State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495380	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE CITY HEALTH AND REHAB CENTER	5539 HIGHWAY FORTY SEVEN CHASE CITY, VA 23924

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 1/5/16 through 1/7/16. The facility was not in compliance with the Virginia Regulations for the Licensure of Nursing Facilities.

The census in this 120 bed facility was 107 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through 19, 23 and 24), and three closed record reviews (Residents # 20 through 22).

F 001 Non Compliance — F 001

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

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

12 VAC 5-371-150 Resident Rights 12 VAC 5-371-150 (B.1) Cross Reference to F-164	12 VAC 5-371-150 Resident Rights 12 VAC 5-371-150 (B.1) Cross Reference to POC F-164
12 VAC 5-371-150 (B.1) Cross Reference to F-201	12 VAC 5-371-150 (B.1) Cross Reference to POC F-201
12 VAC 5-371-150 (B.1) Cross Reference to F-202	12 VAC 5-371-150 (B.1) Cross Reference to POC F-202
12 VAC 5-371-140 Policies and Procedures 12 VAC 5-371-140 (A) Cross Reference to F-226	12 VAC 5-371-140 Policies and Procedures 12 VAC 5-371-140 (A) Cross Reference to POC F-226
12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (C.5) Cross Reference to F-325	12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (C.5) Cross Reference to POC F-325
12 VAC 5-371-340 Dietary and Food Service Program	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin S Parrott LNHA Robin S Parrott LNHA	Administrator	1-21-2016

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F 001	Continued From Page 1 12 VAC 5-371-340 (J) Cross Reference to F-367 12 VAC 5-371-370 Maintenance and Housekeeping 12 VAC 5-371-370 (F) Cross Reference to F-369 12 VAC 5-371-310 Diagnostic Services 12 VAC 5-371-310 (A) Cross Reference to F-502	F 001	12 VAC 5-371-340 Dietary and Food Service Program 12 VAC 5-371-340 (J) Cross Reference to POC F-367 12 VAC 5-371-370 Maintenance and Housekeeping 12 VAC 5-371-370 (F) Cross Reference to POC F-369 12 VAC 5-371-310 Diagnostic Services 12 VAC 5-371-310 (A) Cross Reference to POC F-502	

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F 000	INITIAL COMMENTS	F 000	The statements made in this plan of Correction are not an admission and do not constitute agreement with the alleged deficiencies. To remain in compliance with all state and federal regulation, the Center has taken or will take action set forth in this plan of correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS		**F-164** 483.10(e), 483.75(l)(4) Personal Privacy/Confidentiality of Records	

An unannounced Medicare/Medicaid standard survey was conducted on 1/5/16 through 1/7/16. One complaint was investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through 19, 22 and 24) and three closed record reviews (Residents # 20 through 22).

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

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.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

1. No corrective action could be taken for resident # 20, as he is no longer in facility. The investigation report was returned to facility by the nurse for resident # 4. LPN #5 will be receiving educational coaching on maintaining confidentiality of resident information.
2. Any resident has the potential to be affected if staff fails to ensure confidentiality of resident information. An audit will be conducted to identify any resident who had an incident occur that warranted an investigation for the past 30 days to ensure the investigation is present at facility.

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

Robin S Parrott LNHA | Robin S Parrott LNHA Administrator | 1-21-2016

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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The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to ensure the confidentiality of patient information for two of 24 residents, Resident #20 and Resident #4.

1. During an interview with the facility MSW (master of social work) Resident #20 voiced suicidal ideations with a plan to not eat or take his medications (Resident #20 had refused one does of Lovenox and did not eat breakfast or lunch on that day). During the interview Resident #20 was on 'Skype' with his girlfriend. The MSW asked the girlfriend for the resident's mother's phone number. Resident #20 was listed as his own responsible party.

2. A completed investigation form regarding an injury of unknown origin to Resident #4 was taken out of the facility without authorization by an employed nurse. The investigation form with documented resident information concerning the injury was missing from the facility from 12/22/15 until 1/6/16.

Findings were:

1. During an interview with the facility MSW (master of social work) Resident #20 voiced

3. Nursing staff and Social Services to be educated by DON or designee on policy and procedure for maintaining a resident's right to privacy and confidentiality of his or her personal and clinical records. Nurse Managers to be educated by DON or designee on process for completion of incident investigations to include maintaining resident right to personal and clinical information.
4. The DON or designee will review incident investigations weekly X 4 weeks, then monthly X 2 to ensure that investigations are complete. Findings of the audit will be reported to the QA committee for further analysis as indicated.
5. Date of compliance is February 10, 2016

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suicidal ideations with a plan to not eat or take his medications (Resident #20 had refused one does of Lovenox and did not eat breakfast or lunch on that day). During the interview Resident #20 was on 'Skype' with his girlfriend. The MSW asked the girlfriend for the resident's mother's phone number. Resident #20 was listed as his own responsible party.

Resident #20, was admitted to the facility on 09/09/2015 at 7:18 p.m. His diagnoses included, but were not limited to: spasm of muscle, aftercare following surgery injury and trauma, gastroparesis, suicidal ideations, and hypertension. Further review of the clinical record revealed further diagnoses of quadriplegia, and TBI (traumatic brain injury) from (self inflicted) gunshot wound to the head.

Resident #20 was sent to a local hospital on 09/10/2015 at approximately 2:40 p.m. and subsequently discharged from the facility per nursing documentation on 09/11/2015 at 7:00 a.m.

Due to his short time at the facility (less than 24 hours) no MDS (minimum data set) was completed. Documented in the Nursing Admission Assessment was information that Resident #20 was oriented to self, time and place.

The clinical record was reviewed on 01/06/2016 beginning at approximately 11:00 a.m. The following information was gleaned from the progress note section:
"09/10/2015 Resident arrived to facility at 1918 via [name]
transport via stretcher, alert and verbal able to

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communicate needs to staff, resp even and non labored regular rise and fall to the chest skin warm dry to touch abdomen soft and non distended, small trachea site intact with closure noted, small dime size area to abdomen noted from peg (percutaneous gastrostomy) tube site, 4X4 dressing covering sire no drainage noted, resident incontinence (sic) of bladder and bowl condom catheter intact draining 300 cc of yellow urine for 3pm/11pm shift, incontinence care provided, resident mother in bedroom with resident until 2230 (10:30 p.m.), mother brought in laptop computer for resident noted computer on tray top in reach for resident use. CNA (certified nursing assistant) reported to writer that resident was making suicidal remarks, resident stated to CNA he wanted to go back to the hospital and if he didn't go he would kill himself, resident also c/o of bed stated it was very uncomfortable that he is 6'2 tall and that the bed he was lying in was too short for him, writer responded to resident that the nurse will contact maintenance man in the a.m., staff repositioned resident X several attempts to make resident comfortable however resident continues to c/o discomfort due to bed...call bell in reach, resident consumed all medications via mouth, will continue to monitor." (sic-no punctuation in this entry)

"09/10/2015 8:00 a.m. Resident alert and oriented...Offered breakfast but refused. Accepted meds with no difficulty. Refused lovenox injection. Writer explained purpose of the injection med was still refused. No suicidal ideations made at this time..."

"09/10/2015 9:00 a.m. ...observed on Skype with family and girlfriend. No suicidal ideations made

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to writer..."

"09/10/2015 10:00 a.m. ...observed on Skype with family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 10:09 a.m. Writer in to do body audit, resident lying bed talking to girlfriend on computer via Skype. Compliant with care and assessment. Stated, "I would like to go home" Pleasant mood with writer."

"09/10/2015 11:00 a.m....observed on Skype with family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 11:03 In to speak with Resident about [Name of Mental health program]. Asked first if writer could talk in front of girlfriend which she is on Skype. He asked what [program name] was. So writer explained what it consist (sic) of and he stated, 'absolutely not, don't even try it. get out (sic). Writer left room and told DON (director of nursing) was resident stated."

"09/10/2015 12:00 ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Overheard some conversation with resident and social worker. Social worker explained she is taking his words seriously and will be addressed..."

"09/10/2015 12:55 In to talk with Resident. Asked first if I could talk to him in front of computer that had his girlfriend on and he said yes. In to explain the importance of lovenox. Explain (sic) that it was a blood thinner and it was important that he takes his medication. Explained that he could have a blood clot that

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could go to his lungs, heart and brain. He stated "that he knew that and he was not going to take it." (sic) Girlfriend was pleading with him to take it and he continues to say "no" (Sic) Dr. [Name] notified."

"09/10/2015 1300 (1:00 p.m.) ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Refused lunch..."

"09/10/2015 13:32 MSW (master of social work) interviewed resident and asked how was he doing here at the facility? Resident stated not good. MSW asked resident what is wrong? Resident stated that he did not feel good and he wanted to die? (sic) MSW asked resident who was he talking to on the computer? Resident stated his fiance. MSW asked resident if he wanted to get well and see his fiance? Resident stated not really. MSW asked resident if he had a plan and what was his plan? Resident stated that he was not going to eat or take his medications. MSW explained to the resident that MSW could not take suicidal thoughts lightly. Resident stated that he understood and wanted to leave the facility anyway. MSW went back in the room with Administrator. Administrator explained to resident the importance of medication and why he needed to take the medication, Resident stated that he did not need to take his medication and he understood the consequences. MSW asked fiance for resident's mother's phone number. Resident became highly upset and started making threats that he was going to call his "niggars" and they would take care of her. MSW called resident's mother [phone number listed] and explained to her that he is refusing his medications. The mother stated that he does that everywhere he goes."

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The DON (director of nursing) was interviewed on 01/06/2016 at approximately 12:30 p.m. regarding the discharge of Resident #20. She stated, "We took his threats of not taking his medications and not eating very seriously...he didn't want to be here...he wanted to go to the hospital so we sent him." The MSW note dated 09/10/2015 was discussed. Per the MSW note, Resident #20 became upset after the MSW asked the resident's fiancee for the phone number for Resident #20's mother. The DON was asked why the MSW would call his mother if he was his own RP. She stated, "We already had the number....his mother reviewed all the paperwork with us when he got here, she signed and he made his mark....I don't know why she asked for it."

No further information was obtained prior to the exit conference.

This is a complaint deficiency.
2. A completed investigation form regarding an injury of unknown origin to Resident #4 was taken out of the facility without authorization by an employed nurse. The investigation form with documented resident information concerning the injury was missing from the facility from 12/22/15 until 1/6/16.

Resident #4 was admitted to the facility on 10/5/12 with diagnoses that included Alzheimer's, dementia with behaviors, glaucoma, osteoporosis, urinary tract infection, hypertension, macular degeneration, anxiety, hyperlipidemia, psychosis and gastroesophageal reflux disease. The minimum data set (MDS) dated 11/23/15 assessed Resident #4 with severely impaired

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cognitive skills.

Resident #4's clinical record was reviewed on 1/6/16. A nursing note dated 12/21/15 documented, "App [approximately] 0530 [5:30 a.m.] call to resident room. During morning ADL [activities of daily living] CNA [certified nurses' aide] notice a skin tear to left ring finger. Writer clean with ns [normal saline], measure steri strips applied..." (sic)

On 1/6/16 at 11:15 a.m. the registered nurse unit manager (RN #1) was interviewed about an investigation of Resident #4's skin tear found on 12/21/15. RN #1 stated she would look for the investigation form regarding the skin tear.

On 1/6/16 at 11:20 a.m. the director of nursing (DON) was interviewed about an investigation of Resident #4's skin tear of 12/21/15. The DON stated she would look for the investigation.

On 1/7/16 at 9:25 a.m. the DON was interviewed again about any investigation of Resident #4's skin tear found on 12/21/15. The DON stated the initial investigation form was sent back to licensed practical nurse (LPN) #5 for completion and was not returned. The DON stated when searching for the investigation form yesterday (1/6/16) she found that LPN #5 had taken the form home in her personal tote bag. The DON stated the unit manager should have made sure the form was completed and returned immediately following the incident. The DON stated nurses were not supposed to take any resident documents or records out of the facility.

On 1/7/16 at 10:30 a.m. the unit manager (RN #1) was interviewed again about Resident #4's

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F 164	Continued From page 8 investigation form. RN #1 stated the nurse (LPN #5) failed to document the location of the skin tear on the initial investigation form so she returned the form to LPN #5 for completion. RN #1 stated LPN #5 picked up the investigation form with her personal belongings and took the form home. RN #1 stated, "I don't think she [LPN #5] realized she had it [investigation form]." RN #1 stated the form was missing until the search occurred for the form yesterday (1/6/16). On 1/7/16 the DON presented a copy of Resident #4's skin tear investigation form dated 12/21/15. The investigation form documented the resident's name, room number, date/time of injury, description/location and size of the injury, resident's risk factors for bruising, notifications to family and physician and recommendations to prevent recurrence of injury. These findings were reviewed with the administrator, director of nursing and senior services specialist during a review meeting on 1/7/16 at 11:00 a.m.	F 164		
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;		**F-201** 483.12(a)(2) Reasons for Transfer/Discharge of Resident 1. No corrective action could be taken for resident # 20, as he is no longer a resident. 2. DON or designee will review discharges for the past 30 days to ensure they were completed appropriately according to policy and procedure.	

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The safety of individuals in the facility is endangered;

The health of individuals in the facility would otherwise be endangered;

The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

The facility ceases to operate.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to ensure the proper discharge for one of 24 residents, Resident #20.

Resident #20 was sent to a local hospital following his verbalization of suicidal ideations to the facility staff. Resident #20 stated that his plan was to stop eating and taking his medications. Resident #20 was evaluated and determined not to be a risk to self due to his physical limitations. When the local hospital tried to send Resident #20 back to the facility, the facility refused his readmission.

Findings were:

Resident #20, was admitted to the facility on 09/09/2015 at 7:18 p.m. His diagnoses included,

3. The Administrator, Social Services, Admissions staff and RN's and LPN's will be educated on policy and procedure related to conducting a proper discharge.
4. DON or designee will review discharges weekly X 4 weeks, then randomly for 2 months to ensure proper discharge for the resident. Findings of the audit will be reported to the QA committee for further analysis as indicated.
5. Date of compliance February 10, 2016

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but were not limited to: spasm of muscle, aftercare following surgery injury and trauma, gastroparesis, suicidal ideations, and hypertension. Further review of the clinical record revealed further diagnoses of quadriplegia, and TBI (traumatic brain injury) from (self inflicted)gunshot wound to the head.

Resident #20 was sent to a local hospital on 09/10/2015 at approximately 2:40 p.m. and subsequently discharged from the facility per nursing documentation on 09/11/2015 at 7:00 a.m.

Due to his short time at the facility (less than 24 hours) no MDS (minimum data set) was completed. Documented in the Nursing Admission Assessment was information that Resident #20 was oriented to self, time and place.

The clinical record was reviewed on 01/06/2016 beginning at approximately 11:00 a.m. The following information was gleaned from the progress note section:
"09/10/2015 Resident arrived to facility at 1918 via [name]
transport via stretcher, alert and verbal able to communicate needs to staff, resp even and non labored regular rise and fall to the chest skin warm dry to touch abdomen soft and non distended, small trachea site intact with closure noted, small dime size area to abdomen noted from peg (percutaneous gastrostomy) tube site, 4X4 dressing covering sire no drainage noted, resident incontinence (sic) of bladder and bowl condom catheter intact draining 300 cc of yellow urine for 3pm/11pm shift, incontinence care provided, resident mother in bedroom with

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resident until 2230 (10:30 p.m.), mother brought in laptop computer for resident noted computer on tray top in reach for resident use. CNA (certified nursing assistant) reported to writer that resident was making suicidal remarks, resident stated to CNA he wanted to go back to the hospital and if he didn't go he would kill himself, resident also c/o of bed stated it was very uncomfortable that he is 6'2 tall and that the bed he was lying in was too short for him, writer responded to resident that the nurse will contact maintenance man in the a.m., staff repositioned resident X several attempts to make resident comfortable however resident continues to c/o discomfort due to bed...call bell in reach, resident consumed all medications via mouth, will continue to monitor." (sic-no punctuation in this entry)

"09/10/2015 8:00 a.m. Resident alert and oriented...Offered breakfast but refused. Accepted meds with no difficulty. Refused lovenox injection. Writer explained purpose of the injection med was still refused. No suicidal ideations made at this time..."

"09/10/2015 9:00 a.m. ...observed on Skype with family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 10:00 a.m. ...observed on Skype with family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 10:09 a.m. Writer in to do body audit, resident lying bed talking to girlfriend on computer via Skype. Compliant with care and assessment. Stated, "I would like to go home" Pleasant mood with writer."

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"09/10/2015 11:00 a.m....observed on Skype with family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 11:03 In to speak with Resident about [Name of Mental health program]. Asked first if writer could talk in front of girlfriend which she is on Skype. He asked what [program name] was. So writer explained what it consist (sic) of and he stated, 'absolutely not, don't even try it. get out (sic). Writer left room and told DON (director of nursing) was resident stated."

"09/10/2015 12:00 ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Overheard some conversation with resident and social worker. Social worker explained she is taking his words seriously and will be addressed..."

"09/10/2015 12:55 In to talk with Resident. Asked first if I could talk to him in front of computer that had his girlfriend on and he said yes. In to explain the importance of lovenox. Explain (sic) that it was a blood thinner and it was important that he takes his medication. Explained that he could have a blood clot that could go to his lungs, heart and brain. He stated "that he knew that and he was not going to take it." (sic) Girlfriend was pleading with him to take it and he continues to say "no" (Sic) Dr. [Name] notified."

"09/10/2015 1300 (1:00 p.m.) ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Refused lunch..."

"09/10/2015 13:32 MSW (master of social work)

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interviewed resident and asked how was he doing here at the facility? Resident stated not good. MSW asked resident what is wrong? Resident stated that he did not feel good and he wanted to die? (sic) MSW asked resident who was he talking to on the computer? Resident stated his fiance. MSW asked resident if he wanted to get well and see his fiance? Resident stated not really. MSW asked resident if he had a plan and what was his plan? Resident stated that he was not going to eat or take his medications. MSW explained to the resident that MSW could not take suicidal thoughts lightly. Resident stated that he understood and wanted to leave the facility anyway. MSW went back in the room with Administrator. Administrator explained to resident the importance of medication and why he needed to take the medication, Resident stated that he did not need to take his medication and he understood the consequences. MSW asked fiance for resident's mother's phone number. Resident became highly upset and started making threats that he was going to call his "niggars" and they would take care of her. MSW called resident's mother [phone number listed] and explained to her that he is refusing his medications. The mother stated that he does that everywhere he goes."

"09/10/2015 14:00 Writer was told to send Resident to [name of hospital] per Admission Directors and Administrators."

"09/10/2015 14:00 ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Accepted afternoon meds with no difficulty..."

"09/10/2015 14:40 Resident to hospital for

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suicidal ideations and verbal threats to himself. Conversation with resident heard by social worker. Unit manager advised writer that resident would be sent out for evaluation."

A physician order dated 09/10/2015 was observed: "Send to [name of hospital] ER for eval and tx (treatment)."

The discharge summary in the clinical record was reviewed. The discharge summary was signed by the physician on 10/13/2015 and contained the following information, but not limited to: "Where was the resident discharged to? Hospital; What was the Rehabilitation potential for this resident? See Closed chart; Resident Discharge Diagnosis included: See Closed Chart; Summary of Care Give a brief summary of care while at the facility: Resident was not here but for 1 day. Resident was discharged to ER (emergency room) for evaluation for suicidal ideations. Please see closed chart."

The DON (director of nursing) was interviewed on 01/06/2016 at approximately 12:30 p.m. regarding the discharge of Resident #20. She stated, "We took his threats of not taking his medications and not eating very seriously...he didn't want to be here...he wanted to go to the hospital so we sent him." The MSW note dated 09/10/2015 was discussed. Per the MSW note, Resident #20 became upset after the MSW asked the resident's fiancee for the phone number for Resident #20's mother. The DON was asked why the MSW would call his mother if he was his own RP. She stated, "We already had the number....his mother reviewed all the paperwork with us when he got here, she signed and he made his mark....I don't know why she

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asked for it." The DON was asked if residents at the facility have a right to refuse medications or to eat. She stated, "Yes, but he said he wanted to kill himself." The MAR (medication administration record) was discussed. According to the MAR and the nurse's notes, Resident #20 took all of his medications without difficulty, except his Lovenox (missed one dose). The DON was asked if anyone had addressed that the medication Resident #20 was refusing was an injection, that could have been changed to an oral anticoagulant, had anyone asked if the resident was afraid of shots? The Corporate consultant was in the room and stated, "That's what I asked."

The DON presented a summary letter written by the former administrator regarding the discharge. According to the letter dated 09/11/2015 Resident #20 was expressing active suicidal ideation and had stated to a CNA that if he didn't go back to the hospital he would kill himself. Resident #20 refused his lovenox injection on 09/10/2015 and during an interview with the administrator on that day he explained the consequences of his decision. Per the summary letter, the resident's "girlfriend spoke up and asked him why he was being so difficult, resident responded "You shut up you F------ B----. When I get back there I will kill you right this time". At this time resident stated to the Administrator and Social Worker that "We would see what happens when he brings his n------ up in here." His fiancee then told resident "They are not going to come all the way from [city]; resident states, "yes, they will". Resident was offered to see on-site psych services; patient refused." [Resident name] is his own RP (responsible party) and wants to go to the hospital and the facility arranged transport to return to

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[Name of healthcare system] On-going refusals to accept medical treatment and psych intervention have made it impossible for our facility to meet the needs of this resident and protect the safety of the other residents and staff of [name of nursing home].

The unit manager who worked with Resident #20, the administrator and the MSW who interviewed Resident #20, were all no longer employed at the facility and therefore could not be interviewed.

The Admissions Director was interviewed on 01/06/2016 at approximately 2;30 p.m. regarding the discharge of Resident #20. She stated, "I was told by the [name of former administrator] that he was making suicidal threats...he wanted to be back in [city] and he said he wasn't going to take his medications or eat...her told the staff he was bringing his gang in." The Admissions Director was asked where the gang comment or that the resident had any gang connections was documented. She stated, "I don't know...everything I really know about this is hearsay from [name of former administrator]. The admissions director was asked to go over the events the best that she could. She stated, "He went to the emergency room and was evaluated...they wanted to send him back here sometime during the night. I was going over to the hospital the next day for a partnership meeting. [Name of former administrator] texted me early that morning before the meeting to tell me that we weren't taking him back due to his comment about the gang and bring his gang in here....When I was at the meeting I introduced myself to the hospital administrator. He said something like, you're brave to approach me after what happened last night...those aren't his exact

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words." The admissions director was asked what that comment meant. She stated, " We sent the resident over to the hospital, when they wanted to send him back [name of hospital administrator] got involved because our administrator refused to take him back...The hospital administrator said he was going to report us to the state...he also said he wanted to be sure we knew the difference between suicidal and homicidal...if he was bringing his gang in then that would be homicidal...he also asked me how the resident could commit suicide when he couldn't move his arms, he said his staff had evaluated and determined that he couldn't move his arms enough to be a threat." The Admissions Director was asked if the resident was admitted to the hospital since the facility didn't take him back. She stated, "No, the hospital administrator told me there was no reason to admit him...the hospital got his mom involved. They wanted him home and were trying to make arrangements to get him there, when the hospital called she moved out of her house and into an extended stay hotel to bring him there and take care of him...they did emergency paperwork with Medicaid to get his equipment there....the hospital administrator said we were dumping the resident."

Arrangements were made at approximately 3:15 p.m. on 01/06/2016 to obtain the hospital emergency room visit for Resident #20.

Resident #20's hospital records were obtained on 01/07/2016 and subsequently reviewed. The following information was obtained:

Transport Record from Local Rescue Squad: "Arrived on scene pt (patient) was in bed nurse at

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nursing home said pt was to be transported to [name of local hospital] for altered mental status and to be transported back to [hospital out of the area]..."

Virginia Preadmission Screening Report: "Presenting Crisis Situation Reason for Referral:; Suicidal thoughts/statements w/ (with) plan of hanging himself. Assessment: Client was placed in [name] nursing home for P.T. (physical therapy) on yesterday. Client reportedly told staff all night last night that he wanted to kill himself. Upon interviewing client, he admitted to making suicidal statements and reported he had a plan of hanging himself w/ headphone cord today. He says he is depressed b/c (because) of his injuries and b/c he is 104 miles from his family. I spoke to (name) at nursing home and she reported that 2 months ago he shot his gf (girlfriend) and then attempted to shoot himself in the head; the injury led to paralysis of legs and arms, with very limited mobility of left arm-cannot make a fist, could only raise arm 2-3 inches from body. He cannot eat by himself, cannot walk, uses catheter/briefs to urinate defecate...It does not appear that client has they physical capabilities to carry out harm to himself or others due to paralysis of body. Does not meet criteria for TDO (temporary detention order)....Outcome of the emergency evaluation or ECO (emergency custody order): Referral to voluntary outpatient or community treatment other than crisis stabilization....Risk factors: Does not have physical capability to carry out harm due to paralysis of body. Final Disposition: Referral for OP (outpatient) therapy."

Consultation Record: "Type of Services or Consult Requested: Pre-screening Findings: Suicidal statements w/ plan of hanging himself w/

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headphone cord. Due to paralysis, he does not appear to have the physical capability to carry our harm to self or others. Recommendations: Release to f/u (follow-up) w/ outpatient counseling." The form was dated 9/11/2015 1:00 a.m., and signed by the certified prescreener from the local CSB (community services board).

Emergency Room Nurse's Notes: "09/10 ...Presenting complaint: EMS (emergency medical squad) states pt is a resident of [name] nursing home. Had suicidal ideations today. Stated they tried to send pt back to [name of hospital] but was told that he had to be seen here first. States that pt told them he wanted to kill himself and that he would bring people in to hurt those at the nursing home. Asked pt if he has current suicidal thoughts and he replied 'no'. Asked pt what brought him here, he states he told staff he wanted to kill himself but he doesn ' t really want to..." 09/11 05:43 Valuables inventory done. NOTED THAT IT APPEARS ALL OF PATIENT'S BELONGINGS HAVE BEEN SENT FORM NURSING HOME WITH PATIENT TO ED (emergency department) SUCH AS A BLACK COLORED TV ON COUNTER, SMALL LAPTOP, PILLOW, MULTIPLE TOILETRIES, BLACK PREVALON BOOT."

Further documentation in ER notations: Counseling: ...detailed discussion with the patient and/or guardian regarding: The hospital points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, the need to transfer to another facility for higher level of care. ED Course: [Name] from {name} CSB evaluated patient there is no psych institution including [hospital name] in this area who is willing to accept transfer of this patient

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secondary to his medical condition upon further evaluation by the CSB, the nursing home appears to have dumped this patient her because they do not want to deal with his psych issues. Admin rep [name] involved was in contact with [name] nh (nursing home) administrator and they are still refusing to accept their patient back. patient (sic) has no medical reason for admit to the hospital at this time. [Name of hospital administrator] notified requests hold patient in the emergency room this evening and her will attempt to rectify this situation in the morning." (sic-punctuation is written as appears in hospital record)

A note from the Hospital Case Manager: "Referral for assistance with placement. Patient was sent from [Name of Nursing Home] d/t (due to) suicidal ideations. Patient has been cleared by the CSB for outpatient follow-up for his depression. Spoke to patient who want to go to a nursing facility in Richmond. Per the patient, he has been declined by every nursing home in [City]Spoke to mother, [name number]. Mother is working on arranging for a hotel for patient to be transferred to [city]. She has been trained to care for patient and feels comfortable meeting his needs. She and the patient's father plan to take care of him until the apartment is ready in 2-3 weeks for patient to be transitioned to...Discussed with patient the plan, He is in agreement and actually smiled when I told him the plan."

A meeting was held with the administrator and the DON on 01/07/2016 at approximately 11:00 a.m. Concerns were voiced that Resident #20 was sent out due to suicidal ideations per the clinical record, per interview with the Admissions Director she was told by the former administrator that the resident would not be taken back due to threats

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F 201	Continued From page 21 of bringing his 'gang' to the nursing home, and per the hospital documentation the facility had sent all of the resident's belongings with him to the emergency room and had refused to take the resident back. The DON stated that the resident had told the staff that he did not want to be at the facility. She felt they were respecting his right to be sent to the hospital. The DON was asked if there was any documentation from the physician as to why the resident was discharged, such as the facility being unable to meet his needs or concern for the safety/health of other individuals in the facility. She stated, "He was here such a short period of time that the doctor did not see him." No further information was obtained prior to the exit conference. This is a complaint deficiency.	F 201		
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review	F-202	**F-202** 483.12(a)(3) Documentation for Transfers/Discharges 1. Unable to amend the clinical record for resident # 20. 2. DON or designee to review discharges for the past 30 days to validate that appropriate physician documentation is in place for discharge including but not limited to order and reason for the discharge. BRP	

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and in the course of a complaint investigation, the facility staff failed to ensure the proper documentation regarding the discharge for one of 24 residents, Resident #20.

There was no physician documentation regarding the reason for Resident #20's discharge.

Findings were:

Resident #20, was admitted to the facility on 09/09/2015 at 7:18 p.m. His diagnoses included, but were not limited to: spasm of muscle, aftercare following surgery injury and trauma, gastroparesis, suicidal ideations, and hypertension. Further review of the clinical record revealed further diagnoses of quadriplegia, and TBI (traumatic brain injury) from (self inflicted) gunshot wound to the head.

Resident #20 was sent to a local hospital on 09/10/2015 at approximately 2:40 p.m. and subsequently discharged from the facility per nursing documentation on 09/11/2015 at 7:00 a.m.

Due to his short time at the facility (less than 24 hours) no MDS (minimum data set) was completed. Documented in the Nursing Admission Assessment was information that Resident #20 was oriented to self, time and place.

The clinical record was reviewed on 01/06/2016 beginning at approximately 11:00 a.m. The following information was gleaned from the progress note section:
"09/10/2015 Resident arrived to facility at 1918 via [name]

3. The Administrator, Social Services, Admissions staff and RN's and LPN's will be educated on policy and procedure related to conducting a proper discharge. The Administrator and DON will meet with the Medical Director to review his responsibility in ensuring proper discharge for residents.
4. DON or designee will review discharges weekly for 4 weeks, then randomly review discharges x 2 months to ensure physician's order and reason for discharge is documented. Findings of the audit will be reported to the QA committee for further analysis as indicated.
5. Date of compliance February 10, 2016

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transport via stretcher, alert and verbal able to communicate needs to staff, resp even and non labored regular rise and fall to the chest skin warm dry to touch abdomen soft and non distended, small trachea site intact with closure noted, small dime size area to abdomen noted from peg (percutaneous gastrostomy) tube site, 4X4 dressing covering sire no drainage noted, resident incontinence (sic) of bladder and bowl condom catheter intact draining 300 cc of yellow urine for 3pm/11pm shift, incontinence care provided, resident mother in bedroom with resident until 2230 (10:30 p.m.), mother brought in laptop computer for resident noted computer on tray top in reach for resident use. CNA (certified nursing assistant) reported to writer that resident was making suicidal remarks, resident stated to CNA he wanted to go back to the hospital and if he didn't go he would kill himself, resident also c/o of bed stated it was very uncomfortable that he is 6'2 tall and that the bed he was lying in was too short for him, writer responded to resident that the nurse will contact maintenance man in the a.m., staff repositioned resident X several attempts to make resident comfortable however resident continues to c/o discomfort due to bed...call bell in reach, resident consumed all medications via mouth, will continue to monitor." (sic-no punctuation in this entry)

"09/10/2015 8:00 a.m. Resident alert and oriented...Offered breakfast but refused. Accepted meds with no difficulty. Refused lovenox injection. Writer explained purpose of the injection med was still refused. No suicidal ideations made at this time..."

"09/10/2015 9:00 a.m. ...observed on Skype with

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family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 10:00 a.m. ...observed on Skype with family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 10:09 a.m. Writer in to do body audit, resident lying bed talking to girlfriend on computer via Skype. Compliant with care and assessment. Stated, "I would like to go home" Pleasant mood with writer."

"09/10/2015 11:00 a.m....observed on Skype with family and girlfriend. No suicidal ideations made to writer..."

"09/10/2015 11:03 In to speak with Resident about [Name of Mental health program]. Asked first if writer could talk in front of girlfriend which she is on Skype. He asked what [program name] was. So writer explained what it consist (sic) of and he stated, 'absolutely not, don't even try it. get out (sic). Writer left room and told DON (director of nursing) was resident stated."

"09/10/2015 12:00 ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Overheard some conversation with resident and social worker. Social worker explained she is taking his words seriously and will be addressed..."

"09/10/2015 12:55 In to talk with Resident. Asked first if I could talk to him in front of computer that had his girlfriend on and he said yes. In to explain the importance of lovenox. Explain (sic) that it was a blood thinner and it was important that he takes his medication.

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Explained that he could have a blood clot that could go to his lungs, heart and brain. He stated "that he knew that and he was not going to take it." (sic) Girlfriend was pleading with him to take it and he continues to say "no" (Sic) Dr. [Name] notified."

"09/10/2015 1300 (1:00 p.m.) ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Refused lunch..."

"09/10/2015 13:32 MSW (master of social work) interviewed resident and asked how was he doing here at the facility? Resident stated not good. MSW asked resident what is wrong? Resident stated that he did not feel good and he wanted to die? (sic) MSW asked resident who was he talking to on the computer? Resident stated his fiance. MSW asked resident if he wanted to get well and see his fiance? Resident stated not really. MSW asked resident if he had a plan and what was his plan? Resident stated that he was not going to eat or take his medications. MSW explained to the resident that MSW could not take suicidal thoughts lightly. Resident stated that he understood and wanted to leave the facility anyway. MSW went back in the room with Administrator. Administrator explained to resident the importance of medication and why he needed to take the medication, Resident stated that he did not need to take his medication and he understood the consequences. MSW asked fiance for resident's mother's phone number. Resident became highly upset and started making threats that he was going to call his "niggars" and they would take care of her. MSW called resident's mother [phone number listed] and explained to her that he is refusing his medications. The mother stated that he does that

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everywhere he goes."

"09/10/2015 14:00 Writer was told to send Resident to [name of hospital] per Admission Directors and Administrators."

"09/10/2015 14:00 ...observed on Skype with family and girlfriend. No suicidal ideations made to writer. Accepted afternoon meds with no difficulty..."

"09/10/2015 14:40 Resident to hospital for suicidal ideations and verbal threats to himself. Conversation with resident heard by social worker. Unit manager advised writer that resident would be sent out for evaluation."

A physician order dated 09/10/2015 was observed: "Send to [name of hospital] ER for eval and tx (treatment)."

The discharge summary in the clinical record was reviewed. The discharge summary was signed by the physician on 10/13/2015 and contained the following information, but not limited to: "Where was the resident discharged to? Hospital; What was the Rehabilitation potential for this resident? See Closed chart; Resident Discharge Diagnosis included: See Closed Chart; Summary of Care Give a brief summary of care while at the facility: Resident was not here but for 1 day. Resident was discharged to ER (emergency room) for evaluation for suicidal ideations. Please see closed chart."

Resident #20 was evaluated in the emergency department of the local hospital by prescreener from the local CSB (community service board). Resident #20 was determined to not be a threat

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to himself or others due to his physical limitations form his paralysis. The facility refused to readmit the resident.

The unit manager who worked with Resident #20, the administrator and the MSW who interviewed Resident #20, were all no longer employed at the facility and therefore could not be interviewed.

The Admissions Director was interviewed on 01/06/2016 at approximately 2;30 p.m. regarding the discharge of Resident #20. She stated, "I was told by the [name of former administrator] that he was making suicidal threats...he wanted to be back in [city] and he said he wasn't going to take his medications or eat...her told the staff he was bringing his gang in." The Admissions Director was asked where the gang comment or that the resident had any gang connections was documented. She stated, "I don't know...everything I really know about this is hearsay from [name of former administrator]. The admissions director was asked to go over the events the best that she could. She stated, "He went to the emergency room and was evaluated...they wanted to send him back here sometime during the night. I was going over to the hospital the next day for a partnership meeting. [Name of former administrator] texted me early that morning before the meeting to tell me that we weren't taking him back due to his comment about the gang and bring his gang in here....When I was at the meeting I introduced myself to the hospital administrator. He said something like, you're brave to approach me after what happened last night...those aren't his exact words." The admissions director was asked what that comment meant. She stated, " We sent the resident over to the hospital, when they wanted to

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send him back [name of hospital administrator] got involved because our administrator refused to take him back...The hospital administrator said he was going to report us to the state...he also said he wanted to be sure we knew the difference between suicidal and homicidal...if he was bringing his gang in then that would be homicidal...he also asked me how the resident could commit suicide when he couldn't move his arms, he said his staff had evaluated and determined that he couldn't move his arms enough to be a threat." The Admissions Director was asked if the resident was admitted to the hospital since the facility didn't take him back. She stated, "No, the hospital administrator told me there was no reason to admit him...the hospital got his mom involved. They wanted him home and were trying to make arrangements to get him there, when the hospital called she moved out of her house and into an extended stay hotel to bring him there and take care of him...they did emergency paperwork with Medicaid to get his equipment there....the hospital administrator said we were dumping the resident."

A meeting was held with the administrator and the DON on 01/07/2016 at approximately 11:00 a.m. Concerns were voiced that Resident #20 was sent out due to suicidal ideations per the clinical record, per interview with the Admissions Director she was told by the former administrator that the resident would not be taken back due to threats of bringing his 'gang' to the nursing home, and per the hospital documentation the facility had refused to take the resident back. The DON stated that the resident had told the staff that he did not want to be at the facility. She felt they

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F 202	Continued From page 29 were respecting his right to be sent to the hospital. The DON was asked if there was any documentation from the physician as to why the resident was discharged, such as the facility being unable to meet his needs or concern for the safety/health of other individuals in the facility. She stated, "He was here such a short period of time that the doctor did not see him." No further information was obtained prior to the exit conference. This is a complaint deficiency.	F 202		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to implement their abuse prevention policy to thoroughly investigate injuries of unknown origin for one of 24 residents in the survey sample. Resident #4 experienced a skin tear on 12/21/15 and a skin tear with bruising on 12/22/15. The facility's investigation for the skin tear of 12/21/15 was missing from the facility at the time of the survey. The investigation of the 12/22/15 skin tear/bruising included no statements from the staff members caring for the resident during the shifts prior to the injury.	F 226	**F 226** 483.13(c) Develop/Implement Abuse/ Neglect Policies 1. The investigation for Resident # 4's skin tear dated 12/21/15 has been reviewed and verified by Director of Nursing as complete. LPN #5 will receive educational coaching on completion of investigation of injuries of unknown origin and maintaining confidentiality of resident's personal and clinical information. The investigation for Resident #4's skin tear with bruising dated 12/22/15 has been reviewed and re-investigated to include interviews with staff providing care to her during the shifts prior to the reported injury.	

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The findings include:

Resident #4 was admitted to the facility on 10/5/12 with diagnoses that included Alzheimer's, dementia with behaviors, glaucoma, osteoporosis, urinary tract infection, hypertension, macular degeneration, anxiety, hyperlipidemia, psychosis and gastroesophageal reflux disease. The minimum data set (MDS) dated 11/23/15 assessed Resident #4 with severely impaired cognitive skills.

a) The facility failed to promptly investigate a skin tear of unknown origin. The facility's investigation for a skin tear of 12/21/15 was missing from the facility at the time of the survey.

Resident #4's clinical record was reviewed on 1/6/16. A nursing note dated 12/21/15 documented, "App [approximately] 0530 [5:30 a.m.] call to resident room. During morning ADL [activities of daily living] CNA [certified nurses' aide] notice a skin tear to left ring finger. Writer clean with ns [normal saline], measure steri strips applied..."

On 1/6/16 at 11:15 a.m. the registered nurse unit manager (RN #1) was interviewed about any investigation of Resident #4's skin tear found on 12/21/15. RN #1 did not present a documented investigation and stated she would look for the investigation form.

On 1/6/16 at 11:20 a.m. the director of nursing (DON) was interviewed about an investigation of Resident #4's skin tear of 12/21/15. The DON stated she would look for the investigation.

F 226

2. Any resident has the potential to be affected if staff fail to ensure a thorough investigation to identify source of injury. Incidents with injury of unknown origin for past 30 days will be reviewed to verify they have been thoroughly investigated and documents are accounted for.
3. Nursing staff will be educated on the Center's policy for investigating injury of unknown origin and maintaining confidentiality of resident's personal and clinical information.
4. DON or designee will review incidents with injury of unknown origin to verify that a thorough investigation has been completed per Center policy and documents are accounted for weekly X 4 weeks, then monthly X 2. Findings of the audit will be reported to the QA committee for further analysis as indicated.
5. Date of compliance February 10, 2016.

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On 1/7/16 at 9:25 a.m. the DON was interviewed again about any investigation of Resident #4's skin tear found on 12/21/15. The DON stated the initial investigation form was returned to licensed practical nurse (LPN) #5 for completion and was not returned. The DON stated when searching for the investigation form yesterday (1/6/16) she found that LPN #5 had taken the form home in her personal tote bag. The DON stated the unit manager should have made sure the form was completed and returned immediately following the incident.

On 1/7/16 at 10:30 a.m. the unit manager (RN #1) was interviewed again about Resident #4's investigation form. RN #1 stated the nurse (LPN #5) failed to document the location of the skin tear on the initial investigation form so she returned the form to LPN #5 for completion. RN #1 stated LPN #5 picked up the investigation form with her personal belongings and took the form home. RN #1 stated, "I don't think she [LPN #5] realized she had it [investigation form]." RN #1 stated the form was missing until the search occurred for the form yesterday (1/6/16).

b) The investigation of Resident #4's skin tear/bruising of 12/22/15 was not thoroughly investigated. The investigation included no identification of or statements from staff members caring for the resident during the shifts immediately prior to the injury.

Resident #4's clinical record documented a nursing note dated 12/22/15 stating, "Writer called to room by staff to assess right hand middle finger noted skin tear with scab in place and bruising noted to knuckle. Skin tear measures 2.5 cm [centimeters] x 0.2 cm cleaned

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area with NS [normal saline] and applied 1 steri strip to approximate skin. Scant amount of bleeding noted at this time...Area appears sensitive to the touch to the resident observed facial grimacing upon assessment." (sic)

The facility's investigation dated 12/22/15 of Resident #4's skin tear and bruising of her right middle finger was reviewed. The investigation documented the injury as 2.5 cm x 0.2 cm right middle finger, area scabbed over with bruising noted to right middle finger. The investigation listed the source of the injury as unknown and documented the resident had a history of waving her arms during care. The investigation included statements for the certified nurses' aide (CNA) and licensed practical nurse (LPN) that found and assessed the resident's skin tear/bruised finger at 7:00 a.m. on 12/22/15. The investigation included no identification or statements from staff members caring for Resident #4 during the evening and night shifts prior to 7:00 a.m. on 12/22/15.

On 1/6/16 at 11:15 a.m. the registered nurse unit manager (RN #1) was interviewed about the investigation of Resident #4's skin tear/bruising of 12/22/15. RN #1 stated the resident was already out of bed in her chair at 7:00 a.m. on 12/22/15 when the injury was found and reported by the day shift CNA to the nurse. RN #1 stated it was possible the injury occurred during the transfer. RN #1 stated she did not have statements from the CNA or LPN caring for the resident prior to the assessed injury on 12/22/15. RN #1 stated she was in the process of contacting the nurse and aide caring for Resident #4 prior to 7:00 a.m. on 12/22/15 to obtain statements. When asked why the statements were not obtained

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immediately following the incident, RN #1 stated she did not know. RN #1 stated investigations were usually done promptly after an incident or injury. RN #1 stated statements and investigations were usually done the day after the incident or on a Monday if the incident/injury occurred during a weekend.

On 1/6/16 at 11:20 a.m. the director of nursing (DON) was interviewed about the investigation/reporting of Resident #4's skin tear/bruising of 12/22/15. The DON stated the resident was sometimes resistive to care and had increased behaviors especially when she had a urinary tract infection. The DON stated the resident had a history of "flailing" her arms at times.

The facility's policy titled Abuse Prevention (revised 5/25/12) stated concerning investigation and reporting, "Designated staff will immediately review and investigate all incident reports...The facility will investigate and report incidents or occurrences in accordance with federal and state guidelines...If there is reasonable suspicion of abuse, neglect, resident mistreatment, injuries of unknown origin and misappropriation of property that results in serious bodily injury to the resident, the report must be filed within 2 hours of forming a suspicion. If there is no serious bodily injury, then the report must be filed with 24 hours..."

These findings were reviewed with the administrator, director of nursing and senior services specialist during review meetings on 1/6/16 at 12:50 p.m. and 1/7/16 at 11:00 a.m.

F 325 SS=D 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE — F 325

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Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure additional interventions were put in place for the prevention of weight loss for one of 24 residents in the survey sample, Resident # 10.

The facility staff failed to implement interventions after a 9 lb (pound) weight loss. The resident was weighed again three weeks later and had an additional 10 lb weight loss, for a total of 19 lbs (>10%) within seven weeks.

Findings include:

During clinical record review on 01/05/16 and 01/06/16, Resident # 10's weight records were observed.

The weight records documented:

08/12/15-187
09/09/15-186

1) Resident #10 will be re-assessed by the Interdisciplinary Team to ensure appropriate interventions are in place to prevent further unavoidable weight loss. The physician will be notified of resident's weight history for the past 6 months. His current weight is 176 lbs (within IBW 165-190lbs).
2) Current resident's weights will be reviewed by the interdisciplinary team to identify any resident with a significant weight loss and to verify that interventions are in place to prevent further unavoidable loss. The physician will be notified of any resident with a significant weight loss.
3) The Interdisciplinary team will be educated on the Center's policy for weight management.
4) The Director of Nursing or designee will review charts for residents who have triggered for a significant weight loss weekly to verify interventions are in place to prevent further unavoidable weight loss and to confirm MD notification weekly x 4

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F 325	Continued From page 35 10/07/15-177 10/28/15-167	F 325		

Resident # 10's current CCP (comprehensive care plan) was then reviewed and documented: "...Diet as ordered...Discuss food preferences...Honor food requests as possible...observe and note intake...obtain ordered labs and report to MD (medical doctor)...Provide vitamins/minerals as ordered...Provide high calorie supplement as ordered...Weights as ordered/per protocol. Report significant changes to MD/RD (medical doctor/registered dietitian)...Assist with feeding as needed...large portions with all meals..."

An annual nutrition assessment dated 06/02/15 documented: "...weight 184 stable...mechanical soft, LCS (low concentrated sweets), NAS (no added salt), LARGE PORTIONS...Boost..."

A quarterly assessment dated 09/03/15 documented: "...weight 187...gradual weight loss of 4 # (lb) over 1 year...mechanical soft, LCS (low concentrated sweets), NAS (no added salt), LARGE PORTIONS...Boost..."

No other nutrition or dietary notes were written between June 2, 2015 through October 28, 2015.

Physician progress notes were reviewed from June 2015 through January 2016, there was no mention of the resident's weight loss.

On 01/06/16 at approximately 1:15 p.m., the DON (director of nursing) and the administrator were informed in a meeting with the survey team of concerns regarding Resident # 10 and the 9 lbs weight loss in just under a month, and within 3

weeks then monthly x 2 months. The DON or designee will report findings of reviews to the QA committee for further analysis.

5) Date of compliance is February 10, 2016.

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more week had an additional loss of 10 lbs. The DON voiced that the RD would know more and would follow up on the above concerns. The policy on weight loss was requested at this time, along with an interview with the facility's RD.

On 01/06/16 at approximately 2:30 p.m., the RD was interviewed regarding Resident # 10. The RD voiced that the resident did not have a significant weight loss and that interventions were in place. The RD was made aware that the resident did have a significant weight loss of 9.3% in just under a month and 18.6 % in 7 weeks. The RD again voiced that the facility had interventions in place and asked if she could look in to this further and present a timeline.

On 01/07/16 at approximately 9:40 a.m., the DON and the RD presented the timeline for Resident # 10 and voiced that the resident had been eating well, but had been having behaviors and that interventions were in place. The RD voiced that the resident was getting adequate calories and nutrition. The RD was made aware that behaviors don't tend to make you lose weight and if the resident was eating, then why was he losing weight. The RD then went on to say that the resident was having medication adjustments. The RD was then simply asked, what interventions were put in place for Resident # 10 after October 7th, when the resident was identified with a 9 lb weight loss. The RD pointed to the time line and pointed to new interventions for Resident # 10 that did not start until October 28th, when the resident had already lost another 10 lbs for a total of 19 lbs.

The RD was asked how she is made aware of weight loss. The RD voiced that the she gets a

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print out each time she comes in, if there is a 5 % weight loss trigger. The RD voiced that she comes in 2 to 3 times per month and they (the facility) has an RD consult that comes weekly. The RD voiced that the consult RD would have seen Resident # 10 the week of October 7th (9 lb weight loss). The RD was informed that notes or any information regarding Resident # 10's weight loss could be found in the clinical record. The RD voiced, there is no note from 'name of consult RD.'

The facility policy on weight loss was again requested.

At approximately 10:45 a.m., the policy was presented. The policy titled, "WEIGHTS" documented: "...Monthly weights are obtained by each unit...Weights with a 5 # (lb) change from the previous month are highlighted and a reweigh is obtained within 24 hours...Weekly weights...Significant weight loss of 5% X (times) 30 days or a continual trend of weight loss..."

On 01/07/16 at 11:00 a.m., the survey team met again with the DON and administration. The DON and administrator were asked about Resident # 10 in relation to the facility's policy above. The DON and administration both were asked if Resident # 10 triggered for a re-weigh and both voiced, yes. The administrator and DON were both asked if the resident should have been a weekly weight after the identified 9 lb weight loss on 10/07/16 and both voiced, yes. The DON and administrator were made aware that Resident # 10 did not have a reweigh documented in the clinical record during that time period and that 3 weeks had passed before the resident was weighed again, at which time the

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F 325	Continued From page 38 resident had lost a total of 19 lbs in 7 weeks. No further information or documentation was presented prior to the exit conference on 01/07/16 at noon.	F 325		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure the physician ordered therapeutic diet was served for two of 24 residents in the survey sample: Resident # 13 and Resident # 7. 1. Resident # 13 was not served a physician ordered therapeutic diet for breakfast on 1/6/2016. Resident # 13 was prescribed a mechanical soft diet with fortified foods at each meal; his breakfast tray did not include fortified foods. 2. Resident # 7 was not served a physician ordered therapeutic diet for breakfast on 01/06/2016. Resident #7 was prescribed a regular diet with fortified foods. Resident #7 was also lactose intolerant and was to receive lactose free milk; her breakfast tray contained no fortified foods and a container of whole milk. Findings include: 1. Resident # 13 was admitted to the facility		**F tag 367** 483.35(e) Therapeutic Diet prescribed by Physician 1) Resident # 13 and #7's prescribed diet order will be reviewed with tray ticket to ensure accuracy on tray ticket. Dietary staff working the breakfast meal on 1/6/16 will be re-educated on what constitutes fortified foods and lactose free products. No negative clinical outcome has been identified for Residents #13 or #7. 2) Any resident can be affected if staff fail to follow physician's prescribed therapeutic diet. An audit will be conducted to verify prescribed diet orders match the tray ticket and the diet ordered is meal served to the resident. 3) Dietary staff will be re-educated on following guidelines and the process for verifying residents with therapeutic diets receive appropriate foods on their trays.	

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3/26/10 with diagnoses to include, but not limited to: epilepsy, dementia, high blood pressure, depression, atopic dermatitis, dry eye syndrome, and benign prostate hypertrophy.

The most recent MDS (minimum data set) was an annual review dated 10/16/15. Resident # 13 was coded with moderate impairment in cognition with a total summary score of 09 out of 15.

On 1/5/16 during review of the electronic medical record (EMR) it was noted the current POS (physician order summary) signed by the physician 1/3/16, included an order carried forward from 12/3/12 for "NAS (no added salt) diet, mechanical soft (ground meat) texture, thin consistency. Plate Guard (sic) with meals; add fortified foods with each tray." A review of Resident # 13's weights revealed a 3.4 pound weight loss from 11/6/15 to 12/8/15; from 147.0 pounds to 143.6 pounds respectively. The resident's current weight, dated 1/6/16, was stable at 143.6. Further review of the resident's weights were noted to fluctuate between 143 pounds and 147 pounds over the past six months.

On 1/6/16 at approximately 8:40 a.m. Resident # 13 was observed in his room with CNA (certified nursing assistant) # 1 setting his tray up. The tray included: corn flakes, coffee, ground sausage, one sweet roll, and a container of whole milk.

On 1/6/16 at 9:00 a.m. the dietary manager (DM) was interviewed about Resident # 13's breakfast, and asked which foods were the fortified foods. The DM stated "The eggs were fortified, and he should have gotten oatmeal, which was also fortified." The DM was advised Resident # 13 did

Dietary and nursing staff will be educated on therapeutic diets.

4) The Dietary Manager or designee will monitor 10 residents weekly (random meal times) x 4 weeks then monthly x 2 months to verify prescribed diet has been served to the resident. The DM or designee will report findings to the QA committee for further analysis.
5) Date of compliance is February 10, 2016.

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not receive eggs or oatmeal, and also informed her what was on the resident's breakfast tray. The DM then stated "They probably gave him the wrong one (sweet roll); we have some that are considered fortified. The whole milk would be considered fortified. The RD (registered dietitian will be here after while; you'll need to talk to her."

On 1/6/16 at 2:10 p.m. the RD was interviewed. The RD was asked to identify/define what constituted a fortified food. The RD stated "A fortified diet includes foods that provide additional calories and protein to residents at risk for weight loss. That would include things like magic cup, super cereal, puddings, and super cookies which would have been enhanced by adding extra butter and/or whole milk/cream....." The RD was then informed of the foods served at breakfast to Resident # 13, and was asked if that was considered a fortified diet. The RD replied "Well, I would say that provided enough calories to prevent weight loss; two sweet rolls could be considered fortified." The RD was informed again the resident was served one sweet roll, and asked if the foods served to Resident # 13 at breakfast was a fortified meal as ordered by the physician. The RD stated "No, that was not a fortified breakfast as ordered by the physician."

The administrator, DON (director of nursing), and regional senior services specialist were informed of the above findings during a meeting with facility staff 1/7/16 beginning at 11:00 a.m.

No further information was provided prior to the exit conference.
2. Resident # 7 was not served a physician ordered therapeutic diet for breakfast on 01/06/2016. Resident #7 was prescribed a

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regular diet with fortified foods. Resident #7 was also lactose intolerant and was to receive lactose free milk, her breakfast tray contained no fortified foods and a container of whole milk.

Resident #7 was originally admitted to the facility on 11/09/2011. Her diagnoses included, but were not limited to: Alzheimer's, Vitamin B deficiency, dysphagia following cerebrovascular disease, hypertension, and dementia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/16/2015. Resident #7 was assessed as having impairment with both long and short term memory, as well as severe impairment with daily decision making skills.

The clinical record was reviewed on 01/05/2016. The POS (physician order sheet) contained an order for "Regular diet Regular texture, Thin consistency, ADD Fortified food" Also contained on the POS beside allergies was "Lactose Intolerant."

A meal observation was conducted in the locked unit of the facility during breakfast on 01/06/2016 at approximately 8:30 a.m. Resident #7 was observed sitting at the end of a table in the dining/day area of the unit. Her tray contained: Bacon, one hard boiled egg, one danish, rice krispie cereal and whole milk. The meal ticket beside her plate contained the following: "Fortified Foods, 8 oz (ounces) Lactose Free Milk". Resident #7 was being fed by CNA (certified nursing assistant) #3. The whole milk had been poured over the rice krispies. CNA #3 was asked what items on Resident #7's tray were considered "Fortified." She stated, "I'm not sure, I

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will find out."

At approximately 8:55 a.m., LPN (licensed practical nurse) #4 was observed handing a covered bowl to CNA #3. LPN #4 was interviewed regarding the bowl. She stated, "It was oatmeal." LPN #4 was asked why she had gotten Resident #7 oatmeal. She stated, "She likes it." LPN #4 was asked if the oatmeal she gave to CNA #3 was fortified. She stated, "Yes." LPN was asked if (Name of CNA #3) had requested it. She stated, "She asked me about the fortified foods, I noticed that she didn't have any and I sent to the kitchen to get it." LPN #4 was then asked about the milk on Resident #7's tray, she stated that she would send to the kitchen to get the lactose free milk.

The RD (registered dietician) was interviewed on 01/06/2016 regarding fortified foods. She stated, "Fortified foods provide additional calories and protein...suggestions are magic cups, super cereals-we add brown sugar and butter to the oatmeal, fortified pudding, whole milk, extra butter on trays, super cookies..." The contents of Resident #7's breakfast tray were then discussed. She stated, "The danishes would be fortified if there were two of them on the tray.' The RD was then told what was on Resident #7's tray. She was then asked, if she thought the physician's order for fortified foods for Resident #7 had been followed at that meal. She stated, "No."

The DON (director of nursing) and the administrator were notified of the above information during a meeting on 01/07/2016 at approximately 11:00 a.m.

No further information was obtained prior to the

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F 367	Continued From page 43 exit conference on 01/07/2016.			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS			

The facility must provide special eating equipment and utensils for residents who need them.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review the facility staff failed to ensure physician ordered assistive devices were implemented for one of 24 residents in the survey sample: Resident # 13. Resident # 13 did not have a plate guard applied to his breakfast plate on 1/6/16.

Findings include:

Resident # 13 was admitted to the facility 3/26/10 with diagnoses to include, but not limited to: epilepsy, dementia, high blood pressure, depression, atopic dermatitis, dry eye syndrome, and benign prostate hypertrophy.

The most recent MDS (minimum data set) was an annual review dated 10/16/15. Resident # 13 was coded with moderate impairment in cognition with a total summary score of 09 out of 15.

On 1/5/16 during review of the electronic medical record (EMR) it was noted the current POS (physician order summary) signed by the physician 1/3/16, included an order carried forward from 12/3/12 for "NAS (no added salt) diet, mechanical soft (ground meat) texture, thin consistency. Plate Guard (sic) with meals; add

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F tag 369 483.35(g) Assistive Devices – Eating Equipment/Utensils

1) The Dietary staff and C.N.A #1 working the breakfast meal on 1/6/16 will be educated on the purpose of the plate guard and the process for application of assistive eating devices to the tray prior to leaving the kitchen. The C.N.A obtained the plate guard for the breakfast meal when questioned and no negative clinical outcome was identified for Resident #13.
2) Current resident charts will be reviewed to identify any resident with an order for use of assistive eating utensils/device and the information is on the tray ticket and applied prior to leaving the kitchen.
3) Dietary and nursing staff will be educated on the purpose of special eating utensils/devices for residents and the process for application of utensil/device prior to tray leaving kitchen.
4) The Dietary Manager (DM) or designee will conduct random meal observations 5 x weekly x 4 weeks then monthly x 2 to verify residents with orders for eating utensils/devices

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fortified foods with each tray."

On 1/6/16 at approximately 8:40 a.m. Resident # 13 was observed in his room with CNA(certified nursing assistant) # 1 setting his tray up. CNA # 1 was asked about the plate guard for the resident's plate. CNA # 1 stated "It usually comes from the kitchen, and is already on his plate; sometimes it's not and I'll go get one. I'll do that now; I will go get a plate guard from the kitchen."

On 1/6/16 at 9:00 a.m. the dietary manager (DM) was interviewed about the plate guard. The DM stated "The plate guard should be applied to plate before it leaves the kitchen."

The administrator, DON (director of nursing), and regional senior services specialist were informed of the above findings during a meeting with facility staff 1/7/16 beginning at 11:00 a.m.

No further information was provided prior to the exit conference.

F 502 SS=D 483.75(j)(1) ADMINISTRATION

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure physician ordered laboratory services were obtained for two of 24 residents in the survey sample: Resident # 13 and Resident # 14.

F 369

have them in place prior to leaving the kitchen. The DM or designee will report observation findings to the QA committee for further analysis.

5) Date of compliance is February 10, 2016.

F-502 483.75(j)(1) Administration

1. M.D. made aware that the Keppra level for resident # 13 had not been obtained as ordered per pharmacy recommendation. M.D. made aware that the lipid profile had not been obtained on resident # 14 as ordered per pharmacy recommendation. The labs were obtained for both residents and M.D. aware of results. The nurses responsible for following up on the pharmacy recommendations for both resident #13 and #14 have been educated on process.

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1. Resident # 13's Levetiracetam (anti-seizure medication) level was not obtained per physician order.

2. Resident # 14's LFT (liver function test) was not obtained per physician order.

Findings include:

1. Resident # 13's Levetiracetam level was not obtained per physician order.

Resident # 13 was admitted to the facility 3/26/10 with diagnoses to include, but not limited to: epilepsy, dementia, high blood pressure, depression, atopic dermatitis, dry eye syndrome, and benign prostate hypertrophy.

The most recent MDS (minimum data set) was an annual review dated 10/16/15. Resident # 13 was coded with moderate impairment in cognition with a total summary score of 09 out of 15.

On 1/5/16 during review of the electronic medical record (EMR) it was noted a pharmacy recommendation dated 6/30/15 which included "This resident receives medication which requires laboratory monitoring via CBC, CMP, and Levetiracetam level. Please consider ordering a Levetiracetam level at this time and then every 3-6 months thereafter...." The physician's response on the form was checked "Agree" and was signed and dated by the physician 6/30/15. The current POS (physician order summary) signed and dated by the physician 1/3/16 included a handwritten entry to "Obtain Levetiracetam level Start date 1/3/16..." Further review of the EMR failed to reveal results for the Levetiracetam level.

F 502

2. DON or designee will review pharmacy recommendations for past 30 days to verify if labs were recommended and ordered that the labs have been obtained per M.D. orders. If not obtained per order, M.D. will be notified.
3. DON or designee will review process for addressing pharmacy recommendations with nursing staff.
4. Nurse Managers or Designee will audit pharmacy recommendations monthly x 3 to ensure recommendations for labs have been obtained as ordered by the physician. The DON or designee will review findings and report to the QA committee for further recommendations
5. Date of compliance is February 10, 2016

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On 1/5/16 at 4:00 p.m. a physician was at the nurses' station, and confirmed he was Resident # 13's physician. The physician was asked about the Levetiracetam level and the handwritten addition to the POS. The physician replied "Let me look in my system over here on this computer; I can look it up better on my system." The physician then reviewed information on his system, and told this surveyor " The lab was missed in June; may not have been transcribed correctly...it was given as a one-time order for January and the frequency will be determined based on the results from that lab draw."

On 1/6/16 at 12:50 p.m. the DON (director of nursing) was made aware of the above findings. The DON stated "Yes, we were talking about that. The pharmacy made a nursing recommendation 12/31/15 requesting follow-up and results of that lab. When we looked for it, we realized it had not been done and that's why it was added to the January POS. The order was transcribed incorrectly in June."

No further information was provided prior to the exit conference.

2. Resident # 14's LFT was not obtained per physician order.

Resident # 14 was admitted to the facility 1/10/13 with diagnoses to include, but were not limited to: dementia without behaviors, high blood pressure, high cholesterol level, anxiety, depression, and peripheral artery disease.

The most recent MDS (minimum data set) was an annual assessment dated 10/30/15. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495380	A. BUILDING _____ B. WING _____	C 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE CITY HEALTH AND REHAB CENTER	5539 HIGHWAY FORTY SEVEN CHASE CITY, VA 23924

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 47	F 502		

14 was coded as having severe impairment in cognitive skills with a total summary score of 04 out of 15.

The electronic medical record (EMR) was reviewed 1/6/16 at 2:40 p.m. A pharmacy recommendation for October 2015 was noted for the physician to "Please consider ordering LFT's at this time and then repeat annually." The physician had checked "Agree" for the response, and signed and dated the form 10/6/15. Further review of the EMR failed to reveal results for the lab test.

On 1/6/16 at 3:10 p.m. LPN (licensed practical nurse) # 2 was asked for assistance locating the lab result. LPN # 2 stated "We'll find it and get it to you." At 3:20 p.m. RN (registered nurse) # 1, who was the unit manager, told this surveyor "There's no result for the October lab; it wasn't done. The doctor wrote another order 12/31/15 for the LFT's to be drawn, and they were done at that time."

The administrator, DON (director of nursing), and senior services specialist were informed of the above findings during a meeting with facility staff 1/7/16 at 11:00 a.m.

No further information was provided prior to the exit conference.