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State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495206 | A. BUILDING _____ B. WING _____ | 03/15/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BON SECOURS-MARYVIEW NURSING C | 4775 BRIDGE ROAD SUFFOLK, VA 23435 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection survey was conducted 3/12/18 through 3/19/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 41 resident reviews; 35 current residents and 6 closed. | F 000 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegations of compliance. All alleged deficiencies have been or will be corrected by the date indicated | 4-25-18 |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>The facility was not in compliance with the following Virginia Rules and Regulations for the Liconsure of Nursing Facilities.<br><br>Please cross reference the following:<br><br>12VAC5-371-180 A to F880 Infection Control<br><br>12VAC5-371 - 250 to F657 Care Plan Revision<br><br>12VAC5-371-220 C1 to F684 Quality of Care<br><br>12VAC5-371-220-D to F687 Foot Care<br><br>12VAC5-371-300 A to F755 Pharmacy Services<br><br>12VAC5-371-220 A to F689 Nursing Services<br><br>12VAC5-371-220 A to F 697 Pain Management<br><br>12VAC5-371-250 to F655 Baseline Care Plan | F 001 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| X Patricia Bailey signing for Kathryn Knight Administrator | | 4-11-18 |

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| | | 12VAC5-371-160 A 12VAC5-371-180 A | 12VAC5-371-160 A /F 880<br>1. Resident # 103 and #96 have had no ill-effects from this practice.<br>-Residents #103 and #96's respiratory devices will be stored according to policy and appropriate infection control practice.<br>-Education was completed for staff members #5#2#26 regarding Infection Control Practices.<br>2. Those residents who have respiratory devices or that reside within the facility could potentially be affected by these practices.<br>3.A) The Infection Control Coordinator will complete monthly tracking /trending and reporting on infections and infection prevention within the facility. This report will be provided to the DON/Administrator monthly for their review.<br>B) Education was provided to nursing care staff on Infection control policy and practices. This education included the following:<br>-Hand washing policy including practices followed during the dining and meal times.<br>-Practice of glucometer checks and protection barriers during this practice.<br>-Nebulizer/respiratory device storage<br>C) The Infection Control Coordinator will conduct monthly review/audits of the Infection control tracking numbers, handwashing, glucometer infection control practices and respiratory device storage. The findings of these audits and action items will be provided to the Don monthly for review. | 4-25-18 |

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| | | 12VAC5-371-180D | 4) The DON will report to the Quality Assurance and Performance Improvement Committee monthly for 6 months the findings and action items of these audits to assure practice/policy compliance with infection control practice and policy.<br>5) Date of Compliance of 4/25/18 | 4-25-18 |

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| | | 12VAC5-371-250F | 12VAC5-371-250/F 857<br>1) Rosident # 34 is a discharged rosident. Resident #263's care plan has been reviewed and revised as needed.<br>2) Those residents who reside in the facility with individual needs that require their care plans to be reviewed and revised could potentially be affected by this practice.<br>3) Process review and revisions include the following:<br>a) An Enhanced process has been initiated at the am clinical meeting that will include those items that are reported and need care plan updates or revisions will be updated by mds or unit managers at this meeting.<br>b) The required need for update that is identified outside the am meeting will be directed to the mds/unit manager for ongoing update in between assessments.<br>c) A monthly random audit will occur for care plans and appropriate updates by the unit manager and will be provided to the DON monthly.<br>4) The DON will report audit findings and care plan compliance to Quality Assurance and Performance Improvement Committee (QAPI) monthly for 3 months to ensure compliance with care plan update process/policy.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| | | 12VAC5-371-220C | 12VAC5-371-220C1/F 684<br>1) Resident #267 is a discharged resident.<br>- Education provided to staff member identified #25<br>2) Those residents who receive insulin could potentially be at risk<br>3)<br>a) Education was provided to nurses on:<br>-following physicians order and sliding scale for insulin coverage.<br>b) The nurse managers will conduct weekly audits of the following and report findings to the DON weekly:<br>-medication pass/insulin coverage<br>-documentation related to insulin coverage, glucometer checks and sliding scale physician orders<br>c) pharmacy will audit monthly those residents on sliding scale coverage and provide feedback to the DON monthly.<br>4) The DON will report to Quality Assurance and Performance Improvement Committee (QAPI)monthly for 3 months, the findings of the audits related to medication provided for sliding scale and the follow up to sustain compliance with insulin coverage, glucometer checks and documentation.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| | | 12VAC5-371-220 | 12VAC5-371-220D/F 687<br>1) Resident #263 was seen by an outside podiatrist. Residents care plan was reviewed and updated as needed.<br>2) Those residents with podiatry needs could potentially be affected.<br>3)<br>A) The Nurse managers will refer residents who have been assessed or receives an order for podiatry care to an outside podiatrist.<br>B) Facility will actively seek to find a qualified internal contractor for podiatry care that could visit the facility.<br>C) A facility list will be established of those residents who need podiatry care and follow up appointments as needed. This list will be kept by the Unit Managers. This list will be provided to the DON monthly.<br>D) Education to the nurses was provided on assessment /evaluation/observation of foot/nail care needs during showers or care.<br>4) The DON will submit the podiatry need/ appointment list to Quality Assurance and Performance Improvement Committee (QAPI)monthly for 6 months to assure compliance with foot /podiatry appointments/care.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| | | 12VAC5-371-300A | 12VAC5-371-300A/F 756<br>1. Resident #5's medications and care needs have been re-evaluated and care plans updated as needed.<br>-The medication is now being delivered, labeled and monitored via the facilities external pharmacy vendor.<br>2. Those residents who have medications brought in from an outside source or need reconciled could potentially be affected by this practice.<br>3.<br>A) A review of the policy related to medications provided by family or an outside source was completed by the Don/Administrator.<br>B) Education was provided to the nursing staff on the policy and practice of medications that may be brought in from an outside source. The education also included the following:<br>- If medication is requested to be brought in from an outside source it will be communicated to the DON for review and consideration and practice adherence of the current policy.<br>C) A review and audit will be completed weekly of those residents who may have medications requested or received by an outside source. This audit and action items will be provided to the Don weekly.<br>4) The Don will report to the Quality Assurance and Performance Improvement Committee (QAPI) monthly for 3 months the findings and needed action items regarding medications from any outside source and actions items for policy compliance.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| | | 12VAC5-371-220A | 12VAC5-371-220A/F688<br>1. Plan of Correction/Abatement provided with immediate follow up for oxygen use and safety for residents #25 and #4.<br>A)<br>-Residents #25 and #4's care needs including oxygen use were reviewed and their care plans updated as needed.<br>2. Those residents who receive oxygen and utilize tanks could potentially be affected by this practice.<br>3.<br>A) Education was provided to nursing care staff on:<br>-The oxygen administration, storage, safety and documentation practice per the oxygen policy.<br>B) Audits/rounds will be conducted daily by the Nurse Managers and Environmental services team related to oxygen storage and safety.<br>C) The results and any necessary action items of the safety audits will be provided to the Administrator daily as needed and weekly by report.<br>4. The Administrator will report to Quality Assurance Committee (QAPI) monthly for 6 months the findings of the safety/oxygen rounding and audits and any action items to assure compliance with the oxygen<br><br>5) Date of Compliance<br>4/25/18 | 4/25/18 |

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| | | 12VAC5-371-220 | 12VAC5-371-220A/F 697<br>1. Resident #263 received her ordered and prescribed pain medication. Resident #263's pain medication regimo/orders have been reviewed and residents care plan has boon updated and revised as nooded.<br>2. Those residents that receive pain medication could potentially be affected by this practice.<br>3.<br>A) Education has been provided to nursing staff related to pain medication policy and process. This includes:<br>- Stat medication process<br>-Problem solving, documentation and reporting process if the pain medication is not available.<br>B) Clinical Managers will review and audit the following areas daily and provide a report to the DON weekly:<br>-Audit for those medications that are ordered and reordered for pain control for availability<br>-Audit of the documentation of medication administration for those medications ordered for pain control<br>4) The Don will report monthly for 3 months to the Quality Assurance and Performance Improvement Committee(QAPI) the findings and results of the audits for pain control medication availability and documentation.<br>5) Date of Compliance 4-25-18 | 4/25/18 |

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| | | 12VAC5-371-250 | 12VAC5-371-250/F655<br>1. Residents #25,16,64,213,103,51,57 were offered the opportunity to review their current care plan and progress since admission.<br>-Education and policy requirement provided to identified team members: #4,#5,#2, DON, MDS<br>2. Those residents residing in the facility could potentially be at risk for this practice.<br>3.<br>A)The current practice was reviewed and modified to include:<br>-Baseline care plans will be offered to resident or representative during the interdisciplinary meeting and according the required timeline requirement.<br>-The Signature page will be maintained as a record of the baseline care plans being offered and accepted or refused.<br>B) The MDS Coordinator will audit newly admitted residents and compile a log. The log will indicate that a baseline care plan was offered and documented to new residents per required timeline. This log will be provided to the DON Monthly.<br>4) The DON will report to Quality Assurance and Performance Improvement Committee (QAPI) monthly for 3 months the finding of the baseline care plan audit and any follow up actions items to maintain compliance with the baseline care plan policy.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 3/12/18 through 3/19/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Five (5) complaints were investigated during the survey. | E 000 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegations of compliance. All alleged deficiencies have been or will be corrected by the date indicated<br>E024 | |
| E 024 SS=C | Policies/Procedures-Volunteers and Staffing<br>CFR(s): 483.73(b)(6)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]<br><br>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to ensure the policies were in place for | F 024 | 1) No residents affected at time of survey<br>2) Potential for all residents to be affected.<br>3) a) The Policy and Procedure was revised and updated to reflect the following items:<br>- The use of volunteers and other emergency staffing strategies including the process and role of state and federally designated health care professionals in the event of an emergency.<br>- To include and ensure process review after the table-top exercises as needed and required per regulation.<br>-Also, to include and ensure documentation of Outcome and Actions in the After -Action Improvement Plan.<br>b) Education was provided to staff, residents and families on the following items:<br>-The policy and process for the use and incorporation /involvement of volunteers and other staff during emergencies and table top exercises/drills.<br>4) The Administrator will provide updates to the Quality Assurance and Performance Improvement (QAPI) committee monthly on any emergency drills, exercises, policy changes, role changes, contact information changes, documentation and required after action items.<br>5) Date of compliance 4/25/18 | 4/25/18 |

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

Patricia Bailey Dot signing for Kathryn Knight administrator 4-11-18

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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| E 024 | Continued From page 1<br>volunteers.<br><br>The findings included:<br><br>On 3/19/18 at 2:10 p.m. and interview was conducted with the Director of Long Term Care Project Administrator and the Clinical Analyst. During the interview with the aforementioned persons, the facility staff failed to provide documentation that the policies and procedures for the use of volunteers and other staff strategies were in the emergency preparedness plan. | E 024 | | |
| E 026 SS=C | Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]<br><br>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency | E 026 | E026<br><br>1) No residents affected at time of survey<br>2) Potential for all residents to be affected.<br>3) The policy and procedures were reviewed and revised as needed for providing care and treatment at Alternate Care Sites under the 1135 waiver.<br>a. The Planned current and future Table Top exercises will be evaluated and documented to determine effectiveness of this policy & procedure in practice.<br>4) The Administrator will provide updates to the Quality Assurance and Performance Improvement (QAPI) committee monthly on any emergency drills, exercises, policy changes, role changes, contact information changes, documentation and required after action items<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| E 026 | Continued From page 2<br>management officials.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the emergency preparedness plan and staff interview, the facility staff failed to ensure polices were in place to describe their role to provide care at an alternate site.<br><br>The findings include:<br><br>On 3/19/18 at 2:10 p.m. and interview was conducted with the Director of Long Term Care Project Administrator and the Clinical Analyst. During the interview with the aforementioned persons, the facility staff failed to provide documentation that the policies and procedures in the emergency preparedness plan described the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. | E 026 | | |
| E 031 SS=C | Emergency Officials Contact Information<br>CFR(s): 483.73(c)(2)<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:<br><br>(2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br><br>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, or local emergency preparedness staff. | E 031 | E031<br><br>1) No residents affected at time of survey<br>2) Potential for all residents to be affected.<br>3) The Emergency Preparedness plan was updated to include all required elements including;<br>a) Federal, state, tribal, regional or local emergency preparedness staff's contact information.<br>b) State licensing or certification agency, office of the state long term care ombudsman and other sources of assistance as appropriate for this contact information.<br>c) This information will be validated as needed and at a minimum of monthly for accuracy by the Administrator/designee.<br>4) The Administrator will provide updates to the Quality Assurance and Performance Improvement (QAPI) committee monthly on any emergency drills, exercises, policy changes, role changes, contact information changes, | 4/25/18 |

documentation and required after action items.
5. Date of compliance 4/25/18

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| E 031 | Continued From page 3<br>(ii) The State Licensing and Certification Agency.<br>(iii) The Office of the State Long-Term Care Ombudsman.<br>(iv) Other sources of assistance.<br><br>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br>(iii) The State Licensing and Certification Agency.<br>(iv) The State Protection and Advocacy Agency.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility's emergency preparedness plan and staff interview, the facility failed to ensure facility contact information was in place and reviewed at least annually.<br><br>The findings include:<br><br>On 3/19/18 at 2:10 p.m. and interview was conducted with the Director of Long Term Care Project Administrator and the Clinical Analyst. During the interview with the aforementioned persons, the facility staff failed to provide documentation that the emergency preparedness plan required facility contacts were included in the communication, and documentation that all emergency officials contact information had been reviewed and updated at least annually. | E 031 | | |
| E 032 SS=C | Primary/Alternate Means for Communication<br>CFR(s): 483.73(c)(3)<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least | E 032 | E032<br><br>1) No residents affected at time of survey<br>2) Potential for all residents to be affected.<br>3) The Policy and Procedure was updated to include all required information pertaining to primary/alternate communication including:<br>a) Federal, State, Local laws related to having a | 4/25/18 |

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| | | | primary and alternate means for communication with facility staff, federal, state, tribal, regional, and local emergency staff.<br>b) This information will be validated as needed and at a minimum of monthly for accuracy by the Administrator/designee.<br>4) The Administrator will provide updates to the Quality Assurance and Performance Improvement (QAPI) committee monthly on any emergency drills, exercises, policy changes, role changes, contact information changes, documentation and required after action items.<br>5) Date of compliance 4/25/18 | |

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| E 032 | Continued From page 4<br>annually.] The communication plan must include all of the following:<br><br>(3) Primary and alternate means for communicating with the following:<br>(i) [Facility] staff.<br>(ii) Federal, State, tribal, regional, and local emergency management agencies.<br><br>*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of emergency preparedness plan and staff interview, the facility staff failed to include in the plan communication with staff, Federal, State, Tribal, regional and local emergency agencies.<br><br>The findings include:<br><br>On 3/19/18 at 2:10 p.m. and interview was conducted with the Director of Long Term Care Project Administrator and the Clinical Analyst. During the interview with the aforementioned persons, the facility staff failed to provide documentation that the emergency preperedness communication plan included and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency agencies. | E 032 | | |
| E 039 SS=C | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to | E 039 | E039<br><br>1) No residents affected at time of survey<br>2) Potential for all residents to be affected.<br>3) The Emergency Preparedness policy and procedures were reviewed and updated to | 4/25/18 |

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| | | | include the review and documentation of the analysis of emergency preparedness exercises.<br>a) The planned current and future table top exercises (scheduled as required and needed) will be evaluated and documented to determine effectiveness of this policy & procedure in practice.<br>b) This information will be validated as needed and at a minimum of monthly for accuracy by the Administrator/designee.<br>4) The Administrator will provide updates to the Quality Assurance and Performance Improvement (QAPI) committee monthly on any emergency drills, exercises, policy changes, role changes, contact information changes, documentation and required after action items.<br>5) Date of compliance 4/25/18 | |

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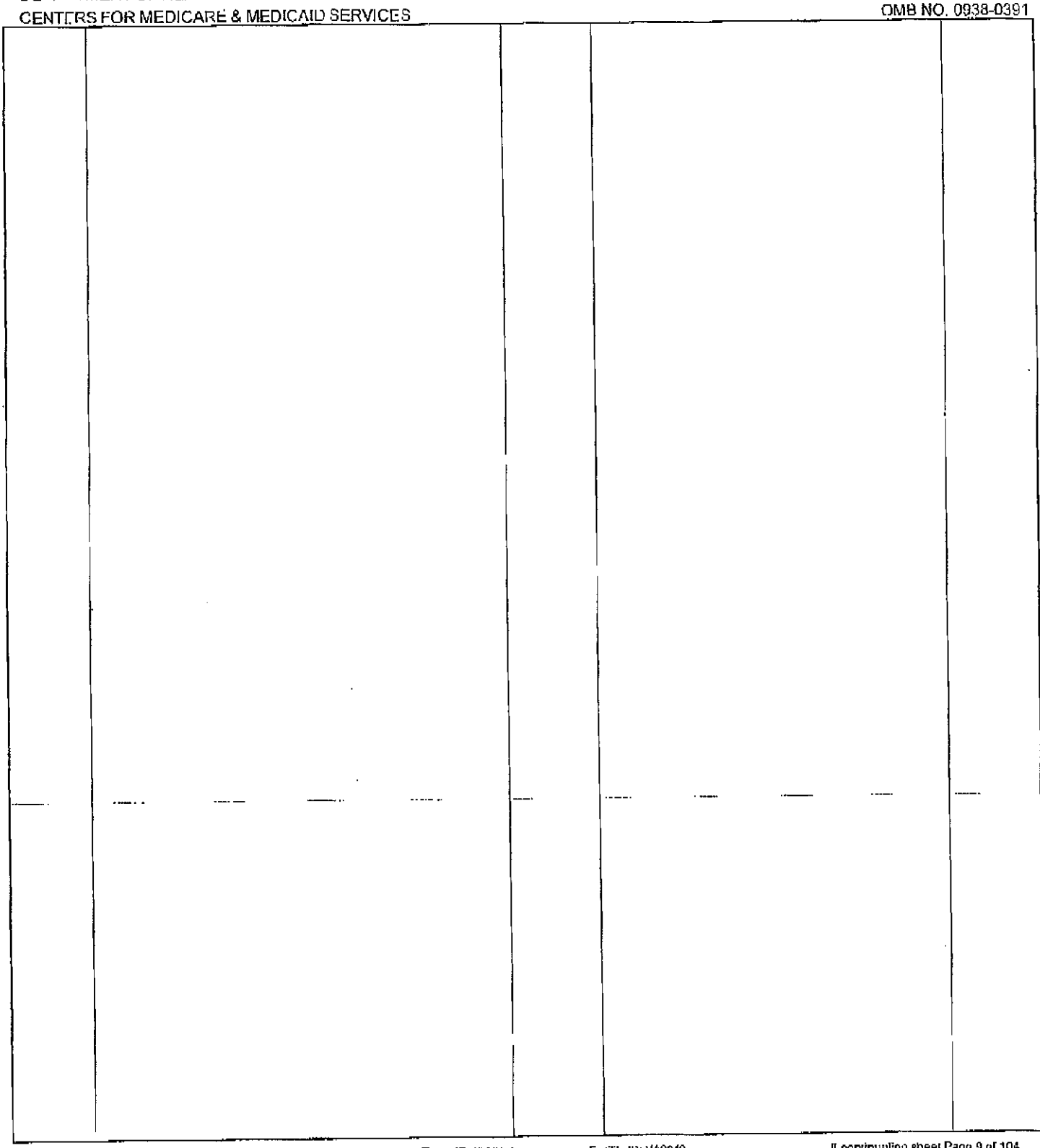

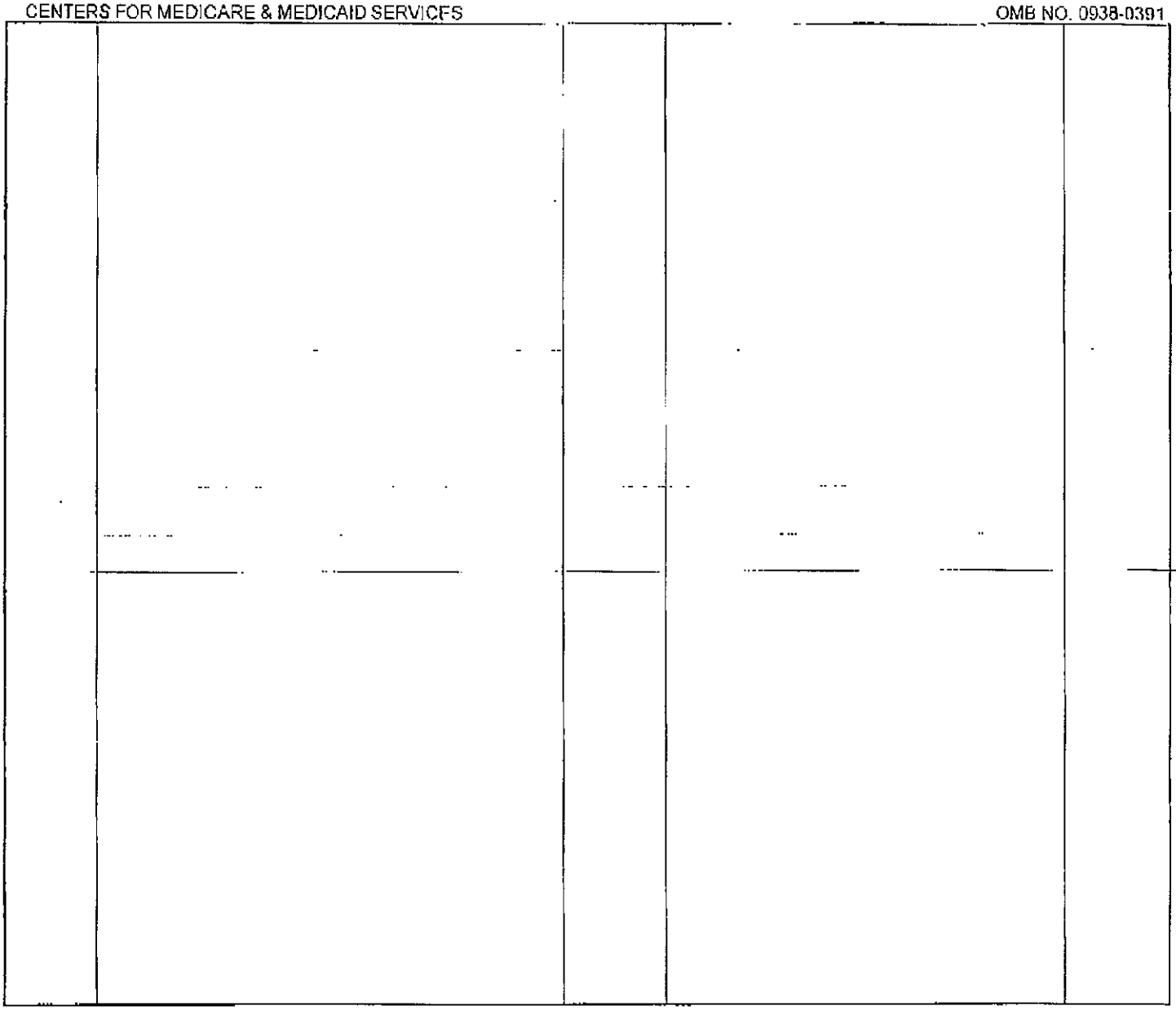

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| E 039 | Continued From page 5<br>test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:<br><br>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]<br><br>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based.<br>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>[iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] | E 039 | | |

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| E 039 | Continued From page 6<br>must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the [illegible]. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility's emergency preparedness plan and staff interview, the facility staff failed to ensure documentation and analysis of their emergency exercises.<br><br>The findings include:<br><br>On 3/19/18 at 2:10 p.m. and interview was conducted with the Director of Long Term Care Project Administrator and the Clinical Analyst. During the interview with the aforementioned persons, the facility staff failed to provide documentation of the facility's emergency preparedness program exercise analysis and response, and how the facility updated its emergency preparedness program based on the exercise analysis. | E 039 | | |
| E 042 SS=C | Integrated EP Program<br>CFR(s): 483.73(f)<br><br>(e) [or (f)]Integrated healthcare systems. If a | E 042 | | |

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| E 042 | Continued From page 7<br>[facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program.<br>If elected, the unified and integrated emergency preparedness program must [do all of the following:]<br><br>(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.<br><br>(2) Be developed and maintained in a manner that takes into account each separatelycertified facility's unique circumstances, patient populations, and services offered.<br><br>(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].<br><br>(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:<br><br>(i) A documented community-based risk assessment, utilizing an all-hazards approach.<br><br>(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards | E 042 | E042<br>1) No residents affected at time of survey<br>2) Potential for all residents to be affected.<br>3) A review and revision to the facilities practice of unified Emergency Preparedness was completed by the Maryview Administration team.<br>a) This review included documentation that the facility choice/option was to not participate in an integrated, unified EP program.<br>b) The Emergency Preparedness policy and procedures were reviewed and updated per current requirements.<br>c) The planned current and future table top exercise (scheduled or required and needed) will be evaluated and documented to determine effectiveness of current policy & procedure in practice.<br>d) This information will be validated as needed and at a minimum of monthly for accuracy by the Administrator/designee.<br>4) The Administrator will provide updates to the Quality Assurance and Performance Improvement (QAPI) committee monthly on any emergency drills, exercises, policy changes, role changes, contact information changes, documentation and required after action items.<br>5. Date of compliance 4/25/18 | 4/25/18 |

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| E 042 | Continued From page 8<br>approach.<br><br>(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of their emergency preparedness (EP) plan and staff interview, the facility staff failed to ensure documentation was in place on their unified and integrated EP program .<br><br>The finding include:<br><br>On 3/19/18 at 2:10 p.m. and interview was conducted with the Director of Long Term Care Project Administrator and the Clinical Analyst. During the interview with the aforementioned persons, the facility staff failed to provide evidence of the following components of their emergency preparedness plan (EP) within this requirement:<br><br>Documentation that the facility has or has not opted to be part of its healthcare system's unified and integrated EP program.<br><br>Documentation that the facility, within the healthcare system's unified and integrated EP system, was actively involved in the development of the unified EP program.<br><br>Documentation that the facility, within the healthcare system's unified and integrated EP system, was actively involved in the annual reviews of the program requirements and any | E 042 | | |

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| E 042 | Continued From page 9<br>program updates.<br><br>Evidence of the entire integrated and unified EP program and all required components (emergency plan, policies and procedures, communication plan, training and testing program). | E 042 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey and extended survey was conducted 03/12/18 through 03/19/18. Immediate Jeopardy was identified in the area of Quality of Care at a Scope Level 4, isolated which constituted Substandard Quality of care. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey.<br><br>The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 41 resident reviews; 35 current residents and 6 closed. | F 000 | | |
| F 553 SS=D | Right to Participate in Planning Care<br>CFR(s): 483.10(c)(2)(3)<br><br>§483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br>(ii) The right to participate in establishing the | F 553 | F553<br><br>1) 2 residents in resident sample, resident #10 and resident #75, were notified of his or her right to participate in the care planning process/meeting<br>2) Current and potential residents could be affected<br>3) A review and revision to the current process was initiated as follows:<br>a) The care plan invitations will be issued to each resident and/or representative. The resident will be invited to their care plan conference. The family/ responsible party will be | 4/25/18 |

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| | | | | invited according to the resident choice and/or residents choice or designee according to capacity.<br>b) Documentation of acceptance or declination will be documented on the invitation log maintained by the social service department or care plan designee.<br>c) Monthly audits will be completed by the Social Service department to review resident's invitation to care plan conference and documentation of invitation process.<br>4) The Social Service Director will provide a report to the Quality Assurance and Performance Improvement Committee (QAPI) monthly for a minimum of 6 months on the results and any action items of the Care Conference Invitation Audits.<br>5) Date of compliance 4/25/18 | |

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| F 553 | Continued From page 10<br>expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br>(iii) The right to be informed, in advance, of changes to the plan of care.<br>(iv) The right to receive the services and/or items included in the plan of care.<br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-<br>(i) Facilitate the inclusion of the resident and/or resident representative.<br>(ii) Include an assessment of the resident's strengths and needs.<br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to invite 2 of 41 residents in the survey sample, to attend their person centered care plan meeting (Resident #10 and #75).<br><br>The findings included:<br><br>f. Resident #10 was originally admitted to the facility on 08/05/13. Diagnosis for Resident #10 included but not limited to Heart Failure and Diabetes Mellitus.<br><br>The current Minimum Data Set (MDS), a quarterly | F 553 | | |

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| F 553 | Continued From page 11<br>assessment with an Assessment Reference Date (ARD) of 2/26/18 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #75 with total dependence of two with bathing, transfer, and personal hygiene, and total dependence of one with toilet, extensive assistance of two with bed mobility and dressing.<br><br>During the initial tour on 3/12/18 at approximately 3:19 p.m., an interview was conducted with Resident #75 who stated, "I never received a letter to attend a care plan meeting."<br><br>An interview was conducted with the Social Worker (SW) on 3/14/18 at approximately 1:45 p.m., who stated, "The receptionist issues out all the care plan letters to the residents and their representative."<br><br>An interview was conducted with the receptionist on 3/14/18 at approximately 2:00 p.m., who stated, "I gave the care plan letter to the resident's representative and not the resident."<br><br>On 3/14/18 at approximately 2:07 p.m., a second interview was conducted with the SW. The SW said moving forward the care plan invitation letter will include the date the resident was issued the [illegible] was mailed to the resident's representative but as of right now, we are unable to show that the resident was invited to attend her care plan meeting.<br><br>The above information was shared with Administration staff during a pre-exit meeting on | F 553 | | |

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| F 553 | Continued From page 12<br>[illegible] additional information<br>2. Resident #75 was admitted to the facility on 1/11/18. Diagnosis for Resident #75 included but not limited to Type II Diabetes and Hypertension .<br><br>The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 2/9/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #75 with extensive assistance of one transfers, bed mobility, dressing, toilet use, personal hygiene and bathing.<br><br>During the initial tour on 3/12/18 at approximately 2:11 p.m., an interview was conducted with Resident #75 who stated, "I have never been invited to attend a care plan meeting."<br><br>An interview was conducted with the Social Worker (SW) on 3/14/18 at approximately 1:45 p.m., who stated, "The receptionist issues out all the care plan letters to the residents and their representative."<br><br>An interview was conducted with the receptionist on 3/14/18 at approximately 2:00 p.m., who stated, "I gave the resident as well the resident's representative a copy of the care plan letter but I'm not able to provide documentation."<br><br>On 3/14/18 at approximately 2:07 p.m., a second interview was conducted with the SW. The SW said moving forward the care plan invitation letter will include the date the resident was issued the care plan letter and the date the care plan letter | F 553 | | |

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| F 553 | Continued From page 13<br>was mailed to the resident's representative but as of right now, we are unable to show that the resident was invited to attend their care plan meeting.<br><br>The above information was shared with Administration staff during a pre-exit meeting on 3/19/18 at 4:00 p.m. No additional information was provided.<br><br>The facility's policy: Patient Centered Care plan (Effective November 2017)<br>-Purpose: To provide necessary care planning that results in care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being consistent with the resident comprehensive assessment and plan of care and based on regulations as outlined in the 2016 Final Rule.<br><br>Procedure:<br>-The resident and/or resident's representative will be included in the care planning process. This will be accomplished through interactions with resident and/or resident's representative prior to final completion of the care plan. Social Services or designated IDT member will document in the resident's medical record if it is determined that a participation of the resident and/or resident' representative was not practicable or necessary for the development of the resident's care plan. | F 553 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident | F 580 | F580<br><br>1)Resident # 75's family and physician were notified of changes.<br>-Education regarding change in condition reporting on policy/practice was provided to staff identified #1 and #2.<br>2) Current residents could potentially be affected | 4/25/18 |

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| | | | by this practice.<br>3) a) Re-Education was provided on the change in condition process/policy and notifications. The re-education was provided for the following team members:<br>- Nurses, contracted nurses and new nursing staff during orientation<br>b) A revised process was initiated to occur in each morning clinical meeting. The process will include the following steps;<br>- Review of resident's reported changes in conditions by the clinical team for appropriate actions per policy.<br>-A log will be utilized by the unit managers to ensure that the appropriate actions have occurred as required per policy / time requirements.<br>c) The unit managers will provide the results of the tool to the DON daily if needed or weekly by report, for review of appropriate follow up and any further action needed.<br>4) The DON will report findings of the Change in Condition log/actions to the Quality Assurance and Performance Improvement committee monthly (QAPI) for a minimum of 3 months to ensure appropriate follow up and compliance.<br>5) Date of Compliance 4/25/18 | |

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| F 580 | Continued From page 14<br>representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement | F 580 | | |

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| F 580 | Continued From page 15<br>its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, and facility documentation review, the facility staff failed notify the physician and resident representative of an abuse allegation with injury for one (1) of 41 residents (Resident #75) in the survey sample.<br><br>The finding included:<br><br>Resident #75 was admitted to the facility on 1/11/18. Diagnosis for Resident #75 included but not limited to Type II Diabetes and Hypertension<br><br>The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 2/9/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #75 with extensive assistance of one transfers, bed mobility, dressing, toilet use, personal hygiene and bathing. The resident was coded to have verbal behaviors directed at others, and other behaviors directed at others, 4 to 6 days out of the 7-day assessment period. She was also coded for reject care 1 to 3 days out of the seven-day assessment period.<br><br>Resident #75's comprehensive care plan documented Resident #75 as having impaired Activities of Daily Living (ADL's) related to generalized weakness/debility. The goal: the | F 580 | | |

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| | resident will attain maximum level of functioning in ADL care needs. Some of the intervention/approaches to manage the goal included but not limited to extensive assistance of one with transfers, dressing and toilet use.<br><br>During the initial tour on 3/12/18 at approximately 2:07 p.m., an interview was conducted with Resident #75 who stated, "On the night shift a ~~Certified Nursing Assistant (CNA)~~ was being mean and abusive to me; I'm scared of her and don't trust her at night but she's gone now." The surveyor asked, "What do you mean by CNA was mean and abusive to you?" The resident replied, "The CNA took me to the bathroom, my leg got caught under the wheel chair, the CNA pushed the wheel chair hard hitting my hand causing a skin tear and bruising." The resident stated, "That is nothing but abuse and I reported her to the nurse." The surveyor observed a large bruise and skin tear to the top of Resident #75's right hand.<br><br>An interview was conducted with License Practical Nurse (LPN) #1 on 3/15/18 at approximately 2:50 p.m., who stated, "CNA #1 came to her and asked if she would come into Resident #75's room because she will not allow me to help her." The LPN went into Resident #75's room and asked, "What is wrong" the resident replied, "Last night (on 3/7/18), CNA #1 was taking me to the bathroom, hit my hand against the wall; that's abuse isn't it, she abused me." The LPN stated she reported the abuse allegation to the Registered Nurse (RN) #1 but only after, she returned to work on 3/9/18. The surveyor asked if she had notified the MD or resident's representative of the allegation of abuse, the LPN replied "No." | | |

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| F 580 | Continued From page 17<br>An interview was conducted with RN #1 on 3/15/18 at approximately 3:10 p.m. She said on 3/9/18 she was assisting Resident #75 to the bathroom and while getting her ready for bed when she observed a large foam dressing to the top of her right hand. When the nurse asked the resident what happened to her hand, she replied, "The CNA pushed me into the bathroom while in my wheel chair and hit my hand on the bathroom door." The nurse said she removed the dressing from the resident's right hand and observed her hand swollen with a gash (open area). The nurse said she cleaned the open area to residents hand with Dermal Wound Cleanser, applied Bacitracin ointment and covered it with a dressing. The RN stated, LPN #1 was working on another unit, she asked her if she know anything about the alleged abuse allegations between Resident #75 and CNA #1, the LPN said, "Yes". The surveyor asked RN#1, "When is an allegation of abuse reported" the RN replied, "Within 2 hours but no later than 24 hours." I should have reported the incident once I found out - I dropped the ball on that one." The survey asked when was the Administrator or Director of Nursing (DON) informed about the allegation of abuse; she replied, "I told the DON on the morning of 3/12/18. I informed her that I was doing an investigation on Resident #75 because the resident told me that CNA #1 abused her on 3/8/17." The surveyor asked if the physician or resident's representative was notified of the alleged allegation of abuse with injury. The RN stated, "The physician was not made aware until the request for an X-ray of resident right hand on 3/13/18 and the resident's representative wasn't notified until today. Doing the record review did not reveal that the Resident #75's representative was every notified." | F 580 | | |

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| F 580 | Continued From page 18<br><br>An X-ray was completed on 3/13/18 with negative<br>A phone interview conducted with CNA #2 on 3/16/18 at approximately 6:45 a.m., who stated, "I was orienting with CNA #1 but was helping Resident #75's roommate while CNA #1 was assisting Resident #75." The CNA stated she helped CNA #1 transfer Resident #75 from the bed to the wheelchair then proceeded to help the roommate get ready for bed while CNA #1 rolled Resident #75 into the bathroom. The CNA stated she pulled the curtain for privacy but did hear Resident #75 say that CNA #1 was hurting her foot and you did it on purpose. CNA#2 stated she did not hear CNA #1 say anything out of the way to Resident #75. CNA #2 also said that Resident #75 made the comment that CNA #1 was not going to take her to the bathroom until the nurse checked out her foot. CNA #2 said that CNA #1 left the room to get the nurse. The CNA stated she completed Resident #75's care by taking her to the bathroom, putting her to bed then got her get dressed for the morning.<br><br>On 3/16/18 at approximately 10:23 a.m., a phone interview was conducted with CNA #1 who said she worked the (7p/7a) shift on 3/7/18. The CNA stated she cared for Resident #75 starting at 7 p.m., with CNA #2 who I was training at that time. She said she and CNA #2 together went in Resident #75's room, they both transferred the resident from the bed to the wheel chair then I rolled Resident #75 into the bathroom. We passed the first towel rack as you enter the bathroom, the resident yelled out, you hurt me, you abused me. The CNA said she asked the resident, "What's wrong"; the resident said you | F 580 | | |

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| F 580 | Continued From page 19<br>hurt my foot. The CNA asked how did I hurt you, the resident replied, "You hurt me." The CNA said the trainee finished providing care for the resident that night. CNA #1 said, the next night I had Resident #75 all night but that morning, the resident stated, "You are not supposed to be taking care of me, I reported you." The CNA said she immediately left the room to go get LPN #1 [redacted]<br><br>The above information was shared with Administration during a pre-exit meeting on 3/19/18 at 4:00 p.m. No additional information was provided.<br><br>The facility's policy: Change in Condition (Effective January 2018)<br><br>Policy: Bon Secours Nursing Facilities shall promptly notify the resident, his or her Attending Physician, and Resident Representative of changes in the resident's medial/mental condition and /or status.<br><br>Procedure: The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-call Physician when there has been:<br>-An accident or incident involving the resident<br>-A discover of injuries of an unknown source<br><br>Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when:<br>-The resident is involved in any accident or incident that resulting in an injury including injuries of an unknown source. | F 580 | [redacted] | |

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| | §483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident | | 1) Resident #79 and resident #94 are no longer utilizing their Medicare Part A benefit<br>2) All residents that are currently utilizing their Medicare A benefit.<br>3) A Process/policy review was compleled by the Administrator, Business office and Social worker, with the revisod process to include the following steps:<br>a) ABN's (forms 10055 and 10123) will be provided per Federal guidelines 48 hours prior to discharge by the Social worker/designee in accordance with policy. The Resident or representative will be given infomation required to appeal stay.<br>b) The Social Worker will submit signed ABN notices to business office weekly as completed.<br>c) The Social Worker will conduct a weekly review of Medicare Part A residents impending discharge dates during morning meeting to ensure all residents requiring 10055 and 10123 have received them.<br>d) The Business office will submit a report monthly to QAPI for a minimum of 3 months to include all discharges with resident name, date of Medicare Part A discharge and date of forms (10055 and 10123) provided, as well as a summary of any findings.<br>5) Date of Compliance 4/25/18 | |

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| F 582 | Continued From page 21 | F 582 | | |

representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews, and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices were issued to 2 of 41 residents (Residents #75 and #94) in the survey sample.

The findings included:

1. Resident #75 was admitted to the nursing facility on 1/11/18 with a diagnosis of congestive heart failure (CHF), neuropathy and difficulty walking.

The Minimum Data Set (MDS) Admission assessment dated 1/17/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was intact in the skills needed for daily decision making.

On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #75 was not listed for

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| F 582 | Continued From page 22<br>having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were provided.<br><br>Resident #75 started a Medicare Part A stay on 1/11/18, and the last covered day of this stay was 2/15/18. Resident #75 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN(CMS-10055) and an NOMNC(CMS-10123). Resident #75 had only used 36 days of her Medicare Part A services. Only an NOMNC was issued, with verbal notification to the resident on 2/13/18.<br><br>2. Resident #94 was admitted to the nursing facility on 9/22/17 with a diagnosis of falling and post operative left hip fracture.<br><br>The Minimum Data Set (MDS) assessment dated 2/19/18 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the skills needed for daily decision making.<br><br>On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that Resident #94 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were | F 582 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495206 | A. BUILDING _____ B. WING _____ | C 03/19/2018 |

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| BON SECOURS-MARYVIEW NURSING C | 4775 BRIDGE ROAD SUFFOLK, VA 23435 |

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| F 582 | Continued From page 23<br>provided.<br><br>Resident #94 started a Medicare Part A stay on 9/23/17, and the last covered day of this stay was 11/22/17. Resident #94 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN(CMS-10055) and an NOMNC(CMS-10123). Resident #94 only used 61 days of his Medicare Part A services. Only an NOMNC was issued, with verbal notification to the resident on 11/20/17.<br><br>On 3/16/18 at 10:30 a.m., the facility Administrator and the social worker stated they were not aware of the issuance of a SNF ABN when Medicare Part A is discontinued by the provider. They only issued the NOMNC to the residents.<br><br>No additional information was provided prior to exit.<br><br>The facility's policy and procedures titled SNF Advanced Beneficiary Notice dated 2/2018 indicated a a skilled ABN of non-coverage form CMS-10055 is issued to SNFs to inform the resident or resident representative when Medicare Part A coverage is expected to be denied for service in order to give option to appeal the denial of coverage. | F 582 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records. | F 583 | F 583<br><br>1)The monitor was removed from identified room. Residents # 34 and #163 are discharged residents.<br>2)Residents residing in the facility could potentially be affected by this practice.<br>3)The review of policy and practices for | 4/25/18 |

resident privacy and confidentiality including camera/monitor use, was completed and revisions were made to the current practices.

a) Revisions to the current practice include:
-review request per policy prior to initiation of any device (camera, monitor, recording)
-obtain consents prior to use per policy
- any requests for use of such devices as cameras, recording or monitors will be reviewed by the Administrator and Risk Manager prior to implementation and according to policy.

4) The Administrator will report any requests for devices or requests that would impact residents privacy or confidentiality (such as recording or monitoring) to the Quality Assurance and Performance Improvement Committee (QAPI) monthly for a minimum of 6 months for review and policy compliance.

5) Date of Compliance 4/25/18.

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| F 583 | Continued From page 24<br><br>§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.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(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.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and resident interview, and the investigation of a Facility Reported Incident (FRI), The facility staff failed to ensure privacy and confidentiality was maintained for two residents (Resident #34 and #163) in the survey sample of 41 residents.<br><br>The findings included: | F 583 | | |

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| F 583 | Continued From page 25<br><br>1. Resident #163 was admitted to the facility on 2/7/18 with diagnoses which included quadriparesis due to severe spinal canal stenosis with advanced cord compression at C2-3 and C3-4. This resident had diagnoses of Cervical spine DJD and neck pain, prerenal azotemia, type 2 diabetes, hypertension, thrombocytopenia.<br><br>No Minimum Data Set information was available due to the resident's short stay in the facility.<br><br>During the investigation of a FRI dated 2/14/18 Resident #163's roommate complained of staff treating him roughly. The roommate stated to the nursing staff, "You are on camera." Resident #163 was discharged from the facility on 2/12/18.<br><br>During an interview on 3/16/18 at 2:15 P.M. with the Director of Nursing (DON) and the Administrator, the DON stated, she had purchased a Digital Video Baby Monitor and placed it in the room to apease Resident #163 who was complaining of staff ignoring him and not providing timely assistance.<br><br>The DON stated, she purchased the Video Baby Monitor because Resident #163 was not resting and was very anxious. According to the manufacturer guide lines, the Video Monitor was capable of having audio when the screen was off so nurses could monitor resident. The camera or viewing devices were given to nursing staff and placed on the nursing cart. The nurses would then be able to monitor Resident #163 at all times.<br><br>The DON and the Administrator were asked if Resident #163 or his Representative had given | F 583 | | |

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| F 583 | Continued From page 26<br>verbal or written consent for the use of the Digital Video Baby Monitor. They both stated, "No".<br><br>2. Resident #34 was admitted to the facility on 12/19/17. This resident was admitted with diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms, Type 2 Diabetes Mellitus, dependence on renal dialysis, chronic obstructive pulmonary disease, severe protein - calorie malnutrition, acute embolism and thrombosis, chronic kidney disease, and cognitive communication deficit.<br><br>An Initial Minimum Data Set (MDS) dated 1/12/18 assessed this resident in the area of Hearing, Speech and Vision as having no concerns. In the area of Cognitive Patterns this resident was assessed as having a Brief Interview for Mental Status (BIMS) as having a score of (13). In the area of Cognitive Patterns this resident was coded as having no concerns. In the area of Mood, this resident was coded as having no concerns. In the area of Behaviors this resident was coded as having no concerns.<br><br>Resident #34 was the roommate to Resident #163 during the time of his stay at the facility. During this time period a Digital Video Baby Monitor was placed in their room. During the investigation of a FRI submitted by the facility, Resident #34 complained to Nursing staff that he was being treated roughly by a CNA (Certified Nursing Assistant). During the facilities investigation a staff member references a "camera" being in the room in her written statement to the facility staff conducting the internal investigation. A written statement from the CNA during the FRI investigation indicated: Resident #34 stated "You are on camera, [and | F 583 | | |

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| F 583 | Continued From page 27<br>the CNA who was treating him roughly) was going to get it."<br><br>During an interview on 3/16/18 at 9:30 A.M. with Resident #34 he stated, he had spoken to his family about the rough treatment of one CNA. When asked about the camera being in the room and whether he gave verbal or written consent this resident stated, "No, I did not give consent for a camera to be in the room."<br><br>Policy: This policy is to define allowable purposes for obtaining film and digital photographs, video images or recordings and/or audio recordings of patients created using a camera or other device (defined collectively as Photography) within the agency standards for the creation, use and retention of the images.<br><br>Definition(S)<br>Audio Recording - For the purposes of this policy, "audio recording" refers to recording an individual's voice using video recording (e.g., video cameras, cellular telephones), tape recorders, wearable technology (e.g., Google Glass), or other technologies capable of capturing audio.<br><br>Consent - Written documentation of the patient's agreement to the photography process (e.g., admission consent, specialized consent, or documentation of verbal consent).<br><br>Personal Representative: The person authorized by law to act on behalf of the patient, such as the parent of a minor, a court -appointed guardian or a person appointed by the patient in a Power of Attorney Document. | F 583 | | |

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| F 583 | Continued From page 28<br>Photography: For the purposes of this policy, "photography" refers to recording an individual's likeness (e.g., image, picture) using photography (e.g., cameras, cellular telephones, tablets, wearable technology and other devices now or in the future that may be capable of retaining such images), video recording (e.g., video cameras, cellular telephones), digital imaging (e.g., digital cameras, web cameras), wearable technology (e.g., Google Glass), or other technologies capable of capturing an image (e.g., Skype). This does not include medical imaging including, but not limited to MRIs, CTs, laparoscopy equipment,etc. or images of specimens. | F 583 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. | F 609 | F 609<br>1)Residents #34 is a discharged resident, and Administrator has spoken with resident #75 to ensure that resident is comfortable with follow up actions and was reassured her well being/safety.<br>a) The facility completed late federal/state required reporting on these FRI(facility reported incidents) per regulatory requirements.<br>b) Facility completed internal investigation on resident # 75 and #34 with post incident follow up.<br>c) Facility completed education with caregiver #1<br>2) Those residents who reside in the facility could potentially be at risk.<br>3)<br>A) Education was provided to interdepartmental facility staff members and contracted nursing staff on the facility policy and practice regarding abuse.<br>Education to facility staff on this policy also included the following:<br>a) Education related to the facility requirements and timelines for investigating and reporting allegations of abuse and state and federal requirements and timeframes.<br>B) The abuse and Neglect process and required reporting/investigation timelines were also reviewed with Department managers, Clinical | 4/25/18 |

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| | | | Managers, Unit Managers and Leadership team.<br>C) A process review meeting occurred with the Don/Abuse Coordinator/Administrator to review the practice and timelines of reporting to appropriate agencies and appropriate required forms and time frame requirements.<br>4) The DON/Abuse Coordinator will provide a report to Quality Assurance and Performance Improvement (QAPI) monthly on Abuse/Neglect allegations, findings and compliance with policy on reporting and investigating.<br>5) Date of Compliance 4/25/18 | |

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| F 609 | Continued From page 29<br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, and review facility documentation, the facility staff failed to notify the State Survey Agency of an allegation of abuse in a timely manner for 2 of 41 residents (Resident #75 and 34) in survey sample.<br><br>1. The facility staff failed to report to the State Survey Agency an allegation of abuse involving Resident #75 within 24 hours of their knowledge of the incident.<br><br>2. 1. The facility staff failed to ensure the results of an investigation of alleged abuse involving Resident #34 was reported to the State Survey Agency within 5 days.<br><br>The finding include:<br><br>1. Resident #75 was admitted to the facility on 1/11/18. Diagnosis for Resident #75 included but not limited to Type II Diabetes and Hypertension .<br><br>The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 2/9/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #75 with extensive assistance of one transfers, | F 609 | | |

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| F 609 | Continued From page 30<br>bed mobility, dressing, toilet use, personal hygiene and bathing. The resident was coded to have verbal behaviors directed at others, and other behaviors directed at others, 4 to 6 days out of the 7-day assessment period. She was also coded for reject care 1 to 3 days out of the seven-day assessment period.<br><br>Resident #75's comprehensive care plan documented Resident #75 as having impaired Activities of Daily Living (ADL's) related to generalized weakness/debility. The goal: the resident will attain maximum level of functioning in ADL care needs. Some of the intervention/approaches to manage goal included but not limited to extensive assistance of one with transfers, dressing and toilet use.<br><br>During the initial tour on 3/12/18 at approximately 2:07 p.m., an interview was conducted with Resident #75 who stated, "On the night shift a Certified Nursing Assistant (CNA) was being mean and abusive to me; I'm scared of her and don't trust her at night but she's gone now." The surveyor asked, "What do you mean by the CNA was mean and abusive to you?" The resident replied, "The CNA took me to the bathroom, my leg got caught under the wheel chair, the CNA pushed the wheel chair hard hitting my hand causing a skin tear and bruising." The resident stated, "That is nothing but abuse and I reported her to the nurse." The surveyor observed a large bruise and skin tear to the top of Resident #75's right hand.<br><br>An interview was conducted with the Director of Nursing (DON) on 3/12/18 at approximately 3:05 p.m., who stated, "I was informed this morning by RN #1 who stated she was getting employee | F 609 | | |



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| F 609 | Continued From page 31<br>statements because Resident #75 accused CNA #1 of abusing her." The surveyor requested the facility reported incident indicating the State survey agency was informed of the abuse allegation.<br><br>A facility reported incident was faxed to the State survey agency on Monday 3/12/18 at 5:40 p.m., and indicated it was reported to the Director of Nursing (DON) on 3/12/18 an allegation of abuse. The facility reported incident revealed Resident #75 indicated on 3/8/18 on the night shift a Certified Nursing Assistant (CNA) pushed her into the bathroom using her wheelchair, her right hand was bumped on the doorjamb causing an open area with bruising to her right hand near base of her middle finger. The final report with the outcome of the investigation dated 3/16/18 indicated CNA #1 was terminated from employment for not following the care practices that are the standard of (Healthcare System).<br><br>An interview was conducted with License Practical Nurse (LPN) #1 on 3/15/18 at approximately 2:50 p.m., who stated, "CNA #1 came to her and asked if she could come into Resident #75's room because she would not allow me to help her." The LPN went into Resident #75's room and asked, "What is wrong" the Resident replied, "Last night on 3/7/18, CNA #1 was taking me to the bathroom, hit my hand against the wall; that's abuse isn't it, she abused me." The LPN stated she reported the abuse allegation to the RN #1 but only after she returned to work on 3/9/18. The surveyor asked the LPN, "When do you report an allegation of abuse" she replied, "Right away."<br><br>An interview was conducted with RN #1 on | F 609 | | |

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| F 609 | Continued From page 32<br>3/15/18 at approximately 3:10 p.m. She said on 3/9/18 she was assisting Resident #75 to the bathroom and while getting her ready for bed when she observed a large foam dressing to the top of her right hand. The nurse asked the resident what happened to her hand, she replied, "The CNA pushed me into the bathroom while in my wheel chair and hit my hand on the bathroom door." The nurse said she removed the dressing from the resident's right hand and observed her hand swollen with a gash (open area). The nurse said she cleaned the open area to residents hand with Dermal Wound Cleanser, applied Bacitracin ointment and covered it with a dressing. The RN stated, LPN #1 was working on another unit. She asked her if she know anything about the alleged abuse allegations between Resident #75 and CNA #1 and the LPN said, "Yes". The surveyor asked RN#1, "When is an allegation of abuse reported?" The RN replied, "Within 2 hours but no later than 24 hours." I should have reported the incident once I found out - I dropped the ball on that one." The surveyor asked when did you inform the Administrator or Director of Nursing (DON) about the allegation of abuse? She replied, "I told the DON on the morning of 3/12/18. I informed her that I was doing an investigation on Resident #75 because the resident told me that CNA #1 abused her on 3/8/17."<br><br>On 03/16/18 at approximately 8:55 a.m., an interview was conducted with the Administrator and DON who stated, "We were told by our Cooperate Nurse that we should not send the final report to the state office until they get the final report from Adult Protection Services." The surveyor requested the APS report, the Administrator stated, "We still do not have the | F 609 | | |

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| F 609 | Continued From page 33<br>final report." The Administrator and DON both stated, "They know now they must send their completed investigation even if they do not have the final report for APS." The DON stated, "The incident should have been reported with 2 hours after the incident occurred."<br><br>The above information was shared with Administration during a pre-exit meeting on 3/19/18 at 4:00 p.m. No additional information was provided.<br><br>2. Resident #34 was admitted to the facility on 12/19/17. This resident was admitted with diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms, Type 2 Diabetes Mellitus, dependence on renal dialysis, chronic obstructive pulmonary disease, severe protein - calorie malnutrition, acute embolism and thrombosis, chronic kidney disease, and cognitive communication deficit.<br><br>An Initial Minimum Data Set (MDS) dated 1/12/18 assessed this resident in the area of Hearing, Speech and Vision as having no concerns. In the area of Cognitive Patterns this resident was assessed as having a Brief Interview for Mental Status (BIMS) as having a score of (13). In the area of Cognitive Patterns this resident was coded as having no concerns. In the area of Mood, this resident was coded as having no concerns. In the area of Behaviors this resident was coded as having no concerns.<br><br>Resident #34 made an allegation of abuse concerning a staff (CNA) certified nursing assistant was treating him roughly.<br><br>A review of the Facility Reported Incident (FRI) | F 609 | | |

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| | 495206 | A. BUILDING _____ B. WING _____ | C 03/19/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BON SECOURS-MARYVIEW NURSING C | 4775 BRIDGE ROAD SUFFOLK, VA 23435 |

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| F 609 | Continued From page 34<br>dated 2/14/18 indicated the following:<br><br>Resident Involved: Resident #34.<br><br>Injuries: None apparent<br>Incident Type: Physical Abuse<br>Name of employee (s) involved:<br>Employee action initiated or taken: Sent home pending investigation<br>Date notification provided to:<br>Responsible Party 2/14/18<br>Physician 2/14/18<br>APS 2/14/18<br>DHP 2/14/18<br>Ombudsman 2/14/18<br>Facility Internal investigation 2/14/18<br>Will completed report forward to (State Agency) 2/20/14 (sic).<br>Name and Title of reporting person: Director of Nursing<br><br>Summary: 87 year old gentleman admitted to facility on 12/19/17. Is alert, pleasant and cooperative, family is attentive. Primary diagnoses are perforated intestine, DM, BPH, ESKD, weakness, CKD, ARD, Dysphagia, Cognitive communication deficit.<br>Incident: At approx. 10:30 A.M. resident stated to his family that CNA was very rough with him when rolling him over as he was not turning himself fast enough and CNA was noted to have pushed resident over roughly which caused resident resident to complain of right hip pain after encounter. Family reported to Nurse Manager the concern, CNA was sent home pending further investigation.<br><br>During an interview on 3/16/18 at 2:15 P.M. with the Director of Nursing (DON) and the | F 609 | | |

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| F 609 | Continued From page 35<br>Administrator, they were asked if the Facility Reported Incident (FRI) had been investigated and results reported to the State Agency. The Administrator stated, the investigation had not been completed. She was waiting on the final investigative report from Adult Protective Services (APS).<br><br>The facility's policy: Abuse Prohibition (Effective 10/23/17).<br><br>-Each resident has the right to be free from abuse, neglect, exploitation; verbal, sexual, physical, mental, corporal punishment and involuntary seclusion.<br><br>-Report Time/Response: Allegations of abuse, neglect, or exploitation are to be reported to the Administrator of the facility immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not involve abuse and do not result in serous bodily injury.<br><br>-All allegations of abuse, neglect, injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator, the State Survey Agency, local abuse agency and to other officials in accordance with state law, by the Abuse Coordinator or designee.<br><br>-If the resident sustains serious bodily injury, the reports must be made within 2 hours of the event. If there is no serious bodily injury, the reports must be filed within 24 hours of the event. | F 609 | | |

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| F 609 | Continued From page 36<br>-In accordance with Section 1150B of the Social Act (the Elder Justice Act), if there is reasonable suspicion of a crime, a report must be made to the state survey agency and to one or more local law enforcement entities.<br><br>-The results of all investigations will be report to the Administrator or designee and to the State Survey Agency within 5 days of the incident. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation<br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, and staff interviews the facility staff failed complete a thorough investigation of a Facility Reported Incident (FRI) for 1 resident (Resident #34) in the survey sample of 41 residents. | F 610 | F 610<br><br>1)Resident #34 is a discharged resident.<br>- The facility did complete a late federal/state required reporting on the FRI (facility reported incidents) per regulatory requirements.<br>-Facility completed a late internal investigation on resident # 34 with post incident follow up.<br>2) Those residents who reside in the facility could potentially be at risk.<br>3)<br>A) A process review meeting occurred with the Don/Abuse Coordinator/Administrator to review the practice and timelines of investigating and reporting to appropriate agencies and appropriate required forms and requirements. This also included the following:<br>-The DON/Abuse Coordinator will report as required all allegations of abuse to the Administrator and appropriate agencies within the time frame requirement of immediate/2 hours/24-hour time frame.<br>- The process of internal investigation, documentation and the follow up of findings/conclusion.<br>4) The DON/Abuse Coordinator will provide a report to Quality Assurance and Performance Improvement (QAPI) monthly on Abuse/Neglect allegations, investigation completions, conclusion findings in regards to compliance with policy on reporting and investigating.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| F 610 | Continued From page 37<br>The findings included:<br><br>Resident #34 was admitted to the facility on 12/19/17. This resident was admitted with diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms,. Type 2 Diabetes Mellitus, dependence on renal dialysis, chronic obstructive pulmonary disease, severe protein - calorie malnutrition, acute embolism and thrombosis, chronic kidney disease, and cognitive communication deficit.<br><br>An Initial Minimum Data Set (MDS) dated 1/12/18 assessed this resident in the area of Hearing, Speech and Vision as having no concerns. In the area of Cognitive Patterns this resident was assessed as having a Brief Interview for Mental Status (BIMS) as having a score of (13). In the area of Cognitive Patterns this resident was coded as having no concerns. In the area of Mood, this resident was coded as having no concerns. In the area of Behaviors this resident was coded as having no concerns.<br><br>Resident #34 made an allegation of abuse concerning a staff (CNA) certified nursing assistant was treating him roughly.<br><br>A review of the Facility Reported Incident (FRI) dated 2/14/18 indicated the following:<br><br>Resident Involved: Resident #34.<br><br>Injuries: None apparent<br>Incident Type: Physical Abuse<br>Name of employee (s) involved:<br>Employee action initiated or taken: Sent home pending investigation<br>Date notification provided to: | F 610 | | |

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| F 610 | Continued From page 38<br>Responsible Party 2/14/18<br>Physician 2/14/18<br>APS 2/14/18<br>DHP 2/14/18<br>Ombudsman 2/14/18<br>Facility Internal investigation 2/14/18<br>Will completed report forward to VDH/OLC 2/20/14 (sic).<br>Name and Title of reporting person: Director of Nursing<br><br>Summary: 87 year old gentleman admitted to facility on 12/19/17. Is alert, pleasant and cooperative, family is attentive. Primary diagnoses are perforated intestine, DM, BPH, ESKD, weakness, CKD, ARD, Dysphagia, Cognitive communication deficit.<br>Incident: At approx. 10:30 A.M. resident stated to his family that CNA was very rough with him when rolling him over as he was not turning himself fast enough and CNA was noted to have pushed resident over roughly which caused resident resident to complain of right hip pain after encounter. Family reported to Nurse Manager the concern, CNA was sent home pending further investigation.<br><br>During an interview on 3/16/18 at 2:15 P.M. with the Director of Nursing (DON) and the Administrator, they were asked if the Facility Reported Incident (FRI) had been investigated and results reported to the State Agency. The Administrator stated, the investigation had not been completed. She was waiting on the final investigative report from Adult Protective Services (APS). | F 610 | | |
| F 625 SS=D | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2) | F 625 | | |

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| F 625 | Continued From page 39<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed send a copy of the Bed-Hold Policy for 1 of 41 residents in the survey sample (Resident #109).<br><br>The facility staff failed to provide Resident #109 or the resident's representative, with a written or a | F 625 | F 625<br><br>1)Resident#109 is a discharged resident<br>2) Those residents admitted or transferred to the facility could potentially be at risk related to this practice.<br>3) The Policy and Practice of Bed Hold was reviewed, and the practice was revised.<br>a) An audit was conducted on current residents to review if bed hold agreement is in place from admission paperwork<br>b) The Transfer packets for residents transferring outside the facility will include the current bed hold policy/paperwork.<br>c)An audit will be conducted monthly by the admission Nurse to assure that each resident has been provided the bed hold policy on admission.<br>d)The Business office will review each morning at am clinical meeting if a resident has received and if they have chosen to utilize a bed hold.<br>e) A report will be provided monthly from the Admission nurse and the Business office to the Administrator on the Bed holds status and compliance.<br>4) The Administrator will report to Quality Assurance and Performance Improvement Committee (QAPI) monthly for 6 months the findings on the bed hold audits and the process to ensure ongoing follow up and compliance with the bed hold policy.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| F 625 | Continued From page 40<br>copy of the bed hold policy after being transferred to the hospital on 1/20/18.<br><br>The finding include:<br><br>Resident #109 was originally admitted to the facility on 06/29/11. Diagnosis for Resident #10 included but not limited to Heart Failure and Seizures.<br><br>The current Minimum Data Set (MDS), a comprehensive assessment with an Assessment Reference Date (ARD) of 02/26/18 coded the resident with a 02 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. In addition, the MDS coded Resident #109 with total dependence of with eating and bathing, extensive assistance of two with bed mobility and toilet use, extensive assistance of one with dressing and personal hygiene.<br><br>The clinical note revealed the following: on 1/20/18, Resident #109 was observed breathing rapidly and using accessory muscle. The resident's vital signs were: (BP 131/78), (P-128), (R-28) with oxygen saturation at 85% on room air and (T-97.5). The resident was started on oxygen at 2 liters. The physician was notified of change in condition with an order to send out to the Emergency Room (ER) for evaluation and treatment. Resident #109 was admitted to the hospital with a diagnosis of hypoxia. The resident was readmitted to the facility on 1/29/18.<br><br>On 03/15/18 at approximately 2:55 p.m., a request was made to the Administrator for evidence that the facility provided written information of the Notice of Bed-Hold Policy to | F 625 | | |

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| F 625 | Continued From page 41<br>the resident or resident representative prior to or after being transferred to the hospital.<br><br>An interview was conducted with the Administrator on 3/15/18 at approximately at 1:35 p.m., who stated, "We could not find evidence that Resident #109 or his family member were ever informed of the facility's bed hold policy."<br><br>On 3/15/18 at approximately at 1:50 p.m., an interview was conducted with Admission who stated, "I did not contact the family related to the bed hold policy because the family came into the building and pick up his personal belongings."<br><br>The above information was shared with the Director of Nursing during a pre-exit meeting on 3/19/18 at 4:00 p.m. No additional information was provided.<br><br>The facility's policy: Virginia Bed Hold Policy (Effective 12/22/17).<br>Policy: (Healthycare System) located in (State) (hereafter called "Facility") shall provide a written information to the resident and his/her family member or legal representative about the bed hold policy upon admission to the Facility, and a second notice will be provided at the time a resident is transferred to the hospital or goes on a therapeutic leave.<br><br>-In the care of an emergency transfer, the resident's representative/family shall be provided with written notice within 24 hours after the transfer. This requirement is met if the resident's copy of the Bed Hold notice is sent with the other papers accompanying the resident to the hospital.<br><br>The written notice shall include the following | F 625 | | |

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| F 625 | Continued From page 42<br>information:<br>-The duration of the state (Medicaid) bed hold policy<br>-The facility's policies regarding bed hold periods permitting a resident to return. | F 625 | | |
| F 655 SS=E | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). | F 655 | F 655<br>1. Residents #25,64,213,96,103,51,57 were offered the opportunity to review their current care plan and progress since admission.<br>-Education and policy requirement provided to identified team members: #4,#5,#2, DON, MDS<br>2. Those residents residing in the facility could potentially be at risk for this practice.<br>3.<br>A)The current practice was reviewed and modified to include:<br>-Baseline care plans will be offered to resident or representative during the interdisciplinary meeting and according the required timeline requirement.<br>-The Signature page will be maintained as a record of the baseline care plans being offered and accepted or refused.<br>B) The MDS Coordinator will audit newly admitted residents and compile a log. The log will indicate that a baseline care plan was offered and documented to new residents per required timeline. This log will be provided to the DON Monthly.<br>4) The DON will report to Quality Assurance and Performance Improvement Committee (QAPI) monthly for 3 months the finding of the baseline care plan audit and any follow up actions items to maintain compliance with the baseline care plan policy.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| F 655 | Continued From page 43<br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, resident interview, and staff interview, the facility failed to provide baseline care plan summaries to the resident or the resident's resprosentative; and failed to document in the medical record that summaries were provided for 7 of 41 residents in the survey sample (Residents #25, #64, #213, #96, #103, #51, and #57).<br><br>The findings included:<br><br>1. Resident #25 was admitted to the facility on 1/8/18. Diagnoses for Resident #25 included but were not limited to COPD (Chronic Obstructive Pulmonary Disease.<br><br>Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of scored Resident #5 with a score of 15 out of a possible 15 BIMS (Brief Interview for Mental Status) indicating no cognitive impairment. The Resident required two staff person assistance with bed mobility and required one staff person assistance with transfers, locomotion on unit, dressing, toilet use and personal hygiene. | F 655 | | |

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| F 655 | Continued From page 44<br><br>The Comprehensive Person Centered Care Plan revised on 10/27/17 identified a focus area of oxygen therapy related to COPD. The goal was to have no signs/symptoms of poor oxygen absorption through the review date. Two interventions included oxygen via nasal canula 2 Liters continuously and oxygen supplies and tubing changes/cleaning per facility protocol.<br><br>Review of the Resident's clinical record did not indicate that a baseline summary care plan was provided to the Resident.<br><br>Resident #25 on 3/14/18 at approximately 2 PM stated that he did not recall receiving a summary baseline careplan.<br><br>The Facility's Director of Nursing stated on 3/16/18 at approximately 2:30 PM that Residents were not given baseline careplan summaries. She stated that residents were given a copy of their baseline careplans.<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.<br><br>2. Resident #64 was admitted to the facility on 1/22/18. Diagnoses for Resident #64 included but are not limited to Unspecified fracture of right femur.<br><br>Resident #64's 14 day Minimum Data Set (MDS) with an Assessment Reference Date of 2/5/18 scored Resident #64 with a 2 out of a possible 15 BIMS score indicating impaired cognition. | F 655 | | |

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| F 655 | Continued From page 45<br>Review of the Resident's clinical record did not indicate that a baseline summary care plan was provided to the Resident.<br><br>Resident #64 on 3/14/18 at approximately 1:45 PM was not able to respond when asked if she received a summary baseline careplan.<br><br>The Facility's Director of Nursing stated on ~~3/16/18~~ at approximately ~~2:30~~ PM that ~~Residents~~ were not given baseline careplan summaries. She stated that residents were given a copy of their baseline careplans.<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.<br>3. Resident #213 was a 69 year old admitted to the facility on 2/16/18 with diagnoses to include (1) Right Fibula Fracture, (2) Diabetes Mellitus, and (3) Hypertension.<br><br>The most recent comprehensive Minimum Data Set (MDS) assessment was a 5 Day Admission with an Assessment Reference Date (ARD) of 2/23/18. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #213 was cognitively intact and capable of daily decision making.<br><br>On 03/12/18 at 12:40 PM during the initial facility tour the resident informed this surveyor that she was a new admission here for rehab because of a fractured ankle. The resident asked if she was provided a 48 baseline care plan summary that was reviewed with her by the facility. Resident #213 stated, "No, I wasn't given anything like that and no plan was reviewed with me." | F 655 | | |

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| F 655 | Continued From page 46 | F 655 | | |

Resident #213's Baseline Care Plan was reviewed and indicated that it had been initiated on 2/18/18.

On 2/15/18 at 2:00 p.m. an interview was conducted with both MDS Coordinators Licensed Practical Nurse (LPN) #4, Licensed Practical Nurse (LPN) #5, and the Infection Control Nurse Registered Nurse (RN) #5. This group was asked who was responsible for doing the 48 hour baseline care plan and summary with the residents. Infection Control Nurse Registered Nurse #5 stated, "I do the 48 hour baseline care plan but we have not been doing the baseline summary and we have no documentation in the medical record to show what we were doing." LPN #5 stated, "No, we didn't do the summaries but we gave them a copy of the initial care plan and a copy of the physician orders. We should have given the patient a 48 hour baseline care plan summary in layman's terms and have documented in the medical record."

On 3/19/18 at 3:55 p.m. a pre-exit conference was held with the Director of Nursing and RN #2 were the above information was shared. No further information was provide by the facility.
4. Resident #96 was admitted to the facility on 2/10/18, diagnoses include but are not limited to pneumonia, cognitive communication deficit, Vitamin B deficiency anemia, gout, atrial flutter, and primary hypertension.

An initial Minimum Data Set (MDS) assessment for resident #96 was completed on 3/7/18 which assessed the resident in the area of Cognitive patterns with a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately

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| F 655 | Continued From page 47<br>impaired cognition. Activities of Daily Living (ADL) section indicated resident #96 needed limited assistance with self-performance and support of one staff member provided for bed mobility, transfers, locomotion on the unit, and toilet use.<br><br>Physician orders include: LCS, NAS diet, Glucerna Shake two times a day, Full Code status, F/U with Cardiovascular doctor for pacemaker check, Floor mat while in bed, licensed nurse rounding, may participate in restorative nursing program, non-pharmacological, pain management, OT/PT/ST evaluate and treat, skin care per MNCC protocol, vital signs every shift for HTN, and weekly skin assessment on Monday7a - 7p.<br><br>An interview on 3/12/18 12:15PM with resident #96 determined there had been no summary of her care plan given within 48 hours to or reviewed with either the resident or her representative.<br><br>5. Resident #103 was admitted to the facility on 2/21/18, diagnoses include but are not limited to acute on chronic right heart failure, anemia, diabetes type II, hyperlipidemia, dementia-unspecified, obstructive sleep apnea, primary hypertension, and atrial fibrillation.<br><br>An Admission Minimum Data Set (MDS) assessment was completed on 3/2/18 for the resident. In the area of Cognitive patterns with a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. Activities of Daily Living (ADL) section indicated resident #103 needed extensive assistance with self-performance in bed mobility, transfers, dressing, toilet use, and personal hygiene and support of two staff member provided. | F 655 | | |

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| F 655 | Continued From page 48<br><br>Resident #103 Physician orders include: Diet NAS regular texture, fluid restriction 1800ml per day, Full Code CPR, May have C-Pap machine from home at home settings at bedtime for sleep apnea. Please apply O2 to C-Pap machine at night (3/9/18), PT & OT to evaluate and treat as indicated, turn and reposition Q2hrs while in bed or chair documented q shift, weekly skin assessment Thursday 7a - 7p.<br><br>An interview on 3/13/18 at 3:13PM with resident #103 determined there had been no summary of his care plan given within 48 hours to ur reviewed with either the resident or his representative.<br>6. Resident #51 was admitted to the nursing facility on 1/17/18 with diagnoses that included acute kidney failure on dialysis, high blood pressure and gastroesophageal reflux disease (GERD.<br><br>The most recent Minimum Data Set (MDS) assessment dated 2/7/18 assessed the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible 15 which indicated the resident was fully intact with cognitive skills for daily decision making.<br><br>Resident #51 had a care plan developed within 48 hours (1/18/18) that included the minimum healthcare information necessary to properly provide care:<br>-Initial goals based on admission orders<br>-Physician orders<br>-Dietary orders<br>-Therapy services<br>-social services<br><br>During an interview with the resident on 3/16/18 | F 655 | | |

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| F 655 | Continued From page 49<br>at 9:30 a.m., he stated he was not issued a copy of his care plan nor a summary of the baseline care plan that included the aforementioned requirements of the 48 hour care plan.<br><br>An interview was conducted with the Administrator on 3/15/18 at approximately 6:15 p.m., who stated "We did not have a real understanding that a baseline summary report needed to be done and reviewed the resident." the surveyor asked, "Who are you referring to as we" she replied, "Our MDS Coordinators, let me get them so they can explain."<br><br>On 3/15/18 at approximately 6:30 p.m., an interview was conducted with the Infection Control Nurse, MDS Coordinator #1 and MDS Coordinator #2, the Infection Control Nurse stated, "We didn't know anything about the baseline care plan summary." The resident's base line care plan was completed within 48 hours in Point Click Care and then updated later by MDS Coordinator with resident's goals. The MDS Coordinator #1 stated, "The process is to give the initial baseline care plan with the medication review to the resident if appropriate or Resident Representative (RR)." The surveyor asked for documentation that the baseline care plan was reviewed with the resident or RR, MDS Coordinator #1 stated, "We do not have any documentation showing to the care plan ever being reviewed with the resident or representative." The surveyor asked if a baseline summary should have been reviewed with the resident or RR, she replied, the MDS Coordinator replied, "Yes."<br><br>The above information was shared with the Director of Nursing and the Unit Manager on the | F 655 | | |

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| F 655 | Continued From page 50<br>Chesapeake Unit during a pre-exit meeting on 3/19/18 at 4:00 p.m. No additional information was provided.<br><br>7. Resident #57 was admitted to the facility on 01/30/18. Diagnosis for Resident #57 included but not limited to Cardiovascular Accident (CVA) and Muscle Weakness.<br><br>The current Minimum Data Set (MDS), a comprehensive assessment with an Assessment Reference Date (ARD) of 2/9/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #57 with total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene and limited assistance of one with eating.<br><br>An interview was conducted with the Administrator on 3/15/18 at approximately 6:15 p.m., who stated "We did not have a real understanding that a baseline summary report needed to be done and reviewed the resident." The surveyor asked, "Who are you referring to as we" she replied, "Our MDS Coordinators, let me get them so they can explain."<br><br>On 3/15/18 at approximately 6:30 p.m., an interview was conducted with the Infection Control Nurse, MDS Coordinator #1 and MDS Coordinator #2, the Infection Control Nurse stated, "We didn't know anything about the baseline care plan summary." The resident's base line care plan was completed within 48 hours in Point Click Care and then updated later by MDS Coordinator with resident's goals. The | F 655 | | |

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| F 655 | Continued From page 51<br>MDS Coordinator #1 stated, "The process is to give the initial baseline care plan with the medication review to the resident if appropriate or Resident Representative (RR)." The surveyor asked for documentation that the baseline care plan was reviewed with the resident or RR, MDS Coordinator #1 stated, "We do not have any documentation showing to the care plan ever being reviewed with the resident or representative." The surveyor asked if a baseline summary should have been reviewed with the resident or RR, she replied, the MDS Coordinator replied, "Yes."<br><br>The above information was shared with the Director of Nursing and the Unit Manager on the Chesapeake Unit during a pre-exit meeting on 3/19/18 at 4:00 p.m. No additional information was provided.<br><br>The Facility Policy: Patient Centered Care Plan (Effective November 2017).<br><br>Purpose: To provide necessary care planning that results in care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being consistent with the resident comprehensive assessment and plan of care and based on regulations as outlines in the 2016 Final Rule.<br><br>-Procedure:<br>A comprehensive care plan will be established in place of the baseline care plan if it is developed within 48 hours of the resident's admission.<br><br>-A summary of the baseline care plan will be provided to the resident and/or representative per guidelines. The summary will include, but is not | F 655 | | |

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| F 655 | Continued From page 52<br>limited to the initial goals for the resident, medications, dietary instructions and any services and treatments to be administered. The summary will also include any update information based on changes made to the comprehensive care plan, as necessary. | F 655 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to–<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by: | F 657 | F 657<br>1) Resident # 34 is a discharged resident. Resident #263's care plan has been reviewed and revised as needed.<br>2) Those residents who reside in the facility with individual needs that require their care plans to be reviewed and revised could potentially be affected by this practice.<br>3) Process review and revisions include the following:<br>a) An Enhanced process has been initiated at the am clinical meeting that will include those items that are reported and need care plan updates or revisions will be updated by mds or unit managers at this meeting.<br>b) The required need for update that is identified outside the am meeting will be directed to the mds/unit manager for ongoing update in between assessments.<br>c) A monthly random audit will occur for care plans and appropriate updates by the unit manager and will be provided to the DON monthly.<br><br>4) The DON will report audit findings and care plan compliance to Quality Assurance and Performance Improvement Committee (QAPI) monthly for 3 months to ensure compliance with care plan update process/policy.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| F 657 | Continued From page 53<br>Based on observation, resident interviews, staff interviews, facility documentation review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 41 residents in the survey sample (Residents #263 and #34).<br><br>The facility failed to include painful thickened toenails on the care plan for Resident # 263.<br><br>The findings included:<br><br>Resident #263 was admitted to the facility on 11/15/17. Diagnoses for Resident #263 included but are not limited to Chronic Pain Syndrome, Anxiety and Mycotic Toenails.<br><br>Resident #263's Significant Change Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/22/18 scored Resident #263 with a BIMS (Brief Interview for Mental Status) score of 15 of a possible 15 indicating no cognitive impairment. The Resident was dependent on one staff person for dressing , toilet use, and hygiene needs.<br><br>The Comprehensive Person Centered Care Plan last revised 1/29/18 did not include a focus area of thickened, long, painful toenails.<br><br>Review of the Resident's Clinical Record last documented a Podiatrist visit on 5/10/17. A Podiatry note dated 3/19/18 documented the following:<br><br>Reason for Consultation: "Mycotic Toenails" The Podiatry note documented under Plan: "Debrided 10 nails." | F 657 | | |

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| F 657 | Continued From page 54<br>The website (https://oig.hhs.gov/oei/reports/oei-04-99-00460.pdf) documented the following:<br><br>Nail debridement involves removal of a diseased toenail bed or viable nail plate. This may be performed manually with an instrument, or with an electric grinder. Podiatrists generally provide nail debridement to patients diagnosed with onychomycosis (i.e., mycosis or mycotic toenails).<br><br>The Director of Nursing (DON) stated on 3/13/18 at approximately 3:45 PM that the facility was currently without a Podiatrist to make visits in the facility. The facility was not able to state the last date a Podiatrist made visits in the Facility. When the DON was asked why the facility could not assist the Resident to make an outside Community Podiatrist, the DON stated, that they facility could assist the Resident with making an appointment and had reached out to the daughter and had been unsuccessful.<br><br>On 3/19/18 at approximately 1:30 PM, Resident #263 stated that she had just come from the Podiatrist where she had her toenails trimmed and stated that they felt so much better. Resident #263 stated that the Doctor told me my toenails were curled under and getting ready to grow into my skin. Resident #263 demonstrated by holding up her hands and curled her fingers under until the fingerlips touched the palm.<br><br>The Facility Policy and Procedure titled, "Nail Care" with an effective date of 12/17 documented the following:<br><br>"Purpose: The purposes of this procedure are to | F 657 | | |

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| F 657 | Continued From page 55<br>clean the nail bed, to keep nails trimmed, and to prevent infections. ... Refer diabetic residents or residents with circulatory impairment, curved, mycotic or other nail abnormalities to podiatrist PRN (as needed). Notify attending MD (Medical Doctor) to obtain order for podiatry consult."<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.<br><br>The facility staff failed to revise a care plan for Resident #34..<br><br>2. Resident #34 was admitted to the facility on 12/19/17. This resident was admitted with diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms, Type 2 Diabetes Mellitus, dependence on renal dialysis, chronic obstructive pulmonary disease, severe protein - calorie malnutrition, acute embolism and thrombosis, chronic kidney disease, and cognitive communication deficit.<br><br>The facility staff failed to revise Resident #34's care plan to include interventions for the use of a Video Monitor.<br><br>An Initial Minimum Data Set (MDS) dated 1/12/18 assessed this resident in the area of Hearing, Speech and Vision as having no concerns. In the area of Cognitive Patterns this resident was assessed as having a Brief Interview for Mental Status (BIMS) as having a score of (13). In the area of Cognitive Patterns this resident was coded as having no concerns. In the area of Mood, this resident was coded as having no concerns. In the area of Behaviors this resident | F 657 | | |

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| F 657 | Continued From page 56<br>was coded as having no concerns.<br><br>Resident # 34 was the roommate to Resident #163 during his stay at the facility and during the time a Digital Video Baby Monitor was placed in their room. Facility staff had placed the Video Monitor in the room to a please Resident #163.<br><br>During the investigation of a FRI submitted by the facility, Resident #34 complained to Nursing staff that he was being treated roughly by a CNA (Certified Nursing Assistant). During the facilities investigation a staff member references a "camera" being in the room in her written statement to the facility staff conducting the internal investigation. A written statement from one CNA during the FRI investigation indicated: Resident #34 stated "You are on camera, [and the CNA who was treating him roughly] was going to get it."<br><br>During an interview on 3/16/18 at 9:30 A.M. with Resident #34 he stated, he had spoken to his family about the rough treatment of one CNA. When asked about the camera being in the room and whether he gave consent this resident stated, No, I did not give consent for a camera to be in the room.<br>During an interview on 3/16/18 at 2:15 P.M. with the Director of Nursing (DON) and the Administrator, the DON stated, she had purchased a Digital Video Baby Monitor and placed it in the room to a please Resident #163 who was complaining of staff ignoring him and not providing timely assistance."<br><br>The DON stated, she purchased the Video Baby Monitor because Resident #163 was afraid. The Video Monitor was capable of having audio when | F 657 | | |

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| F 657 | Continued From page 57<br>the screen is off so nurses could monitor resident. The camera or viewing devices were given to nursing staff and placed on nursing cart. The nurses would then be able to monitor Resident #163 at all times.<br><br>A review of the clinical records did not indicate that a Care Plan for the use of the Video Monitor. During an interview on 3/16/18 at 2:15 P.M. with the DON and the Administrator they stated, there was no Care Plan for the use of the Video Monitor.<br><br>The facility staff failed to ensure the comprehensive care was revised to include the use of a Video Monitor | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow physician orders and to ensure insulin and glucometer checks were done per plan of care for 1 resident of 41 Residents in the survey sample (Resident #267). | F 684 | F 684<br>1) Resident #267 is a discharged resident.<br>- Education provided to staff member identified #25<br>2) Those residents who receive insulin could potentially be at risk<br>3)<br>a) Education was provided to nurses on:<br>-following physicians order and sliding scale for insulin coverage.<br>b) The nurse managers will conduct weekly audits of the following and report findings to the DON weekly:<br>-medication pass/insulin coverage<br>-documentation related to insulin coverage, glucometer checks and sliding scale physician orders<br>c) pharmacy will audit monthly those residents on sliding scale coverage and provide feedback to the DON monthly.<br>4) The DON will report to Quality Assurance and Performance Improvement Committee (QAPI)monthly for 3 months, the findings of the audits related to medication provided for sliding scale and the follow up to sustain compliance | 4/25/18 |

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| | | | with insulin coverage, glucometer checks and documentation.<br>5) Date of Compliance 4/25/18 |

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| F 684 | Continued From page 58<br><br>The findings included:<br><br>Resident #267 was admitted to the facility on 3/21/17. Diagnoses for Resident #267 included but are not limited to Diabetes Mellitus. Resident #261's Admission Minimum Data Set (MDS) with an Assessment Reference Date of 3/28/17 scored Resident #267 with a BIMS score of 14 of a possible 15, indicating no cognitive impairment.<br><br>Resident #267's Patient Centered Care Plan documented a 3/23/17 Focus Area of Diabetes. The Goal documented the resident would be free from signs and symptoms of hyperglycemia throughout the review date. One intervention documented was Sliding Scale Insulin as ordered.<br><br>Resident #267's 3/21/17 Physician orders documented the following:<br><br>Humalog Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale:<br>If 151-200 inject 6 Units<br>201-250 inject 8 Units<br>251-300 inject 10 Units<br>301-350 inject 12 Units<br>subcutaneously before meals and at bedtime for Diabetes Mellitus. Call Medical Doctor less that 60 or greater that 350<br><br>Resident #267's Face Sheet documented discharge date of 4/1/17 at 11:42 AM.<br><br>Resident #267's 4/1/17 11:42 AM, Progress note documented the following:<br><br>"Resident left AMA (against medical advice) today | F 684 | | |

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| F 684 | Continued From page 59<br>at 11:42 a.m. Resident was alert and oriented times 3. Resident and her daughter was upset and had multiple complaints... Before she left the facility AMA she was changed and dressed by the CNA (certified Nursing Assistant) and her blood sugar was checked and insulin given. Resident had no signs or symptoms of distress.<br><br>Review of Resident #267's Clinical Record March and April 2017 Medication Administration Records and Medication Audit reports documented the following:<br><br>March 31, 2017 9 PM Blood glucose was not documented and no sliding scale insulin coverage was documented.<br>April 1, 2017 6 AM and 11:30 AM Blood glucose was not documented and no sliding scale insulin coverage was documented.<br><br>An interview with the Facility Director of Nurses on 3/19/18 at approximately 1:05 PM was conducted. The DON and surveyor reviewed March and April 2017 Medication Administration Report. The DON was asked if the Blood Glucoses and Insulin were administered on 3/31/17 9:00 PM and 4/1/17 6:00 AM and she stated, "If it ain't documented it ain't done."<br><br>Phone calls to the Resident on 3/13/18, 3/14/18 and 3/15/18 were placed without return calls.<br><br>The Facility document titled, "Preparation for Medication Administration" with no date, documented the following:<br><br>Page 42: "Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons | F 684 | | |

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| F 684 | Continued From page 60<br>legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication."<br><br>Page 43: "k. Medications are administered at the time they are prepared. Medications are not pre-poured."<br><br>Page 44: "p. Medications are administered within (60 minutes) of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility."<br><br>Page 44: "Documentation:<br>x. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.<br>y. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided."<br><br>On 3/12/18 during the Task of Medication Administration, it was observed that at 11:26 AM, 9 AM medications were still being passed by | F 684 | | |

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| F 684 | Continued From page 61<br>Licensed Practical Nurse #25.<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.<br><br>COMPLAINT DEFICIENCY | F 684 | | |
| F 687 SS=D | Foot Care<br>CFR(s): 483.25(b)(2)(i)(ii)<br><br>§483.25(b)(2) Foot care.<br>To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:<br>(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<br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interviews, staff interviews, facility documentation review, and clinical record review, the facility staff failed to ensure Podiatry services were provided in a timely manner for 1 Resident of 41 Residents in the survey sample (Resident # 263).<br><br>The findings included:<br><br>Resident #263 was admitted to the facility on 11/15/17. Diagnoses for Resident #263 included but are not limited to Chronic Pain Syndrome, Anxiety, and Mycotic Toenails. | F 687 | F 687<br>1) Resident #263 was seen by an outside podiatrist. Residents care plan was reviewed and updated as needed.<br>2) Those residents with podiatry needs could potentially be affected.<br>3)<br>A) The Nurse managers will refer residents who have been assessed or receives an order for podiatry care to an outside podiatrist.<br>B) Facility will actively seek to find a qualified internal contractor for podiatry care that could visit the facility.<br>C) A facility list will be established of those residents who need podiatry care and follow up appointments as needed. This list will be kept by the Unit Managers. This list will be provided to the DON monthly.<br>D) Education to the nurses was provided on assessment /evaluation/observation of foot/nail care needs during showers or care.<br>4) The DON will submit the podiatry need/ appointment list to Quality Assurance and Performance Improvement Committee (QAPI)monthly for 6 months to assure compliance with foot /podiatry appointments/care.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| F 687 | Continued From page 62<br><br>Resident #263's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date of 1/22/18 scored Resident #263 with a BIMS (Brief Interview for Mental Status) score of 15 of a possible 15 indicating no cognitive impairment. The Resident was dependent on one staff person for dressing, toilet use, and hygiene needs.<br><br>The Comprehensive Person Centered Care Plan last revised 1/29/18 did not include a focus area of thickened, long, painful toenails.<br><br>Resident #263's last documented Podiatrist visit was on 5/10/17.<br><br>A Podiatry note dated 3/19/18 documented the following: Reason for Consultation: Mycotic Toenails." The Podiatry note documented under Plan: "Debrided 10 nails."<br><br>The website (https://oig.hhs.gov/oei/reports/oei-04-99-00460.pdf) documented the following:<br>Nail debridement involves removal of a diseased toenail bed or viable nail plate. This may be performed manually with an instrument, or with an electric grinder. Podiatrists generally provide nail debridement to patients diagnosed with onychomycosis (i.e., mycosis or mycotic toenails).<br><br>On 3/12/18 at approximately 1:45 PM, during the initial tour, the resident complained of painful toenails. The Resident removed her shoes and her toenails were observed thickened and long. She stated the great toe nails were painful. Resident #263 stated that she had informed the | F 687 | | |

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| F 687 | Continued From page 63<br>staff several times.<br><br>On 3/14/18 at approximately 1 PM, Resident #263 was observed sitting in her wheelchair and she stated that her toenails continued to hurt and that she had no Podiatry appointment.<br><br>On 3/15/18 at approximately 4:45 PM, the Resident reported that she had an appointment with a Podiatrist on Monday and reported that her daughter was concerned about having difficulty getting her in and out of the car.<br><br>On 3/13/18 at approximately 3:45 PM the Director of Nursing (DON) stated that the facility was currently without a Podiatrist to make visits in the facility. The facility was not able to state the last date a Podiatrist made visits in the facility. When the DON was asked why the facility could not assist the Resident to make an outside community Podiatrist, the DON stated, that the facility could assist the Resident with making an appointment and had reached out to the daughter and had been unsuccessful.<br><br>On 3/19/18 at approximately 1:30 PM, Resident #263 stated that she had just come from the Podiatrist where she had her toenails trimmed and stated that they felt so much better. Resident #263 stated that the Doctor told me my toenails were curled under and getting ready to grow into my skin. Resident #263 demonstrated by holding up her hands and curled her fingers under until the fingertips touched the palm.<br><br>The Facility Policy and Procedure titled, "Nail Care" with an effective date of 12/17 documented the following: | F 687 | | |

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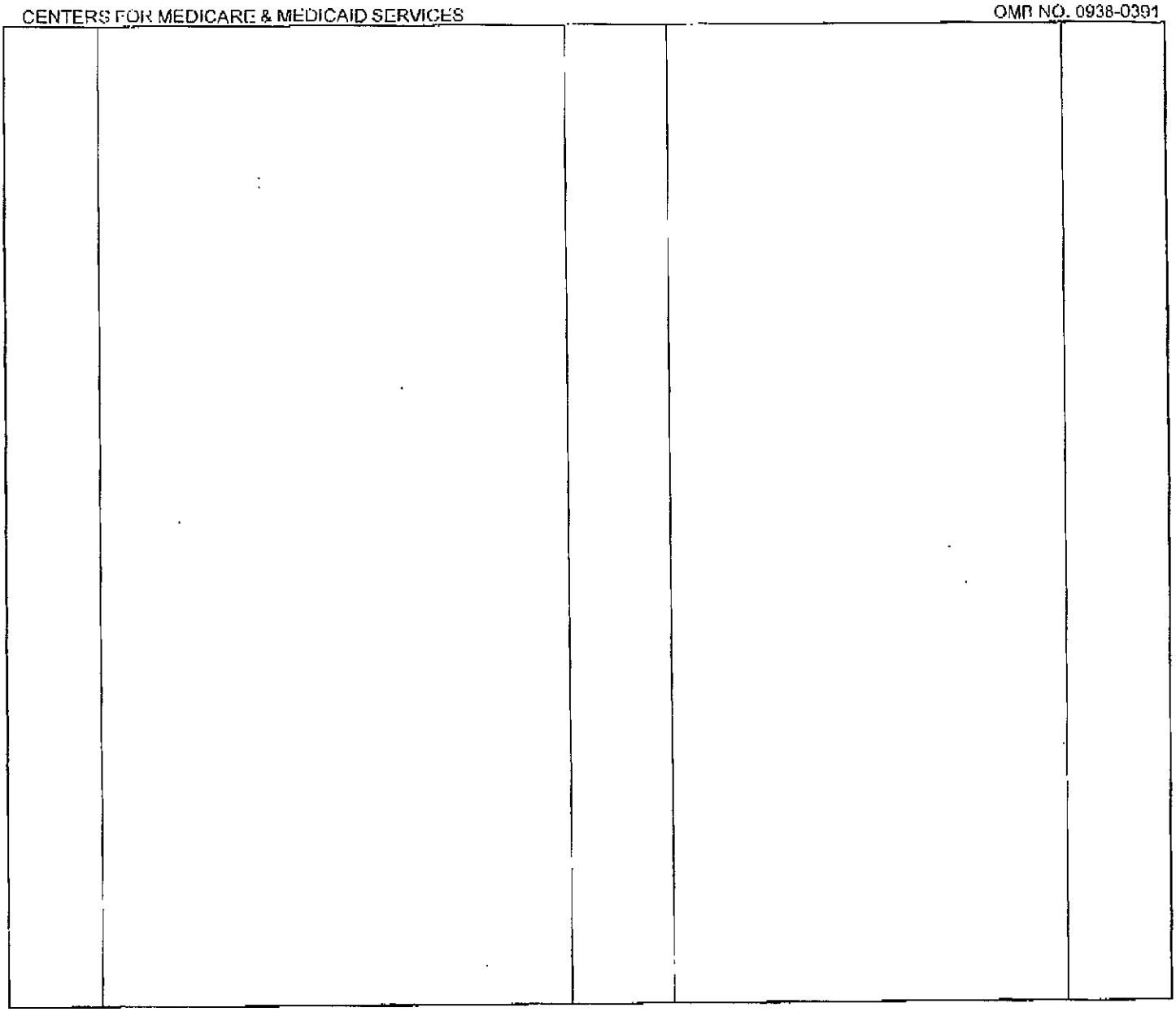
| F 687 | Continued From page 64<br>"Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. ... Refer diabetic residents or residents with circulatory impairment, curved, mycotic or other nail abnormalities to podiatrist PRN (as needed). Notify attending MD (Medical Doctor) to obtain order for podiatry consult."<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding. | F 687 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by.<br>Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to maintain a safe environment for 2 of 41 residents in the survey sample (Resident #25 and Resident #4). This citation was originally found at a level four isolated and upon acceptance of the plan of correction, it was lowered to a level two isolated.<br><br>During initial tour, an oxygen E tank was observed in Resident #40's room. The tank was unsecured. There was approximately 2000 PSI | F 689 | F689<br>1. Plan of Correction/Abatement provided with immediate follow up for oxygen use and safety for residents #25 and #4.<br>A)<br>-Residents #25 and #4's care needs including oxygen use were reviewed and their care plans updated as needed.<br>2. Those residents who receive oxygen and utilize tanks could potentially be affected by this practice.<br>3.<br>A) Education was provided to nursing care staff on:<br>-The oxygen administration, storage, safety and documentation practice per the oxygen policy.<br>B) Audits/rounds will be conducted daily by the Nurse Managers and Environmental services team related to oxygen storage and safety.<br>C) The results and any necessary action items of the safety audits will be provided to the Administrator daily as needed and weekly by report.<br>4. The Administrator will report to Quality Assurance Committee (QAPI) monthly for 6 months the findings of the safety/oxygen rounding and audits and any action items to assure compliance with the oxygen policy.<br>5.Date of Compliance 4/25/18 | 4/25/18 |



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| F 689 | Continued From page 65<br>(pounds-force per square inch) reading on the gauge of the tank. It was sitting, without a stand or holder, left of the door going out to the hall. The observation constituted the notification of immediate jeopardy.<br><br>An additional unsecured oxygen tank was observed sitting in the corner of Resident #4's room. There was approximately 2000 PSI reading on the gauge of the tank. The oxygen tank was in a black sleeve but was not secured at the time of the observation.<br><br>The findings included:<br><br>1. Resident #25 was admitted to the facility on 1/8/18. Diagnoses for Resident #25 included but were not limited to COPD (Chronic Obstructive Pulmonary Disease). Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of assessed the resident with 15 out of a possible 15 BIMS (Brief Interview for Mental Status), indicating no cognitive impairment. The Resident required two staff person assistance with bed mobility and required one staff person assistance with transfers, locomotion on unit, dressing, toilet use and personal hygiene.<br><br>The Comprehensive Person Centered Care Plan revised on 10/27/17 identified a focus area of oxygen therapy related to COPD. The goal was to have no signs/symptoms of poor oxygen absorption through the review date. Two interventions included oxygen via nasal canula 2 Liters continuously and oxygen supplies and tubing changes/cleaning per facility protocol.<br><br>Physician Orders of 1/8/18 documented the | F 689 | | |

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| F 689 | Continued From page 66<br>following: Oxygen at 2 L/hr (liters/hour) by nasal canula continuously every shift for COPD.<br><br>On 03/12/18 at approximately 11:40 AM, during the initial tour, Resident #25 stated he gets short of breath when going to the bathroom because his portable oxygen tank for his wheel chair is not in the holder. An oxygen concentrator was observed in the Resident's room.<br><br>Resident #25 was asked where his portable tank was. He stated he didn't know, that it was "over there somewhere." A free standing oxygen type E tank was found to the left of the door going out to the hall. The tank was not secured in a holder to prevent it from falling over.<br><br>On 03/12/18 at approximately 11:45 AM, two additional surveyors were asked to come into the room. The surveyors turned on the portable oxygen tank and found there to be 2000 PSI left in tank.<br><br>On 03/12/18 at approximately 12:05 PM, the survey team met and a call was placed to the State Agency. After discussion with the State Agency Supervisors, the decision was made to call Immediate Jeopardy.<br><br>On 03/12/18 at approximately 12:10 PM the Survey Team met with the Administrator and the Director of Nursing (DON) to discuss concern of Immediate Jeopardy.<br><br>On 03/12/18 at approximately 12:20 PM, this surveyor walked to Resident #25's room and showed the freestanding oxygen E tank to the Administrator and Director of Nursing (DON). It remained sitting in the corner by the door going to | F 689 | | |

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| F 689 | Continued From page 67<br>the exit, without a stand to secure it. The oxygen E tank was lifted by the DON and taken to the nurses station where LPN#31 took the oxygen E tank and held it while the DON was directing her to take the tank and place in in the Resident's wheel chair oxygen caddy.<br><br>On 03/12/18 at approximately 4:35 PM, the facility's initial Plan of Correction (POC) was received from Administrator and DON was reviewed by the Surveyor.<br><br>On 03/12/18 at approximately 4:37 PM the DON and Administrator were informed of changes required prior to the acceptance of POC and at 4:45 PM, the POC was denied due to being incomplete.<br><br>On 3/13/18 at approximately 11:05 AM, the POC was received from the Administrator and DON.<br><br>The POC was reviewed by survey team but not accepted after interviewing 7 staff members who stated they were never in-serviced on the proper storage of oxygen E tanks as part of the POC.<br><br>On 3/13/18 at 11:30 AM, the supervisor at the State Agency was informed that the POC was received from Administrator but not accepted by survey team.<br><br>On 3/13/18 at 11:59 AM, two staff members were interviewed about being in-serviced on proper storage of oxygen E tanks. Staff stated they were not in-serviced.<br><br>On 3/13/18 at approximately 12:04 PM, the POC was again denied. | F 689 | | |

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| F 689 | Continued From page 68<br>On 3/13/18 at approximately 12:46 PM, the Survey Team received the POC from the Administrator and DON. The POC was reviewed by survey team and denied and returned to the Administrator for additional information.<br><br>On 3/13/18 at approximately 1:00 PM, the POC was accepted and the immediate Jeopardy was abated. The POC documented the following:<br>1. 3/12/18 surveyor noted that unsecured oxygen cylinder was left in resident room, said tank was removed from resident room by DON at 1220 PM. Resident's oxygen tank will be secured in an oxygen tank holder or oxygen tank cart, designed for carrying and storage of oxygen "E" cylinder canisters. Surveyor identified that oxygen tank was found to be sitting in corner of room unsecured, was in black sleeve to secure to wheelchair was found not to be at this time, was removed from corner of room by DON and secured to back of wheelchair at 1226 PM.<br>2. All residents with orders for oxygen will be reviewed to determine if oxygen tanks are in use on a continuous basis or as needed basis, completed 3/12/18 at 1400 (2:00 PM); 100% physical inspection of facility to identify and remove unsecured oxygen canisters in all areas, completed 3/12/18 at 1300 (1:00 PM).<br>3. Nursing, housekeeping, facilities, activities, therapies will be in-serviced in the safe use of portable "E" oxygen cylinders including the securing of tank in device designed for that use per policy, 3/12/18; staff coming into facility through agency will read and sign policy for proper use and storage of oxygen prior to start of their shift beginning 3/12/18; new employee orientation will include review of safe oxygen storage procedures and securement in alignment with policy - records of signatures to be kept by | F 689 | | |

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| F 689 | Continued From page 69<br>education department.<br>4. Nursing Supervisor and/or Charge Nurse will make rounds on residents with portable oxygen tanks and will observe each designated oxygen storage area on their unit every shift for 7 days. Any observed variances will be immediately corrected and noted as such on audit sheet; daily audit sheet will be given to DON who is responsible for ensuring that audits are completed and will analyze for trends, patterns and further actions necessary; upon completion of the first 7 day audits, the trends will be analyzed and audits may be reduced to 3 times per week for 7 days. The results of the 2 week audits will be reported to QAPI (Quality Assurance and Performance Improvement) Committee for additional oversight and recommendation for the frequency of continued audits.<br>5. Responsible - DON/Night Supervisor/Nurse Administrator<br>6. Implementation 3/12/18<br><br>On 03/15/18 at approximately 04:13 PM, Resident # 25 was observed lying in bed, oxygen E tank cylinder was observed in a secure location in the wheelchair oxygen tank holder.<br><br>On 3/16/18 at approximately 3:49 PM, Resident #25 was observed in his room, oxygen E tank cylinder safely secured in wheel chair oxygen holder.<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.<br>2. On 3/12/18 at 12:20 P.M. an unsecured oxygen tank was observed sitting in the corner of | F 689 | | |

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| F 689 | Continued From page 70<br>Resident #4's room. The oxygen tank was in a black sleeve which to be secured to a wheelchair. The oxygen tank was found not to be secured at the time.<br><br>Resident #4 was admitted to the facility on 9/26/17 with diagnoses which included major laceration of spleen, Hypo-osmolality and hyponatremia, history of falling, elevated white blood cell count, reflux, anxiety, depression, Chronic Obstructive Pulmonary Disease, hypertension, hypothyroidism, arteriosclerotic heart disease of native coronary artery without angina pectoris, vitamin B 12 deficiency, anemia, and chronic atrial fibrillation.<br><br>Resident #4's unsecured oxygen tank was noted to have 2000 PSI remaining in the tank.<br><br>A Quarterly Minimum Data Set (MDS) dated 3/12/18 assessed this resident in the areas of Hearing, and Speech as having no concerns. This resident was assessed in the area of Vision as requiring glasses. In the area of Cognitive Patterns this resident was coded in the area of Brief Interview for Mental Status (BIMS) as a 15. This resident had no concerns in the area of Mood, or Behaviors. In the area of Activities of Daily Living (ADL) this resident was assessed as requiring supervision or limited assistance in the areas of transfer, dressing, eating, toilet use and personal hygiene. This resident was assessed as using a walker and wheelchair as mobility devices. In the area of Special Treatments, Procedures and Programs no concerns were assessed.<br><br>A Revised Care Plan dated 10/16/17 indicated: "Focus- History of Congestive Heart Failure | F 689 | | |

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| F 689 | Continued From page 71<br>Intervention- Oxygon 2 L (liters) via nasal canula PRN (as needed) as ordered. O/2 sats (oxygen saturation) to be obtained every shift as ordered. Focus- History of falls Interventions- The Resident needs a safe environment with even floors free from spills and or clutter.<br><br>Focus- I use Oxygen Therapy at times because of Emphysema and History of CHF. Sometimes I have shortness of breath. Goal- I will have no s/sx (signs/symptoms) of poor oxygen absorption. Intervention- Change residents position every 2 hours to facilitate lung secretion movement and drainage. Give medications as ordered by physician. Monitor/document side effects and effectiveness. If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g. changing from mask to a nasal canula). Return resident to usual oxygen delivery method after the meal. Oxygen Settings -Oxygen 2 L via nasal canula to keep SpO2 > 93% as needed as ordered. Oxygen supplies and tubing changes /cleaning per facility protocol."<br><br>A physician's order dated 10/2/17 indicated: "Check O 2 sats Q (every) shift, oxygen 2/L via nasal canula (Dyspnea) to keep Sp02>93% as needed."<br><br>The Administrator and the Director of Nursing were called to Resident #4's room on 3/12/18 at 12:26 P.M. at which time the oxygen tank was removed from the room.<br><br>During an interview on 3/12/18 at 12:30 P.M. with the Administrator and the Director of Nursing, they were asked if the oxygen tank was secured as first observed. They both stated, "No." The DON stated the oxygen tank should have been | F 689 | | |

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| F 689 | Continued From page 72<br>secured in the black sleeve and attached to Resident #4's wheelchair.<br><br>03/13/18 at 1:04 PM the facility Policy and Procedure titled, "Oxygen Tank Storage" with an effective date of 1/2018 ws reviewed and documented the following:<br><br>"Oxygen tanks will be stored in compliance with safety regulations, thus keeping residents and staff safety at a priority.<br><br>Rationale<br>The facility establishes and maintains a safe, functional environment: interior spaces meet the need of the resident population and are safe and suitable to the care, treatment and services provided. The primary source of oxygen for resident use is the oxygen concentrator. However, there are times when the resident may require the use of an oxygen e cylinder for transportation to appointments within or outside the facility.<br><br>Procedure:<br>O2 (Oxygen) tanks must be stored in a safe and consistent manner.<br>1. All O2 tanks must be stored in an approved Ox tank storage rack.<br>2. All O2 tank storage racks must be approved by Facility Services.<br>3. Empty O2 tanks must be in a separate rack from Full or Mid-Range filled O2 tanks.<br>B. Other O2 tank safety items:<br>1. All O2 tanks are to be placed only in an approved O2 tank holder when in use.<br>a. Wheelchair holders as appropriate or in wheeled storage devices if resident is ambulatory. | F 689 | | |

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| F 689 | Continued From page 73<br>5. O2 tanks will not be left in free-standing position. | F 689 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interviews, staff interviews, facility documentation review, and clinical record review, the facility staff failed to ensure pain management with prescribed Fentanyl Patch after Hospice services were discontinued for 1 Resident of 41 residents in the Survey Sample (Resident # 263).<br><br>The findings included:<br><br>Resident #263 was admitted to the facility on 11/15/17. Diagnoses for Resident #263 included but are not limited to Chronic Pain Syndrome, Anxiety and Mycotic Toenails.<br><br>Resident #263's Significant Change Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/22/18 scored Resident #263 with a BIMS (Brief Interview for Mental Status) score of 15 of a possible 15 indicating no cognitive impairment. The Resident was dependent on one staff person for dressing, toilet use, and hygiene needs.<br><br>The Comprehensive Person Centered Care Plan | F 697 | F 697<br>1. Resident #263 received her ordered and prescribed pain medication. Resident #263's pain medication regime/orders have been reviewed and residents care plan has been updated and revised as needed.<br>2. Those residents that receive pain medication could potentially be affected by this practice.<br>3.<br>A) Education has been provided to nursing staff related to pain medication policy and process. This includes:<br>- Stat medication process<br>-Problem solving, documentation and reporting process if the pain medication is not available.<br>B) Clinical Managers will review and audit the following areas daily and provide a report to the DON weekly:<br>-Audit for those medications that are ordered and reordered for pain control for availability<br>-Audit of the documentation of medication administration for those medications ordered for pain control<br>4) The Don will report monthly for 3 months to the Quality Assurance and Performance Improvement Committee(QAPI) the findings and results of the audits for pain control medication availability and documentation.<br>5) Date of Compliance 4-25-18 | 4/25/18 |

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| F 697 | Continued From page 74<br>last revised 1/30/18 identified the Resident at risk for pain related to the diagnosis of Chronic Pain Syndrome, Anxiety, Chronic Inflammation of the Pancreas, Lupus, Osteoarthritis, status post acute upper gastro-intestinal bleed, GERD (gastro-esophageal reflux disease), discomfort with current dentition. The goal was "I will voice a level of comfort through the review date." Interventions included but are not limited to the following:<br><br>Apply and remove Duragesic* (1) patch as ordered<br>Administer medications as ordered for pain.<br>Monitor/Document for side effects and effectiveness.<br>Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.<br>Evaluate the effectiveness of pain interventions .<br>Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.<br>Monitor/document for probable cause of each pain episode. Remove/limit causes where possible.<br>Staff to Assess pain every 4 hours for pain management and document in Nursing Progress notes; include intervention and Responses as ordered.<br><br>Resident #263's Clinical Record documented the following Physician Order:<br><br>1/16/18 Physician ordered Fentanyl Patch 72 Hour 75 MCG/H IR Apply 1 patch transdermally one time a day every 3 days related to Chronic Pain Syndrome and remove per schedule. | F 697 | | |

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| F 697 | Continued From page 75<br>1/16/18 Physician ordered Oxycodone HCl Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for pain<br><br>Review of Resident #263 January 2018 Medication Administration Record documented the last applied Duragesic 100 Patch 72 hour 100 MCG/HR was applied on 1/9/18 21:00 (9 PM) and removed 1/12/18 20:59 (8:59 PM). The Duragesic 75 MCG/HR patch was applied on 1/20/18 at 21:00 (9 PM)<br><br>Resident #263's Clinical Record progress notes documented the following:<br><br>1/15/18 15:00 (3 PM) Received call from ...hospice stating that patient was discharged from hospice services as of 1/14/17 (sic - 2017 was date documented)<br><br>1/15/18 18:28 (6:28 PM) This writer called Dr. (Physician Name) office requesting scripts for Duragesic patch and Oxycodone<br><br>1/15/18 20:17 (8:17 PM) Duragesic 100 Patch 72 Hour 100 MCG/HR (micrograms per hour) Apply 1 patch transdermally every 72 hours for pain and remove per schedule. No patch available in E stat (emergency stat) Call placed to MD (Medical Doctor) per off going nurse.<br><br>1/15/18 20:19 (8:19 PM) No patch on resident.<br><br>1/16/18 19:01 On call MD notified that fentanyl patches are not on site and is not available from back-up pharmacy. Order received to hold Fentanyl patches until arrive on 1/17/18.<br><br>1/17/18 00:10 (12:10 AM) Oxycodone HCl Tablet | F 697 | | |

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| F 697 | Continued From page 76<br>5 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for pain<br><br>1/17/18 08:21 (8:21 AM) Fentanyl Patch 72 hour 75 MCG/HR Apply 1 patch transdermally one time a day every 3 day(s) related to Chronic Pain Syndrome and remove per schedule. nothing to remove d/t (due to) no old patch noted on resident's body prior to placing a new fentanyl.<br><br>1/17/18 08:25 (8:25 AM) A new fentanyl 75 mcg/hr patch was placed to right upper arm near area. Resident thanked this writer for applying the patch.<br><br>Review of Resident #263 January 2018 MAR documented the following pain assessments<br><br>1/12/18 20:00 8 PM - 5 of 10 pain scale with 10 being worst pain ever<br>1/13/18 00:00 12 AM - 5 of 10 pain scale<br>1/13/18 08:00 8 AM - 10 pain scale of 10<br>1/13/18 12:00 12 PM - 3 pain scale of 10<br>1/13/18 16:00 4 PM - 6 pain scale of 10<br>1/14/18 12:00 12 PM - 10 pain scale of 10<br>1/14/18 20:00 8 PM - 5 pain scale of 10<br>1/15/18 00:00 12 AM - pain scale 2 of 10<br>1/15/18 04:00 4 AM - pain scale 2 of 10<br>1/15/18 20:00 8 PM - pain scale 10 of 10<br>1/16/18 00:00 12 AM - pain scale 5 of 10<br>1/16/18 04:00 4 AM - pain scale 8 of 10<br>1/16/18 08:00 8 AM - pain scale 8 of 10<br>1/16/18 12:00 12 PM - pain scale 8 of 10<br>1/16/18 16:00 4 PM - pain scale 8 of 10<br>1/17/18 00:00 12 AM - pain scale 4 of 10<br>1/17/18 08:00 8 AM - pain scale 6 of 10<br>1/17/18 12:00 12 PM - pain scale 5 of 10<br>1/17/18 16:00 4 PM - pain scale 2 of 10 | F 697 | | |

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| F 697 | Continued From page 77<br>A Medication Audit report showing times of Duragesic/Fentanyl patch applied documented the following:<br><br>Duragesic 100 MCG/HR Patch last applied 1/12/18 20:59 (8:59 PM)<br>Fentanyl 75 MCG/HR Patch began 1/20/18 21:00 (9 PM) | F 697 | | |
| | On 03/14/18 at approximately 1:30 PM, during group meeting, Resident #263 stated her "nerve" patch was stopped for days. The Resident reported increased pain during this time.<br><br>On 3/15/18, the Director of Nursing (DON) confirmed that Resident #263 did go several days without her Fentanyl Patch. She stated that the resident was on Hospice Services at one point and Hospice had discontinued care and the facility was not aware until the Fentanyl Patches were no longer provided.<br><br>The Facility Policy and Procedure titled, "Pain Assessment, Reassessment and Management" with an effective date of 2/2018 documented the following:<br><br>"Policy: ...(facility) shall respect and support the resident's right to optimal pain assessment and management. Pain shall be assessed in all residents in the organization. The organization shall also address the appropriateness and effectiveness of pain management.<br>Rationale: Effective pain assessment and management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the resident experiencing pain enhances healing and promotes both physical and psychological | | | |

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| F 697 | Continued From page 78 | F 697 | | |

wellness. It is beneficial for the resident and his or her family and/or support structure, as appropriate, to be involved in all aspects of his or her care, including pain management.
During the assessment process, information shall be gathered on the existence of pain and its effect on many aspects of the resident. Since pain is rarely a static process, the assessment process shall be ongoing, not simply a one-time event. The information obtained in the assessment shall allow for the formulation of a plan of care with goals related to pain management.

The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.

Definitions:

1. Fentanyl/Duragesic Patch: Medline plus documented the following:

Fentanyl patches are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Fentanyl is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain.
Transdermal fentanyl comes as a patch to apply to the skin. The patch is usually applied to the skin once every 72 hours. Change your patch at about the same time of day every time you change it. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not

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| F 697 | Continued From page 79<br>understand. Apply fentanyl patches exactly as directed. | F 697 | | |
| F 698<br>SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to communicate ongoing assessments of condition and monitoring for complications before and after dialysis treatments for 1 of 41 residents in the survey sample (Resident #51).<br><br>The Facility staff failed to communicate ongoing assessments for Resident #51 who attended outpatient dialysis three days per week on Tuesday, Thursday and Saturday.<br><br>The findings include:<br><br>Resident #51 was admitted to the nursing facility on 1/17/18 with diagnoses that included end stage renal disease (ESRD), high blood pressure and gastroesophageal reflux disease (GERD).<br><br>The most recent Minimum Data Set (MDS) assessment dated 2/7/18 assessed the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible 15, which indicated the resident was fully intact with cognitive skills for daily decision making. The | F 698 | F 698.<br>1) Resident #51's care plan and needs have been reviewed, and care plans updated and revised as needed. No ill-effect occurred to resident #51 related to this practice.<br>-Education related to the dialysis care and communication tool has been provided to identified staff member #6.<br>2) Those residents receiving dialysis services could potentially be at risk related to this practice.<br>3)<br>A) The policy, process and communication tool has been reviewed by the Nursing Administration team related to communication and documentation of residents who are receiving dialysis services.<br>B) Education has been provided to nursing staff related to the communication process and the use of the dialysis communication tool.<br><br>C) The Administrator/Don has had communication related to the use and importance of this tool with the outside dialysis center.<br>D) The Clinical Manager/ Supervisors will audit this information weekly and provide the findings and follow up actions items of this audit to the DON weekly for review.<br>4) The DON will report to Quality Assurance and Performance Improvement Committee monthly for 3 months regarding the findings of the dialysis communication tool and process and needed follow up actions items needed to assist in compliance.<br>5)Date of Compliance is 4/25/18 | 4/25/18 |

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| F 698 | Continued From page 80<br>resident was coded to receive outpatient dialysis treatments.<br><br>Resident #51's physician orders contained an order, signed and dated on 1/17/18, for outpatient dialysis services three days a week on Tuesday , Thursday and Saturday.<br><br>The dialysis binder reviewed from 1/18/18 to 3/17/18 indicated the licensed nurses recorded vital signs and weight on the "Dialysis Communication Sheet" when the resident left out for dialysis, but there was no return information recorded from the dialysis center.<br><br>No information was observed in the clinical record, the electronic chart, or in the binder, that indicated a record of a resident assessment from the dialysis center.<br><br>On 3/16/18 at 9:00 a.m., Resident #51 was interviewed about the facility and his trips to dialysis. The resident was asked if he took any documentation (such as a notebook) over with him from the facility to share with the dialysis clinic or if the dialysis clinic ever sent anything back to the facility staff with him. Resident #51 said a book goes with him on dialysis days and he comes back with the same binder.<br><br>On 3/16/18 at 11:30 a.m., the assigned Licensed Practical Nurse (LPN) #6 was asked about dialysis communication sheets. She said she was a traveling nurse, and always saw return information from the dialysis center regarding weight, vital signs, dressings and a note regarding the toleration of the dialysis treatment, as well as any other pertinent information. She stated based on the examination of Resident | F 698 | | |

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| F 698 | Continued From page 81<br>#51's Dialysis Communication Sheet, the communication was only one way.<br><br>On 3/19/18 at 1:00 p.m., the Director of Nursing and Unit Manager were interviewed and indicated they expected dialysis to utilize the communication process to document resident assessment details to include vital signs, medications given, condition of the access, bruit and thrill and especially the post dialysis weight upon the resident's completion of dialysis treatment.<br><br>On 3/19/18 at 4:00 p.m., the facility's Administrator was not present in the facility for the pre-exit debriefing, thus the debriefing was held with the DON, Director of Long-Term Care project Administrator and Clinical Analyst. No further information was provided prior to exit.<br><br>The facility's policy and procedure titled ESRD and Dialysis dated 2/2018 indicated a dialysis communication sheet will be utilized for pre, current and post care of the dialysis resident. The intent of this policy was that the facility assures that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice including the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility; ongoing assessment and oversight of the resident before and after dialysis treatments; and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. | F 698 | | |
| F 730 SS=E | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7) | F 730 | | |

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| F 730 | Continued From page 82<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on an extended survey task, a review of the facility's competencies for the Certified Nursing Assistants (CNA) was completed. The facility staff failed to demonstrate the required 12 hours continual competencies were completed for 6 CNAs.<br><br>The findings included:<br><br>During an interview with the Staff Development Coordinator (SDC) on 3/19/18 at 10:45 a.m., she stated she and the Director of Nursing (DON) discovered problems existed with the transference of an old paper system of recording required educational competencies to the new electronic portal system. They stated they had not recognized the problem existed until the CNA competencies were requested by this surveyor. They further said, after several days of cross referencing and analysis of educational requirements, as well as interviews, they identified 6 CNA's that had not completed any of their mandatory annual competencies to equal 12 hours. All 6 had "0" hours.<br><br>The SDC presented a list of the facilities required training that included the following mandatory annual competencies:<br>-Client rights and promotion of independence | F 730 | F730<br>1. No resident was identified in this citation.<br>2. The residents who reside at the facility could potentially be affected by this practice.<br>-Those staff members who were identified and did not meet the educational 12- hour requirement were removed from the schedule.<br>3.<br>A) A system was developed to assist the Clinical Educatnr to be able to monitor staff members for compliance monthly with the required education requirement.<br>B) A process was developed for the Clinical Educatnr /DON to take necessary action, ongoing and monthly, regarding staff members who do nnt meet the 12-hour requirement and to remove them from the schedule.<br>C) The Clinical Educator will monitor monthly staff members compliance of educational requirements and provide a report tn the DON.<br><br>4) The DON will report to the Quality Assurance and Performance Improvement Committee monthly for 6 months, the findings of the Education requirements audits and any needed fnllow up action items to onsure compliance.<br>5) Date of Compliance 4/25/18 | 4/25/18 |

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| F 730 | Continued From page 83<br>-Basic restorative services<br>-Communication and interpersonal skills<br>-Safety and emergency procedures<br>-Rules and regulations that affect CNA practice<br>-Mandatory reporting related to client or resident abuse, neglect, abandonment and exploitation<br>-Basic technical skills<br>-Personal care skills<br>-Mental health and social service needs<br>-Care of cognitively impaired residents<br>-Infection control<br><br>During the pre-exit debriefing conducted on 3/19/18 at 4:00 p.m. with the Director of Long-Term Care project Administrator, the DON stated she removed the CNAs from the schedule until they completed the mandatory competencies because they were not newly hired CNAs and failed to attempt any of the required trainings. She stated there was no system in place to track CNA training and one would have to be created. | F 730 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. | F 755 | F 755<br>1. Resident #5's medications and care needs have been re-evaluated and care plans updated as needed.<br>-The medication is now being delivered, labeled and monitored via the facilities external pharmacy vendor.<br>2.Those residents who have medications brought in from an outside source or need reconciled could potentially be affected by this practice.<br>3.<br>A) A review of the policy related to medications provided by family or an outside source was completed by the Don/Administrator.<br>B) Education was provided to the nursing staff on the policy and practice of medications that may be brought in from an outside source. The education also included the following: | 4/25/18 |

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| | | | - If medication is requested to be brought in from an outside source it will be communicated to the DON for review and consideration and practice adherence of the current policy.<br>C) A review and audit will be completed weekly of those residents who may have medications requested or received by an outside source. This audit and action items will be provided to the Don weekly.<br>4) The Don will report to the Quality Assurance and Performance Improvement Committee (QAPI) monthly for 3 months the findings and needed action items regarding medications from any outside source and actions items for policy compliance.<br>5) Date of Compliance 4/25/18 | |

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| F 755 | Continued From page 84<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure medications accepted from family or outside sources were reconciled by the facility for 1 of 41 residents in the survey sample (Resident #5).<br><br>The findings included:<br><br>Resident #5 was admitted to the facility on 5/1/17. Diagnoses for Resident #5 included but are not limited to Parkinson's disease.<br><br>Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 2/19/18 scored Resident #5 with a BIMS score of 15 out of a possible 15, indicating no cognitive impairment. The Resident was dependent on staff for dressing, toilet use, personal hygiene, bed mobility and transfers. | F 755 | | |

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| F 755 | Continued From page 85 | F 755 | | |

The Comprehensive Person Centered Care Plan last revised 10/23/17 identified the Resident used a Duopa Pump via PEG Tube for Parkinson's disease. The goal was to not have discomfort or complications related to Parkinson's disease through review date. One intervention included: Administer Duopa Suspension per orders. Suspension is to be infused with external infusion pump per orders. Take out of refrigerator 20 minutes before infusions.

5/11/17 Physician orders documented the following:

Duopa Suspension 4.63-20 MG/ML (milligrams/milliliter) Give 12 ml via J-Tube in the morning for Parkinson's disease. 3 ml/hr for 4.3 hours equals 13 ml to be infused with external infusion pump, one cassette daily.

The Facility Pharmacist stated on 3/19/18 at approximately 2 PM, that she had once looked at the Duopa Suspension as requested to do so by the Unit Nurses. The Facility Pharmacist stated that the Resident's daughter brings in the medication. The Pharmacist stated that the Daughter brought in the medication as it is a high cost medication. The Pharmacist was asked how the facility confirmed that the medication was kept refrigerated appropriately.The Pharmacist stated that it was the Resident's daughter, so she would hope she would store the medication appropriately.

A page 26 document provided by the facility documented the following:

"12. MEDICATIONS BROUGHT TO FACILITY

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| F 755 | Continued From page 86<br>BY RESIDENT OR FAMILY MEMBER"<br>"Policy: Medications brought into the facility by a resident or family member are used only upon written order by the resident's attending physician, after the contents are verified, and if the packaging meets the facility's guidelines. Other unauthorized medications are not accepted by the facility."<br><br>"Procedures"<br>"a. Use of medications brought to the facility by a resident or family member is allowed only when the following conditions are met.<br>1. The medication name, dosage form, and strength have been verified by:<br>a. consulting a tablet identification reference, e.g., Physicians's Desk Reference, or<br>b. calling the dispensing pharmacy for a physical description of the medication.<br>2. The medication was ordered by the resident's physician and entered in the resident's medical record for bedside storage and self-administration by the resident.<br>3. The medication container is clearly labeled in accordance with facility procedures for medication labeling and packaged in a manner consistent with facility guidelines for medications.<br>4. The medications are received directly from another health care facility, e.g., discharge medications arriving with the resident from an acute hospital in the interim until medications for the resident are received from the provider pharmacy.<br>b. Medications not ordered by the resident's physician, or unacceptable for other reasons, are returned to the family or designated agent. If unclaimed within thirty days, the medications are disposed of in accordance with facility medication destruction/disposal procedures." | F 755 | | |

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| BON SECOURS-MARYVIEW NURSING C | 4775 BRIDGE ROAD SUFFOLK, VA 23435 |

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| F 755 | Continued From page 87<br><br>A Facility Policy and Procedure Manual documented with a revision date of 5/25/16 titled, "Medication Management - Medications Brought to facility by Resident/Family" documented the following:<br><br>"Policy: It is the policy of this facility that all medications brought into the facility by the Resident or responsible party/family only be used if permitted by the State regulations and that they are verified before use in the facility.<br>Procedure:<br>1. Medication brought into the facility may not be administered until the following conditions have been met:<br>a. State regulations allow such use in the facility<br>b. Medications must be ordered bythe Resident's physician on the orderform<br>c The contents of each container must be labeled in accordance with State regulations and pharmacy policies<br>d. The contents of each container musthave been positively identified by a licensed pharmacist.<br>3. Medications not identified by the pharmacist or ordered by the physician must be returned to the family. ..."<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding. | F 755 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is | F 842 | F842<br><br>1) Resident #413 Tod Hose is in place as ordered . Residents care needs were reviewed, and care plans were updated as needed.<br>-Staff member #2 was educated related to the | 4/25/18 |

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| | | | | policy and documentation requirements.<br>2) Those residents who have care needs or Ted hose ordered and require documentation of this device/product could potentially be at risk for this practice.<br>3)<br>A) Education has been provided to nursing staff related to the application and required documentation of this product on the TAR(Treatment Administration Record). This education also included:<br>-Education was also provided related to documentation of care that is completed vs. documentation if care is not completed.<br>B) Audits will be completed weekly by the Clinical Nurse managers for application and documentation on the TAR for the use of TED hose products.<br>C) The Nurse managers will provide the feedback and follow up actions of the TED hose/documentation audit to the DON weekly.<br>4) The DON will report to Quality Assurance and Performance Improvement Committee (QAPI) monthly for 3 months the findings and action items for the TED/Hose documentation audit and compliance with this practice/policy.<br>5) Date of Compliance 4/25/18 | |

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| F 842 | Continued From page 88<br>resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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.<br><br>§483.70(i)(3) The facility must safeguard medical | F 842 | | |

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| F 842 | Continued From page 89<br>record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interview, the facility staff failed to ensure medical records were accurately documented for 1 of 41 residents in the survey sample (Resident #413).<br><br>Facility staff failed to maintain accurate Treatment Administration Record (TAR).<br><br>The findings included:<br><br>Resident #413 was admitted to the facility on 3/7/18, diagnoses included but not limited to GI bleed, hyperlipidemia, hereditary hemochromatosis, essential hypertension, | F 842 | | |

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| F 842 | Continued From page 90 | F 842 | | |

atherosclerotic heart disease, acute embolism and thrombosis of left lower extremity, metabolic encephalopathy, and chronic liver disease.

This resident was admitted on 3/7/18 and discharged on 3/16/18 and did not have an MDS completed.

A Care Plan dated 3/8/18 indicated: Focus - Diuretic therapy related to edema. Goal - Resident will be free of discomfort or adverse side effects of diuretic therapy through the next review date. Interventions - Administer Lasix as ordered, Administer medications as ordered, Monitor dose, Report pertinent lab results to MD (Especially HCT, Na+, K+). Focus - Activities of Daily Living needs related to impaired mobility, Goal - Will attain maximum level of functioning in ADL care needs, Intervention - Occupational and Physical Therapy to evaluate and treat as ordered.

Physician order review included: Diet LCS, NAS diet regular consistency, Full Code CPR, Accu checks 2x a day, daily weights x 14 days due to increased fluid load, licensed nurse rounding, OT/PT/ST to evaluate and treat, apply TED (Thrombo-Embolic Deterrent) hose in the morning for edema and remove per schedule (ordered 3/12/18).

On 03/12/18 at 1:40 PM resident #413 was observed resting in bed with his daughter at his side. The resident was noted to have pitting edema in bilateral lower extremities. The resident was observed without TED hose in place.

On 03/13/18 at 11:30 AM Resident #143 was observed in the therapy gym working with the

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| F 842 | Continued From page 91<br>Physical Thrapy. Resident #143 was not wearing TED hose.<br><br>The TAR was reviewed on 3/13/18 at 11:40 AM. TED hose was signed off at 0600 (6:00 AM) as having been applied.<br><br>RN #2 was interviewed on 03/13/18 at 11:35 AM and was asked to check to see if the resident had his TED hose on. She stated "no".<br><br>On 3/13/18 at 11:40 AM, RN#2 was observed reviewing the TAR which has been signed off at 0600 on 3/13/18. When asked how the process for documenting Resident #413 application of TED hose is to work RN#2 said "she should not have signed the TED hose off if she did not apply them." RN#2 went with another nurse to find a pair of TED hose for the resident.<br><br>On 03/14/18 at 11:30 AM Resident #413 was observed in his room and was not wearing his TED hose as ordered. A review of the TAR noted the TED stockings were signed off at 03/14/18 at 0600 by nursing. RN#2 was made aware by the surveyor.<br><br>A review of policy for Physician orders: Receiving and Recording notes:<br>Procedure # 6 Treatment Orders - When recording treatment orders, specify:<br>a.) The specific treatment, frequency, specific location/site, and duration of the treatment. | F 842 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an | F 880 | F 880<br><br>1. Resident # 103 and #96 have had no ill effects from this practice.<br>Residents #103 and #96's respiratory devices will be stored according to policy and appropriate infection control practice. | 4/25/18 |

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| | | | -Education was completed for staff members #5#2#26 regarding Infection Control Practices.<br>2 Those residents who have respiratory devices or that reside within the facility could potentially be affected by these practices.<br>3.<br>A) The Infection Control Coordinator will complete monthly tracking /trending and reporting on infections and infection prevention within the facility. This report will be provided to the DON/Administrator monthly for their review.<br>B) Education was provided to nursing care staff on infection control policy and practices. This education included the following:<br>-Hand washing policy including practices followed during the dining and meal times.<br>-Practice of glucometer checks and protection barriers during this practice.<br>-Nebulizer/respiratory device storage<br>C) The Infection Control Coordinator will conduct monthly review/audits of the infection control tracking numbers, handwashing, glucometer infection control practices and respiratory device storage. The findings of these audits and action items will be provided to the Don monthly for review.<br>4) The DON will report to the Quality Assurance and Performance Improvement Committee monthly for 6 months the findings and action items of these audits to assure practice/policy compliance with infection control practice and policy.<br>5) Date of Compliance of 4/25/18 | |

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| F 880 | Continued From page 92<br>infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual - arrangement based upon the facility assessment conducted according to §483.70(o) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and | F 880 | | |

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| F 880 | Continued From page 93<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation,clinical record review, facility document review, and staff interviews, the facility staff failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections.<br><br>1. The facility staff failed to report and track infection control data for months.<br><br>2. The facility staff failed to ensure infection control measures were implemented during a glucometer check to prevent the potential of cross contamination. | F 880 | | |

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| F 880 | Continued From page 94<br><br>3. The facility staff failed to ensure handwashing between feeding of residents in the dining room was implemented to prevent the potential of cross contamination.<br><br>4. Facility failed to ensure resident # 96 nebulizer was stored in a sanitary manner.<br><br>5. Facility failed to store respiratory equipment in a sanitary manner for resident #103.<br><br>The findings included:<br><br>1. On 3/16/18 at approximately 2:00 p.m. the facility Infection Control Program was reviewed with the Infection Control Nurse RN (Registered Nurse) #5. The review indicated that the facility was missing infection data in the program data books. RN #5 stated, "I just took over the infection control program in January."<br><br>On 3/19/18 at 1:10 PM an interview with the Infection Control Nurse, RN #5 was conducted. The surveyor asked if there was an effective infection control program in place. RN #5 stated, "No, not the entire year. I did find months with no data. I now have the pathway and we have done a PIP (Performance Improvement Plan) for compliance. I have a much better understanding of what is need and how to do the tracking from here forward."<br><br>RN #5 provided the surveyor with a timeline from January 2017 through February 2018 of the facility infection control program months that had no infection control data reported or tracked which in documented in part, as follows: | F 880 | | |

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| F 880 | Continued From page 95<br>April 2017:<br>Chesapeake Unit: No Data<br>Nansemond Unit: No Data<br><br>September 2017:<br>Chesapeake Unit: No Data<br>Nansemond Unit: No Data<br><br>October 2017:<br>Chesapeake Unit: No Data<br>Nansemond Unit: No Data<br><br>November 2017:<br>Chesapeake Unit: No Data<br>Nansemond Unit: No Data<br><br>December 2017:<br>Chesapeake Unit: Listing Report Only<br>Nansemond Unit: Listing Report Only<br><br>January 2018:<br>Chesapeake Unit: Listing Report Only<br>Nansemond Unit: Listing Report Only<br><br>February 2018:<br>Chesapeake Unit: Listing Report Only<br>Nansemond Unit: Listing Report Only<br><br>The facility policy titled, "Infection Control Plan 2017-2018" is documented in part, as follows:<br><br>Plan Document:<br><br>"The Infection Prevention and Control Plan shall ensure that this organization develops, implements and maintains an active, organization wide program for the prevention, control and investigation of infections and communicable diseases in order to reduce the risks of endemic | F 880 | | |

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| F 880 | Continued From page 96<br>and epidemic infections in residents, visitors and healthcare workers,and to optimize use of resources.<br><br>*Once the risks are identified, prioritized and documented, the Infection Prevention and Control Committee and Infection Preventionist(s) shall establish goals and measurable objectives based on the identified risks which will be used to develop an Infection Prevention and Control Plan.<br><br>On 3/19/18 at 3:55 p.m. a pre-exit conference was held with the Director of Nursing and RN #2 where the above information was shared. The Director of Nursing was asked if the facility had an effective Infection Control Program in place. The Director of Nursing stated, "No,-we did not, but Infection Control Nurse RN #5 just look over this program." The surveyor asked, "Why should the facility have an effective infection control program in place." The Director of Nursing stated, " In order to track infections to see if they are any commonalities and provide education and prevent the spread of infections."<br><br>Prior to exit no further information was shared.<br><br>2. On 3/15/18 at approximately 4:04 PM, LPN #26 was observed to gather supplies to perform a glucometer check. The LPN gathered the glucometer and glucometer box and entered the Resident's room. The LPN placed a barrier on the bedside table and placed the glucometer on top of the paper barrier. The LPN placed a plastic box containing glucometer supplies, lancets, alcohol wipes on top of the Resident's bed. The LPN sanitized the glucometer and proceeded with obtaining the glucose check after the glucometer | F 880 | | |

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| BON SECOURS-MARYVIEW NURSING C | 4775 BRIDGE ROAD SUFFOLK, VA 23435 |

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| F 880 | Continued From page 97<br>was dry.<br><br>The LPN proceeded to obtain the glucose check, and then gathered her supplies to return to the medication cart. The LPN sanitized the glucometer.<br><br>The LPN was asked what her thoughts were about placing the glucometer box on top of a resident's bed. LPN #26 stated, "It's an infection control issue." When asked the specific reasnn for it being an infection control issue, LPN #26 stated, "It can possibly spread infection from one resident to another."<br><br>The Facility Policy and Procedure with an effective date of 3/28/17 titled, "Equipment and Supplies Handling, Storage and Cleaning Of" documented the following:<br><br>"All resident equipment and supplies will be stored, handled and cleaned according to Joint Commission and Infection Control Standards."<br><br>The Director of Nurses (DON) was asked her expectation of the glucometer box being placed on a resident bed and then returned to the medication cart on 3/16/18 at approximately 10:46 AM. The DON stated that equipment should be cleaned and placed on barrier when in a resident room and after use to prevent the potential spread of infection.<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.<br><br>3. An observation was made on 3/13/18 at | F 880 | | |

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| F 880 | Continued From page 98<br>approximately 12 noon, in the main dining room of CNA#5 sitting between two residents feeding a female resident and then turning around and feeding the second resident without handwashing. CNA #5 was observed sitting at a table of 4 residents. The CNA was observed assisting two residents during lunch. The CNA was observed on occasion get up from the table and observed to sanitize hands prior to returning to the table. The CNA was observed on multiple occasions while sitting between a female and male resident to assist the female and then turn around and assist the male resident without being observed to perform hand hygiene. On one occasion the CNA assisted the male patient to blow his nose, then place the soiled napkin on the table and turn around and take a utensil and feed the female resident and then turn around pick up a utensil and feed the male resident without hand hygiene between the care of the two residents.<br><br>On 03/13/18 at approximately 12:23 PM, theCNA was asked if she always sanitized hands between her two residents she stated, "No." She stated she did sanitize during their meal. Asked if she sanitized after feeding one every time prior to feeding the next resident, the CNA stated,"No."<br><br>The Facility Policy and Procedure titled, "Hand Hygiene" with an effective date of 1/2012,documented the following:<br><br>"Indications for Hand Hygiene"<br>"CDC Recommendations are:<br>1. Before and after having direct contact with patient.<br>8. After contact with body fluids, excretions, mucous membranes, non-intact skin and wound dressings." | F 880 | | |

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| F 880 | Continued From page 99<br><br>"Proper hand hygiene is a basic expectation of job performance in the health care environment."<br><br>The Director of Nursing on 3/16/18 at approximately 2:49 PM, was asked the expectations of handwashing between residents during feeding two residents. The DON stated that her expectation was to either wash hands or sanitize hands between resident care."<br><br>The facility administration was informed of the findings during a pre-exit briefing on 3/20/18 at approximately 3:55 PM. The facility did not present any further information about the finding.<br><br>4. Resident #96 was admitted to the facility on 2/10/18, diagnoses include but are not limited to pneumonia, cognitive communication deficit, Vitamin B deficiency anemia, gout, atrial flutter, and primary hypertension.<br><br>An initial Minimum Data Set (MDS) assessment for resident #96 was completed on 3/7/18 which assessed the resident in the area of Cognitive patterns with a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Activities of Daily Living (ADL) section indicated resident #96 needed limited assistance with self-performance and support of one staff member provided for bed mobility, transfers, locomotion on the unit, and toilet use.<br><br>A Care Plan initiated 2/11/18 indicated: Focus -Diagnosed with Mycobacterium Avium Complex (MAC), Goal - none listed. Intervention - administer Rifampin and Zithromax daily on Monday. Wednesday, and Friday as ordered. | F 880 | | |

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| F 880 | Continued From page 100<br>Auscultate lung sounds. Listen for crackles and diminished breath sounds due to atelectasis (In aspiration pneumonia rhonchi and wheezing are also present), Monitor vital signs, Monitor/document mental changes, stupor, and s/sx of congestive heart failure. Also Care Planned for, Focus- Recent episode of wheezing (2/22/18) Goal - Have no complications related to SOB (shortness of breath) though the review date. Interventions - Obtain chest x-ray as ordered, Administer DuoNeb via inhalation every 6 hours as ordered, monitor and document changes in orientation, increasod restlessness, anxiety, and air hunger. Monitor breathing patterns and abnormalities, report to MD. Obtain vital signs with O2 (oxygen) sats every shift x 5 days as ordered.<br><br>Resident #96 was observed on 03/12/18 at 12:15 with a nebulizer machine at the bedside. The mouthpiece was attached and placed on top of the machine (not in a bag). The mouthpiece was dated 3/12/18.<br><br>On 03/12/18 at 2:55 PM, the Nebulizer was observed out and open resting on top of the machine.<br><br>On 03/13/18 at 2:35 PM, the Nebulizer mouthpiece was observed resting on top of the machine, not in a bag.<br><br>On 03/14/18 at 12:35 PM Resident #96's nebulizer mouthpiece, and tubing were observed placed on the bedside table, not in a bag.<br><br>On 3/13/18 at 2:40PM with Registered Nurse (RN) #2 was asked to observe resident #96's nebulizer equipment. RN#2 was observed to walk | F 880 | | |

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| F 880 | Continued From page 101<br>to the nebulizer machine and mouthpiece which was located on the bedside table, to the right of the resident's bed. RN#2 picked up the equipment and stated "this should be in a bag, I will take care of this." During an interview with RN #2 at 3/14/18 at 2:44 PM when the surveyor asked why it should be in a bag, RN#2 stated to prevent the spread of infection.<br><br>The facility policy (#SNF-030) for Respiratory Equipment - Use and Maintenance noted under the subtitle Medication Nebulizer/Continuous Aerosol:<br>Procedure # 7. Store circuit in plastic bag, marked with the date and resident's name, between uses.<br><br>5. Resident #103 was admitted to the facility on 2/21/18, diagnoses include but are not limited to acute on chronic right heart failure, anemia, diabetes type II, hyperlipidemia, dementia-unspecified, obstructive sleep apnea, primary hypertension, and atrial fibrillation.<br><br>An Admission Minimum Data Set (MDS) assessment was completed on 3/2/18 for the resident. In the area of Cognitive patterns with a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. Activities of Daily Living (ADL) section indicated resident #103 needed extensive assistance with self-performance in bed mobility, transfers, dressing, toilet use, and personal hygiene and support of two staff member provided.<br><br>A Care Plan initiated 2/22/18 indicated: Focus -Use of oxygen therapy. Goal - will have no s/sx of poor oxygen absorption through the review date. Interventions - Encourage or assist with | F 880 | | |

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| F 880 | Continued From page 102<br>ambulation as indicated. Resident who should be ambulatory, provide extension tubing or portable oxygen apparatus. Give medications as ordered by physician, monitor/document side effects and effectiveness. Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, increased heart rate (tachycardia) Restlessness, Diaphoresis, Headaches, Lethargy, Confusion Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, skin color. Also Care Planned for- Focus -Obstructive Sleep Apnea. Goal- be free of any complications related to OSA through the review date. Interventions - May have C-PAP (Continuous Positive Airway Pressure) machine from home at home settings. Apply at HS (bedtime) as ordered.<br><br>Resident #103 Physician orders included: May have C-Pap machine from home @ home settings at bedtime for sleep apnea. Please apply O2 to C-Pap machine at night (3/9/18), PT & OT to evaluate and treat as indicated, turn and reposition Q2hrs while in bed or chair documented q shift, weekly skin assessment Thursday 7a - 7p.<br><br>On 03/12/18 at 12:30 PM, Resident #103 was observed with an O2 concentrator administering oxygen via nasal cannula at 2 liters. The CPAP mask and tubing were onbserved on top of the machine (not in a bag).<br><br>On 03/13/18 at 3:13 PM the CPAP mask was observed on top of the machine, not placed in a bag.<br><br>On 03/14/18 at 11:34 AM, during an interview with Resident #103 and his wife, it was determined | F 880 | | |

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| F 880 | Continued From page 103<br>that the resident "wears a CPAP mask at night for sleep apnea." The mask and tubing were observed placed directly on the bedside table and had not been placed in a plastic bag.<br><br>On 03/14/18 at 12:30 PM the CPAP mask was observed on the bedside visitor chair, not in a bag.<br><br>On 3/14/18 at 12:35 PM, Registered Nurse (RN) #2 was asked to come to Resident #103's room to observe his CPAP. RN #2 was observed to walk to the machine, mask and tubing which were located in the guest chair, to the right of the resident's bed. RN#2 was observed to pick up the apparatus and place it on the bedside table.<br><br>On 3/14/18 at 12:40 PM, RN#2 was asked how the CPAP should be stored. RN#2 stated "this should be in a bag, I will fix this." The surveyor then asked why it should be in a bag and RN#2 stated to prevent the spread of infection.<br><br>A review of the facility policy #SNF-030 for Respiratory Equipment - Use and Maintenance noted under the subtitle CPAP:<br>PROCEDURE #2. Store mask in a plastic bag when not in use.<br><br>Facility failed to store CPAP respiratory equipment in a sanitary manner for resident #103. | F 880 | | |