pre-admission screening and Resident review).

Resident #1 was admitted to the facility on 06/24/16 and readmitted on 08/17/16. Diagnoses included but not limited to neurogenic bladder, urinary tract infection, quadriplegia, malnutrition, anxiety, depression, respiratory failure, and

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dysphagia.

The most recent comprehensive MDS with an ARD (assessment reference date) of 08/25/16 coded the Resident as 15 of 15 in section C, cognitive patterns.

Resident #1's clinical record was reviewed on 01/03/17. The surveyor could not locate a level 1 PASRR. Surveyor discussed the missing PASRR with the SW (social worker) on 01/04/17 at approximately 1415. SW stated that Resident had been admitted to the facility from a hospital in North Carolina (NC), and she was not sure if the PASRR from NC would transfer to Virginia. SW stated that she would see if she could locate the PASRR.

The concern of the missing PASRR was discussed with the administrative staff on 01/04/17 at approximately 1455.

The administrator informed the surveyor on 01/05/17 at approximately 0920 that the PASRR could not be located.

No further information provided prior to exit.

4. For Resident #3 the facility staff failed to obtain a level 1 PASRR (pre-admission screening and Resident review).

Resident #3 was admitted to the facility on 11/09/12 and readmitted on 04/17/14. Diagnoses included but not limited to hypertension, seizure disorder, anxiety, depression, bipolar disorder, and dysphagia.

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The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/25/16 coded the Resident as having both long and short-term memory impairment and having severely impaired skills for decision making. This is an annual MDS.

Resident #3's clinical record was reviewed on 01/04/17. The surveyor could not locate a level 1 PASRR. Surveyor discussed the missing PASRR with the SW (social worker) on 01/04/17 at approximately 1415. SW stated that she would try to locate the PASRR.

The concern of the missing PASRR was discussed with the administrative staff on 01/04/17 at approximately 1455.

The administrator informed the surveyor on 01/05/17 at approximately 0920 that the PASRR could not be located.

No further information provided prior to exit.

5. The facility staff failed to ensure a PASRR (preadmission screening and resident review) had been completed for Resident #6. The facility staff were unable to locate Resident #6's PASRR in the clinical record.

The surveyor reviewed Resident #6's clinical record on 1/3/17 and 1/4/17. Resident #6 was admitted to the facility 3/1/13 with diagnoses that included but not limited to anxiety, chronic pain, multiple sclerosis, fibromyalgia, depression, pseudobulbar effect, hypertension, hypothyroidism, anemia, left above the knee amputation, morbid obesity, congestive heart failure, and gastroesophageal reflux disease.

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Resident #6's significant change in assessment MDS (minimum data set) with an assessment reference date (ARD) of 11/18/16 assessed the resident with a cognitive summary score of 15 and without signs of delirium, behaviors, or psychosis.

During the record review the surveyor was unable to locate the PASRR. The surveyor interviewed the social worker on 1/4/17 and requested the PASRR on Resident #6. The social worker stated she thought the admission office kept them and the social worker stated she might have them she wasn't sure and that she would check.

The surveyor informed the facility administrative staff of the missing PASRR on 1/04/17 at 2:55 p.m. during an end of the day meeting with the survey team.

The administrator and social worker informed the surveyor on 1/5/17 at 9:30 a.m. that "You're not going to find any PASRRs. We can't find them. We have called the local Department of Social Services to see if they have any."

No further information was provided to the surveyor prior to the exit on 1/5/17.

6. The facility staff failed to complete a Pre-Admission Screening and Resident Review for Resident #9.

Resident #9 was readmitted to the facility on

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6/8/13 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, stroke, dementia, anxiety, depression, and psychotic disorder. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/10/16 scored the resident as having a BIMS (Brief Mental Status) score of 1 out of a possible score of 15. Resident #9 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and dressing.

During the clinical record review on 1/4/17, the surveyor noted that a Pre-admission Screening and Resident Review (PASRR) had not been completed within 30 days to the resident being admitted to the nursing facility.

In the end of the day meeting on 1/4/17 at approximately 3:00 pm, the administrative team was notified of the above documented findings. The administrator stated she would have someone to look into this and provide the surveyor with the information needed.

On 1/5/17 at approximately 8:30 am, the administrator and social worker provided a copy of a letter to the surveyor dated for 6/17/10 addressed to the administrator of the nursing facility from the " Commonwealth of Virginia Department of Medical Assistive Services (DMAS) " which stated the facility could bill Medicaid for Resident #9's services at the facility. In the top right hand corner of the letter was hand written in " Need Level 1 dated 7/31/10 Thank You " . The surveyor asked the social worker if the facility had a copy of the original PASSR that was completed on Resident #9. The social worker stated " This is all that we can find. "

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F 285	Continued From page 33 The administrative team was notified of the above documented findings again on 1/5/17 at 11:05 am in the conference room. No further information was provided to the surveyor prior to the exit conference on 1/5/17.	F 285		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide	F 309	1. a. Resident #19 received the Bisacodyl tablet on 1/4/17. b. Bowel Movements (BMS) were assessed on 1/5/17 for Resident #2 and Resident #5. No negative outcomes were determined. 2. a. Two random medication observations will be conducted weekly for six weeks to ensure all prescribed medications are given. b. A 100% audit of all residents conducted to monitor BMs to include documentation & accuracy of such. 3. Inservices initiated on 1/24/17 for licensed nurses and CNAs by DON or designee on monitoring and documenting Bowel Movements of residents in medical record to include PCC Dashboard. Ongoing audit of BMS on Point Click Care (PCC.) 4. The results of the ongoing audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	2/10/17

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the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well- being in accordance with the comprehensive assessment and plan of care for 3 of 19 residents (Resident #19, Resident #2, and Resident #5).

The findings included:

1. The facility staff failed to follow physician orders during a medication pass and pour observation for Resident #19. Licensed practical nurse #3 failed to administer physician ordered Bisacodyl tablet delayed release 10 mg (milligrams) during a medication pass observation on 1/4/17.

The surveyor observed a medication pass and pour on 1/4/17 with licensed practical nurse #3. L.P.N. #3 prepared seven medications [ASA 81 mg (milligrams), Baclofen 15 mg, Lasix 20 mg, Lopressor 12.5 mg, Miralax 17 gm (grams), Thera tablet, and Vitamin C 500 mg]. L.P.N. #3 administered the medications at 8:00 a.m.

The surveyor reconciled the medications administered with the signed physician orders. Resident #19 had a physician order dated 11/21/16 that read "Bisacodyl tablet delayed release 5 mg Give 1 tablet by mouth one time a day for constipation TOTAL DOSE=10 mg."

L.P.N. #3 failed to administer the Biscadoyl during the observed medication pass.

The surveyor interviewed L.P.N. #3 at 9:35 a.m. concerning the missed dose of Bisacodyl. L.P.N. #3 reviewed the electronic medication record and stated "It should have been given. If I give it now,

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will it be an error?" L.P.N. #3 stated she would administer the Bisacodyl to Resident #19.

Resident #19 was admitted to the facility 6/25/1999 with diagnoses that included but not limited to quadriplegia, chronic pain syndrome, right knee/foot contractures, left knee/left foot contractures, neuromuscular dysfunction of bladder, dislocation of C5/C6 cervical vertebrae, pressure ulcers right and left buttocks (resolved), and major depressive disorder.

Quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/22/16 assessed the resident with a cognitive summary score of 15 and without signs of delirium, behaviors, or psychosis.

The surveyor informed the administrative staff of the above medication pass error on 1/4/17 at 2:55 p.m. and requested the facility policy on medication administration.

The facility policy titled "Administering Medications" was reviewed 1/5/17. The policy read in part "3. Medications must be administered in accordance with the orders."

No further information was provided prior to the exit conference on 1/5/17.

2. For Resident #2, the facility staff failed to ensure the Resident had routine BM's (bowel movements).

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The record review revealed that Resident #2 had been admitted to the facility on 12/03/15. Diagnoses included, but were not limited to, encephalopathy, hypertension, muscle weakness, unsteadiness on feet, cognitive communication deficit, dementia, psoriasis, and paranoid schizophrenia.

Section C (cognitive patterns) of the Resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/21/16 included a BIMS (brief interview for mental status) score of 7 out of a possible 15. Section G (functional status) was coded (1/2) to indicate the Resident required supervision of one person for transfers and toilet use. Personal hygiene was coded (3/2) to indicate the Resident required extensive assistance of one person to complete this task. Section H (bladder and bowel) was coded to indicate the Resident was always continent in both of these areas.

The Residents CCP (comprehensive care plan) included the focus areas of falls, alert with confusion, memory loss, ADL (activities of daily living) self-care deficit, and at risk for constipation related to decreased mobility, medications side effects, and pain. Interventions included, but were not limited to, "...Alert MD to changes in Bowel movement patterns...Follow facility bowel protocol for bowel management..."

Attempts to interview the Resident were unsuccessful.

A review of Resident #2's BM records indicated that Resident #2 had a BM on 12/18/16 but did not have another BM until 12/24/16.

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Resident #2 was not receiving any routine medications for constipation. A review of the Residents eMAR (electronic medication administration record) for 12/2016 indicated the Resident had not received any prn (as needed) medications for constipation.

When the surveyor entered the room on 01/03/17 Resident #2 asked the surveyor to assist her to the bathroom. A staff person assisted this Resident to the bathroom.

On 01/04/17 the surveyor and the nurse consultant reviewed the Resident's BM record. After reviewing this record the nurse consultant verbalized to the surveyor that the facility did not have standing orders and the staff would need to call the physician.

On 01/04/17 at approximately 10:40 a.m. the surveyor interviewed CNA (certified nursing assistant) #1. CNA #1 verbalized to the surveyor that the Resident was able to go to the bathroom by herself.

During an end of the day meeting with the survey team on 01/04/17 beginning at approximately 2:55 p.m. the administrative staff were notified of the above. During this meeting the administrative staff verbalized to the survey team that the facility did not have any standing orders regarding a bowel protocol.

No further information regarding this issue was provided to the survey team prior to the exit conference.

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3. For Resident #5, the facility staff failed to ensure the Resident had routine BM's (bowel movements).

The record review revealed that Resident #5 had been admitted to the facility 07/30/07. Diagnoses included, but were not limited to, constipation, paranoid schizophrenia, hypertension, drug induced tremor, major depressive disorder, klinefelter syndrome, peripheral autonomic neuropathy, and dysphagia.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/27/16 had a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (4/2) for toilet use to indicate the Resident was totally dependent on one staff and (3/2) for personal hygiene to indicate the Resident required extensive assistance of one person in this area. Section H (bladder and bowel) was coded (3/3) to indicate the Resident was always incontinent in both areas.

The Residents CCP (comprehensive care plan) included the focus area of potential for pressure ulcer related to medical diagnosis...incontinence of bowel and bladder, ADL (activities of daily living) self-care deficit, and bowel incontinence. Interventions included, but were not limited to, check Resident and assist with toileting as needed.

A review of Resident #5's BM record indicated that Resident #5 had a BM on 12/25/16 but did not have another BM until 01/03/17.

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A review of the Resident's eMAR's (electronic medication administration records) and physician orders indicated the Resident was receiving the following medications.
Bisacodyl 5 mg tablet by mouth one time a day for constipation.
Docusate sodium 100 mg 1 by mouth one time a day for constipation.
Lactulose 45 ml by mouth one time a day related to slow transit constipation.
Miralax give 6 gram by mouth one time a day for constipation.

A review of the Resident's eMAR's indicated the medications had been administered per the physician's orders.

On 01/04/17 at approximately 10:05 a.m. the nurse consultant was made aware of the issue regarding Resident #5's BM's and verbalized to the surveyor that the facility did not have standing orders in regards to BM's.

On 01/04/17 at approximately 1:50 p.m. Resident #5 was interviewed regarding his BM's when asked if he thought he had went from 12/25/16-01/03/17 without a BM Resident #5 stated he had one yesterday and he probably did go that long without a BM.

During an end of the day meeting with the survey team on 01/04/17 beginning at approximately 2:55 p.m. the administrative staff were notified of the above in regards to Resident #5. During this meeting the administrative staff verbalized to the survey team that the facility did not have any standing orders regarding a bowel protocol.

No further information regarding this issue was

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provided to the survey team prior to the exit conference.

F 315 SS=D 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER

(e) Incontinence.
(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate

F 309

F 315

2/17/17

1. Resident #1 was discharged home on 1/4/17.
2. A 100 % audit for all residents with foley catheters to determine if foley output is being recorded was conducted and completed 1/9/17 by DON or designee. No issues identified.
3. Inservices were initiated on 1/24/17 for Licensed by DON or designee regarding documenting foley catheter output. Weekly Audit will be conducted by DON or designee for six weeks and randomly thereafter to ensure foley catheter output is documented.
4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

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treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to record foley catheter output for 1 of 19 Residents, Resident #1.

The findings included:

For Resident #1 the facility staff failed to record foley catheter output per the physician's order.

Resident #1 was admitted to the facility on 06/24/16 and readmitted on 08/17/16. Diagnoses included but not limited to neurogenic bladder, urinary tract infection, quadriplegia, malnutrition, anxiety, depression, respiratory failure, and dysphagia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/21/16 coded the Resident as 15 of 15 in section C, cognitive patterns.

Resident #1's clinical record was reviewed on 01/03/17. It contained a POS (physician's order summary) dated 12/20/16 which read in part "document foley catheter output every shift" Resident #1's TAR's (treatment administration record) for the months of December 2016 and January 2017 were reviewed and contained an entry which read in part "document foley catheter output every shift". For the month of December, no output was recorded from 12/20/16-12/31/16. The TAR contained a check mark and staff initials only. For January, no output was recorded on the TAR, only check marks and staff initials.

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The concern of not recording the foley catheter output was discussed with the administrative team on 01/04/17 at approximately 1455.

No further information was provided prior to exit.

F 328 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE SS=D FOR SPECIAL NEEDS

(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

F 315

F 328

2/17/17

1. Clarification of order was obtained for oxygen Resident #5 on 1/4/17.
2. A 100% audit was conducted and completed by DON or designee on 1/9/17 for all residents with Oxygen to ensure orders have been obtained and are accurate. No issues noted.
3. Inservices initiated on 1/24/17 for Licensed Nursing staff by DON or designee regarding obtaining physician orders for the usage of oxygen. Random audits will be conducted by the DON or designee on all admissions and readmissions to ensure orders are obtained for oxygen.
4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

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(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to obtain a physicians order prior to the use of continuous O2 (oxygen) for 1 of 19 Residents, Resident #5.

The findings included.

Resident #5 was observed on 01/03/17 and 01/04/17 to have continuous O2 in use at 2 liters a minute via nasal cannula. Resident #5 did not have a physicians order for the use of this O2.

The record review revealed that Resident #5 had

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been admitted to the facility 07/30/07. Diagnoses included, but were not limited to, paranoid schizophrenia, hypertension, drug induced tremor, major depressive disorder, klinefelter syndrome, peripheral autonomic neuropathy, dysphagia, and constipation.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/27/16 had a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section O (special treatments, procedures, and programs) was coded to indicate the Resident used O2 while a Resident at the facility.

The Residents CCP (comprehensive care plan) included the focus area requires continuous O2 due to shortness of breath. Interventions included, but were not limited to, O2 per MD orders.

Resident #5's initial observation by the surveyor was on 01/03/17 at approximately 3:05 p.m. During this observation Resident #5 was observed to have O2 in place via nasal cannula at 2 liters a minute.

Resident #5 was again observed on 01/04/17 at 8:35 a.m. and on 01/04/17 at 9:40 a.m. and was noted by the surveyor to have O2 in place via nasal cannula at 2 liters a minute.

During the record review the surveyor was unable to locate any orders for this O2. The Resident did have orders to change and label their O2 tubing and humidified H20 (water) every night shift on Sunday for O2 therapy and clean filters on O2 concentrator every night shift every Sunday for

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F 328	Continued From page 45 infection control. The Resident had been readmitted to the facility on 12/23/16. On 01/04/17 at approximately 10:50 a.m. RN (registered nurse) #4 was made aware that Resident #5 did not have an order for their O2. RN #4 verbalized to the surveyor that the Resident had been on O2 prior to their recent hospitalization. The administrative team was notified of the missing O2 order on 01/04/17 at approximately 2:55 p.m. On 01/05/17 the facility provided the surveyor with a copy of a physicians order that read "Oxygen continuous at 2 liters/min (minute) via nasal cannula Medical DX (diagnosis) SOB (shortness of breath)." This order was dated 01/04/17. No further information regarding the O2 was provided to the survey team prior to the exit conference.	F 328		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		

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F 371	Continued From page 46 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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to prepare and serve food under sanitary conditions. The findings include: On 1/3/17, during initial tour of the facility, the kitchen was observed. The dietary manager gave the surveyor a tour of the kitchen at approximately 11:45am. A hair net was provided for the surveyor at her request. During the tour of the kitchen, two female staff members were observed to be preparing food for the day. Both had on hair nets but their hair was not restrained by the net. One had hair coming out from under the net on both sides of her head and at the back. The other had a braid that was not restrained by the net. On 1/4/17, the surveyor returned to the kitchen to check the dish washer. The male washing and moving the clean dishes to storage was noticed	F 371	1. Beard restraints currently being utilized by male staff. Hair nets currently worn properly by females to restrain the hair and braids. 2. All dietary staff inserviced on proper hair and facial hair restraint usage by Dietary Manager. 3. Routine audits will be ongoing by Dietary Manager or designee to ensure hair and beard restraints are utilized. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	2/3/17

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F 371	Continued From page 47 to have a beard and mustache. Another male was observed working in the kitchen who had a beard and a mustache; neither of the men had a beard restraint on. During the end of the day meeting on 1/4/17, the administration, director of nurses and the regional nurse were informed of the aforementioned. On 1/5/17 at 11:05am, the administrator, director of nurses, and regional nurse were informed of the kitchen issues. Prior to exit, no further information was provided to the surveyor related to the kitchen.	F 371		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a physician ordered medication was available for 1 out 19 residents. (Resident #10)	F 425	1. Fentanyl Patch was received on 11/17/16 For Resident #10. 2. 100% audit on residents with orders for Fentanyl patches was conducted and completed by DON or designee on 1/6/17 to ensure availability of Fentanyl Patches. No further issues noted.	2/17/17

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The findings included:

Resident #10 was readmitted to the facility on 12/1/16 with the following diagnoses of, but not limited to anemia, high blood pressure, stroke, respiratory failure, chronic obstructive pulmonary disease and depression. The admission 5 day MOS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/8/16 scored the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #10 was also coded as being totally dependent on 1 staff member for personal hygiene and bathing.

Resident #1O's clinical record was reviewed by the surveyor on 1/4/17. The surveyor also reviewed the MAR (Medication Administration Record) for the month of November, 2016. On the MAR for 11/16/16, the resident was ordered to have a " Fentanyl patch 72 Hour 25 MCG/HR (microgram per hour) Apply 1 patch topically every 72 hours for pain and remove per schedule. " This was on the MAR to be administered on 11/16/16 at 2159 (10:59 pm). On the MAR for this date and time, the following documentation was noted " 9 ... (initials of a nurse) 2133 " . At the bottom of the MAR was a " Chart Codes/Follow Up Codes " in which it was noted by the surveyor that a 9 was documented to represent " Other/See Nurses ' Notes " . The following was noted in the nurses' notes dated and timed for 11/16/2016 at 2133 (10:33 pm) which stated the following, " not available from pharmacy. Pharmacy notified. "

The administrative team was notified of the above documented findings on 1/4/17 at approximately 3 pm by the surveyor in the conference room.

3. Inservices initiated on 1/24/17 for Licensed Nursing by DON or designee on proper protocols for obtaining unavailable medications from the pharmacy. Audit of available Fentanyl Patches will be conducted for 30 days to ensure availability as prescribed. Random audits will occur thereafter.
4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

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F 425	Continued From page 49 The interim director of nursing stated, " I will have to look into this a little farther. " On 1/5/17 at 9 am, the interim director of nursing stated " I don't know why this medication was not available to be given to the resident. The nurses may have failed to get a hard prescription from the physician to send to the pharmacy in time." The surveyor asked what the procedure was for the staff to obtain Fentanyl from the pharmacy. The interim director of nursing stated " The nurses have to get a written prescription, not a verbal order, from the physician to fax to the pharmacy when the resident is getting low on the medication. They should do this several days in advance of needing the medication for the resident so that this doesn't happen. " No further information was provided to the surveyor prior to the exit conference on 1/5/17.	F 425		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441	1. a. Infection Control log was updated to include Resident #7 with diagnosis of Chicken Pox. b. Blankets for Resident #3 were laundered and replaced on 1/4/17. Staff will continue to monitor that blankets for Resident #3 do not touch the floor.	2/17/17

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(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective

F 441

2. a. A 100% audit was conducted and completed on 1/26/17 by DON and designee to ensure all infections were recorded in the past 90 days.

   b. Room rounds conducted for entire facility and completed on 1/4/17 to ensure bed covers were are not resting on the floor. No other issues were identified.

3. a. DON and designee was inserviced by Administrator on completion of monthly Infection Control Log on 1/26/17. Infection Control log to be reviewed monthly by Administrator.

   b. Inservices initiated on 1/24/17 to all departmental staff members by Administrator or designee regarding Infection Control practices to include handling of dirty linen. Routine rounds to be conducted to ensure infection control practices are being followed.

4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

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during their hospitalization. The administrator stated one resident had returned to the facility and the second one was still hospitalized. The administrator stated the local health department would visit the facility 1/3/17 and do a walk through and on 1/4/17, a nurse with the Virginia Department of Health would be on site to observe wound care.

The administrator was asked if the two residents diagnosed with Strep A had been reported to the local Virginia Department of Health. The administrator stated the hospital had reported the Strep A because the illness had been diagnosed there.

Letter from the Commonwealth of Virginia-Virginia Department of Health dated 12/30/16 to the facility read in part "Invasive cases of GAS (e.g. bloodstream infections) are reportable to the Local health department in accordance with the Code of Virginia, Section 32.1."

The surveyor and the interim director of nursing reviewed the November 2016, December 2016, and January 2017 infection control logs on 1/4/17 at 12:40 p.m. The infection control logs were incomplete. The infection control logs did not contain information if re-cultures were done or if the illness was resolved. The interim director of nursing stated she saw that part of the infection control logs were incomplete.

The surveyor requested the facility infection control policy from the interim director of nursing on 1/4/17 at 12:40 p.m.

The surveyor reviewed the facility policy titled "Infections-Clinical Protocol" on 1/4/17. The

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policy read "Assessment and Recognition 1. As part of the initial assessment, the physician will help identify individuals who have had a recent infection or who are at risk for developing an infection. 2. For any individual suspected of having an infection, or who has a change in function, appetite, mental status, etc., that suggests an infection, nursing staff will obtain a complete set of vital signs (temperature, heart rate, blood pressure, and respiratory rate) and will identify and document specific changes in condition, function, and mental status. a. Infection may be suspected based on clinical signs and symptoms and/or temperature. 3. If a possible infection is identified, the nurse or nursing assistant will report immediately to a Charge Nurse/Supervisor who will perform an additional assessment or verify that an adequate assessment has been done. 4. The nurse will notify the physician of the findings, including all pertinent details about the resident's condition, not just the temperature or lab test results. 5. The nursing staff and physician will identify possible complications of infections such as sepsis and delirium. Monitoring and Follow-Up 5.a. If an individual's infection is not resolved by the initial course of antibiotics, the physician will review the situation in detail and may need to examine the individual before prescribing a continuation or change in antibiotics after the initial course."

The surveyor informed the administrative staff of the concern with the infection control logs during the end of the day meeting on 1/4/17 at 2:55 p.m.

No further information was provided prior to the exit conference on 1/5/17.

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2. The facility staff failed to track Resident #7's diagnosis of chickenpox on the December 2016 infection control log. Resident #7 was diagnosed with Varicella virus on 12/15/16.

Resident #7 was admitted to the facility on 6/8/13 and readmitted on 4/10/15. Her diagnoses included but were not limited to anemia, heart failure, adrenocortical insufficiency, Down Syndrome, rheumatic aortic stenosis, thyroid disease, and depression.

Resident #7's MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/10/16 assessed the resident with a cognitive summary score of 4 out of 15 in Section C. Resident #7 was also coded in Section G to require assistance with activities of daily living. Resident #7's was care planned to have chicken pox.

During the initial tour on 1/3/17, one surveyor was informed that a resident in the facility currently had chickenpox and was on isolation. The resident was identified as Resident #7. The surveyor reviewed the progress notes of Resident #7 on 1/5/17. The 12/15/16 11:32 a.m. progress note read "Resident noted to have what appear to be chickenpox rash all over body. MD (medical doctor) assessed. PA (physician assistant) notified with new orders to place patient in contact precautions. Notified the local health department (other #4) regarding residents clinical diagnosis-pending a return call at present time. Primary nurse notified residents RP (responsible party) regarding new diagnosis and monitoring. Nursing will continue to monitor clinical status at present time."

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Progress note dated 12/15/16 13:46(1:46 p.m.) read "Spoke with other #4 at the Local Health department and updated her on new diagnosis of chickenpox. Information given to other #4 that resident was in a private room at present time under isolation precautions per attending orders. Resident afebrile at present time. Other #4 stated the isolation should remain in place until areas are scabbed over which typically takes 5-7 days. Attempted notification to RP regarding conversation with Local Health department and reporting. Pending call at present time. Nursing will continue to monitor and provide comfort PRN (as need)."

During review of the infection control log with the interim director of nursing on 1/4/17 at 12:40 p.m., the surveyor noted that Resident #7's infection (chickenpox) was not listed on the December 2016 infection control log. The interim director of nursing stated that Resident #7's illness was missing and stated she would add to the December 2016 tracking.

The surveyor informed the administrative staff of the above concern with the tracking of facility infections in the end of the day meeting on 1/4/17 at 2:55 p.m.

No further information was provided prior to the exit conference on 1/5/17.

3. For Resident #3 the facility staff failed to follow established infection control guidelines by allowing bed covers to rest in the floor.

Resident #3 was admitted to the facility on

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11/09/12 and readmitted on 04/17/14. Diagnoses included but not limited to hypertension, seizure disorder, anxiety, depression, bipolar disorder, and dysphagia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/25/16 coded the Resident as having both long and short-term memory impairment and having severely impaired skills for decision making. This is an annual MDS.

Surveyor observed Resident #3 on 01/03/17 at approximately 1155. Resident was sitting up in wheelchair in bedroom, dressed in street clothes. Surveyor observed pillow lying on floor beside Resident's wheelchair and blanket on bed hanging in the floor all the way down on side of bed.

Surveyor observed Resident #3 in bedroom on 01/03/17 at approximately 1420. Resident was sitting up in wheelchair, dressing in street clothes. Surveyor observed lower corner of blanket on bed lying on the floor.

Surveyor observed Resident #3 in bedroom on 01/04/17 at approximately 0800. Resident was resting on bed, eyes closed. Blankets on bed were hanging in the floor.

Surveyor observed Resident #3 in bedroom on 01/04/17 at approximately 1030. Resident resting on bed dressed in street clothes, eyes open. Blankets from bed were hanging down and resting on the floor.

Surveyor spoke with DON (director of nursing) on 01/04/17 at approximately 1315 regarding

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F 441	Continued From page 57 Resident #3. Surveyor asked DON if she considered blankets hanging in the floor to be an infection control issue and DON stated that she did. Surveyor informed DON of observations at this time. The concern of the blankets hanging in the floor was discussed with the administrative team during a meeting on 01/04/17 at approximately 1455. No further information was provided prior to exit.	F 441		
F 514	483. 70(i)(1)(5) RES SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 514	1. a. Resident # 6, Resident #8, and Resident #4 are currently receiving showers and documentation reflects current care. b. Resident #10 is currently receiving all prescribed treatments and medication. 2. a. A 100% audit conducted and completed on 1/23/17 by DON or designee of all showers for past 30 days. No negative outcomes resulted. b. A 100% audit conducted and completed on 1/23/17 by DON or designee of MARS/TARS for past 30 days. No negative outcomes resulted.	2/17/17

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F 514	Continued From page 58 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 4 of 19 residents (Resident #6, Resident #8, Resident #4, and Resident #10). The findings included: 1. The facility staff failed to document Resident #6's baths/showers. The surveyor reviewed Resident #6's clinical record on 1/3/17 and 1/4/17. Resident #6 was admitted to the facility 3/1/13 with diagnoses that included but not limited to anxiety, chronic pain, multiple sclerosis, fibromyalgia, depression, pseudobulbar effect, hypertension, hypothyroidism, anemia, left above the knee amputation, morbid obesity, congestive heart failure, and gastroesophageal reflux disease. Resident #6's significant change in assessment MDS (minimum data set) with an assessment reference date (ARD) of 11/18/16 assessed the resident with a cognitive summary score of 15 and without signs of delirium, behaviors, or psychosis. Resident #6 was coded to require	F 514	3. a. Inservices initiated on 1/24/17 for CNAs by DON or designee on need for proper and complete documentation of care, particularly baths and showers. Audit will be conducted for the next month and randomly thereafter to ensure baths/showers are documented. b. Inservices initiated for Licensed Nurses on 1/24/17 by DON or designee on Policy of Medication Administration and Missed Documentation. Audit will be conducted for the next month and randomly thereafter to ensure medications are given according to physician orders. Point Click Care dashboard will be monitored ongoing checked for holes in MARS/TARS by DON or designee. 4. The results of the audit will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

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extensive assistance of one person for personal hygiene and was totally dependent on one person for baths.

The surveyor reviewed Resident #6's shower documentation for October 2016, November 2016, and December 2016. Seven showers were documented in October 2016. November 2016 did not have any showers recorded. December 2016 had three recorded showers.

The surveyor interviewed Resident #6 on 1/3/17 at 3:20 p.m. Resident #6 was asked how often she received a shower or a bath. Resident #6 stated she received showers two times a week.

The surveyor informed the administrative staff of the lack of documentation of Resident #6's showers in the clinical record in the end of the day meeting on 1/4/17 at 2:55 p.m.

The surveyor reviewed the facility policy on documentation titled "Charting and Documentation" on 1/5/17. The policy read in part "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record."

No further information was provided prior to the exit conference on 1/5/17.

2. The facility staff failed to document Resident #8's showers.

The clinical record of Resident #8 was reviewed 1/4/17. Resident #8 was admitted to the facility 8/1/16 with diagnoses that included but not limited

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to alcohol abuse, nicotine dependence, convulsions, gastroesophageal reflux disease (GERD), sepsis, urinary tract infection, toxic encephalopathy, bipolar disorder, and facial bone fractures.

Resident #8's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/13/16 assessed the resident with a cognitive summary score of 15. Resident #8 was assessed to need supervision of one person for personal hygiene and extensive assistance of one person for bathing.

Resident #8's bath/shower record for December 2016 was reviewed 1/4/17. The shower record had four documented showers.

The surveyor interviewed Resident #8 on 1/5/17 at 8:00 a.m. Resident #8 stated he got showers two times a week at the facility. Resident #8 stated if he went to his sister's house, he would take a shower there.

The surveyor informed the administrative staff of the concern with the documentation of baths/showers on Resident #8 on 1/5/17 at 11:10 a.m. The administrator stated that documentation was something to work on especially residents who refuse.

The surveyor reviewed the facility policy on documentation titled "Charting and Documentation" on 1/5/17. The policy read in part "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record."

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3. The facility staff failed to document Resident #4's showers.

Resident #4 was admitted to the facility on 9/13/16 with diagnoses that included, but were not limited to alcohol abuse, cognitive communication deficit, low back pain, and cirrhosis of the liver.

Resident #4's most recent MDS (minimum data set) assessment completed on this resident was a Significant change assessment with an ARD (assessment reference date) of 12/12/16. Section C (cognitive patterns) of this assessment scored the resident a 15, indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood. He was also coded requiring the assistance of 1 person for bed mobility, dressing, bathing, and hygiene.

Review of Resident #4's Bathing Report for the month of December 2016 revealed he did not have regular documentation for showers for 30 days. He was documented to be independent, but only had 2 showers documented for 30 days.

Resident #4 was interviewed on 1/4/17 and asked if he received assistance to get showers and he said, " I get 2 showers a week and would like more. " The surveyor asked him if the staff would

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let him have more than 2 a week. He replied, " They will if they have time to help me. "

During the end of the day meeting on 1/4/17, the administration, director of nurses, and the regional nurse were informed of the aforementioned.

Prior to exit on 1/5/17 at 11:05am, the administrator, director of nurses, and regional nurse were informed of the shower issues.

4. The facility staff failed to maintain a complete and accurate MAR (Medication Administration Record) on Resident #10.

Resident #10 was readmitted to the facility on 12/1/16 with the following diagnoses of, but not limited to anemia, high blood pressure, stroke, respiratory failure, chronic obstructive pulmonary disease and depression. The admission 5 day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/8/16 scored the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #10 was also coded as being totally dependent on 1 staff member for personal hygiene and bathing.

Resident #10's clinical record was reviewed by the surveyor on 1/4/17. On the MAR for the month of December, 2016 the boxes for the following medications were left blank for the date of 12/18/16 at 1800 (6 pm):

· " ...Lipitor 20 mg (milligram) Give 1 tablet via (by) peg tube one time a day

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F 514	Continued From page 63 · ...Administer Jevity at 88cc/hr (per hour) X (times) 12 hours via peg tube · Flexeril 10 mg Give 10 mg via peg tube two times a day at 1800 · Lactobacillus capsule Give 1 capsule by mouth two times a day · Zantac Syrup 15 mg/ml (milligram per milliliter... " The administrative team was notified of the above documented findings on 1/4/17 at approximately 3 pm by the surveyor in the conference room. The administrator stated, " I think he was out of the facility on 12/18 but I will check on that. " On 1/5/17 at 9 am, the administrator notified the surveyor that the resident was in the facility on 12/18/16 and doesn't know why these medications were not given. No further information was provided to the surveyor prior to the exit conference on 1/5/17.	F 514		