STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TCC AND REHABILITATION-NANSEMOND POINT	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/8/17 through 8/10/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 148 certified bed facility was 134 at the time of the survey. The survey sample consisted of current Resident reviews (Residents #1 through #21) and 13 closed record reviews (Residents #22 through #34).	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	09/22/2017
F 167 SS=B	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167	F167 1. The results of facility most recent survey were posted in the main lobby entrance of Butler Hall where the receptionist desk is located on 08/10/2017. 2. The results of facility most recent survey posted in the main lobby entrance of Butler Hall where the receptionist desk is located was checked by the Director of Nursing/designee to ensure placed in a place readily accessible to residents, and family members and legal representatives of residents. 3. Executive Director/Administrator was in-serviced on 09/19/2017 on posting the results of facility most recent survey in a place readily accessible to residents, and family members and legal representatives of residents at both entrances. 4. The Director of Nursing/designee will review monthly for three months. The Director of Nursing/designee will review monthly that both entrances have the last 3 years of surveys posted in both lobbies. The findings will be reviewed in the monthly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 09/28/2017

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

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F 167	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations the facility staff failed to post location of survey results in the main entrance so visitors entering the facility through that entrance would have knowledge of past survey location. The findings include: During general observations of the facility, conducted 8/8/17 through 8/10/17, a search for the survey results posting uncovered it was located on a wall of the Holladay Hall entrance. There were no postings of where the survey results were located in the Main lobby or at the Joyner Hall entrance. The Main lobby entrance is where the receptionist desk is located and it adjoins the short stay rehabilitation unit. It is also where the receptionist is available for visitor's questions. On 8/10/17 at approximately 11:00 a.m., the receptionist stated if anyone inquired about the survey results she would direct them to the Holladay Hall entrance. Thus, a verbal request must be voiced by a visitor or other interested party in order to view the results. On 8/10/17 at approximately 5:00 p.m., during the	F 167	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Performance Improvement which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy.	

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F 167	Continued From page 2 pre-exit briefing the Administrator, Director of Nursing and Corporate Director of Clinical Operations was asked if they knew what percent of visitors per day utilized the Main entrance and/or Joyner entrance. No one was certain and the Administrator stated it was not anything they had considered. The Administrator stated a posting identical to the Holladay Hall posting would be made for the Main entrance.	F 167	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	09/22/2017
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to ensure 2 of 35 residents in	F 224	F224 1. Resident #36 and #26 medication were PRN for pain, there was no negative outcome to Resident #36 or #26 identified. 2. All residents have the potential to be affected by the sited deficiency. A Narcotic count was conducted on all the medication carts immediately by the Director of Nursing. No other discrepancies were identified. 3. Staff Development Coordinator/Director of Nursing completed in-service on 09/20/2017 for all staff on Abuse focusing on misappropriation. 4. DNS/Designee will randomly conduct narcotic count weekly X 4 weeks, then Bi-weekly X 1month and monthly X 2 months to ensure compliance. 5. All abuse investigations are reviewed and discussed at the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy	

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F 224	Continued From page 3 the survey sample were free from misappropriation of personnel property, Resident #35 and #26. 1. Registered Nurse #3 deliberately took an estimated 14 tablets of the medication Tramadol (1) from Resident #35's medication supply, without administering the medications. 2. Registered Nurse #3 deliberately took two tablets of the medication Tramadol from Resident #26's medication supply, without administering the medication. A Facility Reported Incident (FRI) sent to the State Survey Agency on 4/12/17 reported that an investigation of an allegation of misappropriation of resident's narcotic medication was underway for both Resident #35 and #26. The facility's investigation completed on 4/14/17 substantiated the allegation and the nurse was terminated. The findings included: 1. Resident #35 was admitted to the facility with an initial admission date of 8/3/15 and readmission date of 6/21/17 with diagnoses to include but not limited to dementia, and pathological fracture of the right leg. The current MDS (Minimum Data Set) was a significant change with an assessment reference date of 5/8/17. The MDS coded the resident as having severely impaired cognitive skills for daily decision making. The resident was on Hospice care. The Physician Order Summary included an order dated 3/21/17 for Tramadol Hcl 50 milligrams one	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 224	Continued From page 4 tablet by mouth four time as day as needed for pain not relieved by Tylenol. According to the FRI investigation it was determined that Registered Nurse #3 (RN #3) had taken approximately 14 tablets of Tramadol Hcl 50 milligrams from Resident #35's supply and the sign off narcotic sheet. During the investigation, RN #3 admitted to the Director of Nursing that she had taken the Tramadol and stated she has "a problem and needs help", as evidenced in the investigation notes. The nurse was terminated. Adult Protective Services were also notified by the facility and conducted an independent investigation. The investigation concluded based on a preponderance of evidence that adult abuse, neglect or exploitation had occurred, the complaint was substantiated. 2. The complainant alleged that the facility informed her that a staff member had taken Tramadol from Resident #26's supply and as a result of the investigation the staff member was terminated. Resident #26 was admitted for a short term Respite/ Holiday relief care stay at the facility on 3/15/17. Diagnoses included but not limited to, diabetes, chronic ischemic heart disease, and an unstageable ulcer of the left heel. The admission MDS (Minimum Data Set) with an assessment reference date of 3/25/17 coded the resident as scoring a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact.	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 224	Continued From page 5 The Physician Order Summary report evidenced an order dated 3/20/17 to administer Tramadol HCL tablet 50 mg (milligrams) every 6 hours as needed for moderate pain. According to the FRI investigation it was determined that Registered Nurse #3 (RN #3) had removed one 50 mg tablet of Tramadol from the resident's supply on 4/2/17 at 7:00 a.m, and on 4/6/17 at 8:00 a.m., without administering the doses. During the investigation RN #3 admitted to the Director of Nursing that she had taken the Tramadol and stated she has "a problem and needs help", as evidenced in the investigation notes. The nurse was terminated. The Treatment Administration Record for April 2017 evidenced there was no administration of Tramadol to Resident #26 on 4/2/17 and 4/6/17. Adult Protective Services were also notified by the facility on 4/17/17 and conducted an independent investigation. The investigation concluded based on a preponderance of evidence that adult abuse, neglect or exploitation had occurred, the complaint was substantiated. COMPLAINT DEFICIENCY 1. Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 224	Continued From page 6 pain. https://medlineplus.gov/druginfo/meds/a695011.	F 224	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	09/22/2017
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.	F 278	F278 1. Resident #17, #27, #28, #29, #30, #31, #32, #33 and #34 has been coded accurately in the Minimum Data Set (MDS) assessment to reflect the resident's status. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. Director of Nursing in-serviced Minimum Data Set (MDS) coordinators on 09/20/2017 to accurately code residents in Minimum Data Set (MDS) to reflect accurate resident's status. DNS/Case Manager/MDS Coordinators will audit 5 residents' assessment per week X 12 weeks, then 5 residents' monthly to validate accuracy of MDS assessments. 4. Audits will be performed by Case Manager weekly x three months, then monthly ongoing. Results will be reviewed by the DNS and Case Manager in the monthly Quality Assessment/ Performance Improvement meeting which consists of Executive Director, Medical Director, Director of Nursing, Staff Development, Social	

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F 278	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documents, staff interviews and review of the facility's policy, the facility staff failed to accurately code Minimum Data Set (MDS) assessments for 9 of 35 residents, (Resident #17, and #27 through #34) in the survey sample. 1. The facility staff failed to accurately code Resident #17's Annual MDS assessment at "A1500" and "A1510". 2. The facility staff failed to accurately code Resident #27's Initial Admission MDS assessment at "A0600A and A0600B". 3. The facility staff failed to accurately code Resident #28's Initial Admission MDS assessment at "A0600A and A0600B". 4. The facility staff failed to accurately code Resident #29's Initial Admission MDS assessment at "A0800". 5. The facility staff failed to accurately code Resident #30's Initial Admission MDS assessment at "A0500 and A0600A". 6. The facility staff failed to accurately code Resident #31's Initial Admission MDS assessment at "A0800". 7. The facility staff failed to accurately code Resident #32's Initial Admission MDS assessment at "A0800". 8. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A0600, A0900, and A0600A". 9. The facility staff failed to accurately code Resident #34's Initial Admission MDS assessment at "A0800". The Findings include:	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Services Director, Dietitian, C.N.A & Pharmacy to ensure compliance is sustained ongoing.	09/22/2017

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F 278	Continued From page 8 1. Resident #17 was originally admitted to the facility 4/8/08 and readmitted 4/4/16 after an acute hospitalization. The current diagnoses included intellectual disability, cerebral palsy, and a seizure disorder. The Annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/1/17 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview indicated the resident was with long and short term memory problems and severely impaired decision making abilities. The Virginia Level II Preadmission Screening and Resident Review (PASRR) summary of findings completed 9/14/08 revealed Resident #17's disability was severe mental retardation with related conditions of cerebral palsy and a seizure disorder. The assessor further stated the resident does not communicate verbally and her orientation level was unable to be determined. The PASRR Determination Summary read " ... sensory stimulation is recommended to involve the resident with her environment and provide a medium for interaction." Review of the 5/1/17 MDS assessment revealed at "A1500" a response of "no" to the question; "Is this resident currently considered by the state level PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?" The Resident Assessment Instrument dated October 2016 stated at page A-18 read;	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 9 "*All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), ("mental retardation" (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the resident's method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions). *Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State. *A resident with MI or intellectual disability (ID)/ Developmental disability (DD) must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when a Significant Change in Status Assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change." On 8/10/17 at approximately 1:40 p.m., an	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 10 interview was conducted with Social Worker #2, assigned to Resident #17. Social Worker #2 stated she did not code section "A1500" of the MDS assessment and after speaking with the MDS Coordinators she learned they did not know what PASRR was; therefore, they did not code it either. At section "Z0400 B" of the MDS assessment the MDS Coordinator certified the information for section "A" of the MDS assessment was accurate and collected in accordance with requirements. The MDS Coordinator stated they don't have a facility policy on MDS completion for they follow the guidelines of the Resident Assessment Instrument. On 8/10/17 at approximately 5:00 p.m., during the pre-exit briefing the Administrator, Director of Nursing and Corporate Director of Clinical Operations were made aware of the above information. No additional information was presented. 2. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #27 was admitted to the Facility on 6/7/16. Resident #27's Discharge MDS (Minimum Data Set - an assessment protocol) with an ARD (Assessment Reference Date) of 6/12/16 documented a BIMS (Brief Interview for Mental Status) score of 3 indicating a severe cognitive impairment. Resident #27's Diagnosis included but was not limited to: Dementia in other diseases classified elsewhere without behavioral disturbance. Resident #27's initial MDS was coded inaccurately affecting Resident #27's identifying information in the following MDS sections: A0600-B Medicare Number A0600-A Social Security Number The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. 3. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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	495247	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 278	Continued From page 12 When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #28 was admitted to the Facility on 5/5/16. Resident #28's Discharge MDS with an ARD of 5/25/16 coded a BIMS score of 13 indicating no cognitive impairment. Resident #28's Diagnosis included but was not limited to: Failure to Thrive. Resident #28's initial MDS was coded inaccurately affecting Resident #28's identifying information in the following sections: A0600-B Medicare Number A0600-A Social Security Number The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. 4. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 13 "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #29 was admitted to the Facility on 4/23/15. Resident #29's Discharge MDS with an ARD of 6/17/15 coded a BIMS score of 15 indicating no cognitive impairment. Resident #29's Diagnoses included but were not limited to: Generalized Muscle Weakness and Muscular Wasting and Disuse Atrophy. Resident #29's initial MDS was coded inaccurately affecting Resident #29's identifying information in the following section: A0800 Resident #29 was initially listed as a male when she is a female. The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 14 5. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #30 was admitted to the Facility on 10/14/16. Resident #30's Discharge Death In Facility MDS coded a BIMS score of 15 indicating no cognitive impairment. Resident #30's Diagnoses included but were not limited to: Pneumonia. Resident #30's initial MDS was inaccurately coded affecting Resident #30's identifying information in the following sections: A0600A Social Security Number A0500 Legal Name of Resident	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 15 The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. 6. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #31 was admitted to the Facility on 11/17/14. Resident #31's Discharge MDS coded a BIMS score of 15 indicating no cognitive impairment. Resident #31's Diagnosis included but was not limited to: Sepsis. Resident #31's initial MDS was inaccurately coded affecting Resident #31's identifying	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 16 information in the following section: A0800 was coded as a male when Resident is female The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. 7. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was refereed to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #32 was admitted to the Facility on 10/21/16. Resident #32's Death In Facility Discharge MDS coded Resident #32 as having both Short and Long Term Memory Problems. Resident #32's Diagnosis included but was not	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continuec From page 17 limited to: Failure to Thrive. Resident #32's initial MDS was inaccurately coded affecting Resident #32's identifying information in the following sections: A0800 was coded as female when Resident is male The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. 8. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was refereed to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #33 was admitted to the Facility on 12/7/14 with a readmission of 9/7/15. Resident	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 18 #33's Discharge MDS coded Resident #33 as having a 15 BIMS score, indicating no cognitive impairment. Resident #33's Diagnosis included but was not limited to: End Stage Renal Disease. Resident #33's initial MDS was inaccurately coded affecting Resident #33's identifying information in the following sections: A0600 Medicare Number A0900 Date of Birth A0600A Social Security Number The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. 9. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 19 On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17. Resident #34 was admitted to the Facility on 4/5/17. Resident #34's Admission MDS coded Resident #34 as having a BIMS score of 9 indicating a moderate impairment of cognition. Resident #34 Diagnosis included but was not limited to: Chronic Obstructive Pulmonary Disease. Resident #34's initial MDS was inaccurately coded affecting Resident 34's identifying information in the following sections: A0800 Resident coded as Male when Resident is Female On 8/9/17 at approximately 11:20 a.m. the MDS Coordinator stated that the RAI (Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14 October 2016) acts as the Policy and Procedural Guide. On 8/10/17 at approximately 11:20 a.m. the MDS Coordinator #4 stated that all 8 Residents previously on the 8/8/17 "Missing Obra Assessment Report" are off and that she was so happy to have learned about this report. The Facility Policy titled, "NCD MDS Transmission" with a Release date of 9/26/16,documented the following: "Assessment data is entered into a computer, and the encoded data is electronically transmitted to the state database. The transmitted data is a format that conforms to standard record layouts and data dictionaries and	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 278	Continued From page 20 passes standardized edits defined by CMS (Center for Medicare Service) and the State." The Facility Policy titled, "Documentation of Resident's Health Status, Needs and Services" with a date of 10/31/09 date, documented the following: "Documentation should be factual, accurate, complete and timely." The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	09/22/2017
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual	F 285	F285 1. Community Service Board has been contacted for resident #17 to incorporate resident's care and services recommendations from PASRR level 11 determination to meet requirement for MI & MR residents. 2. All residents residing in the facility have been identified as having the potential to be affected. Reviewed all residents for MI/MR, PASSR Level II diagnosis and if requirements are met. 3. The Executive Director in-serviced on 09/19/2017 the Director of Social Services on the policy for incorporating the recommendations from the PASRR level 11 determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care to meet the requirement for MI & MR residents. All new admissions will be reviewed in clinical morning meeting for PASSR level II determination to determine if appropriate recommendations and care plan addresses disability.	

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F 285	Continued From page 21 disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 285	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Results of all Residents with PASRR II determination will be reviewed and discussed by the Executive Director, reviewed and analyzed by the interdisciplinary Team which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy at the monthly Quality Assessment and Performance Improvement meeting for three months with a subsequent plan of correction as needed.	09/22/2017

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F 285	Continued From page 22 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual	F 285	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 285	Continued From page 23 disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and review of the facility's policy the facility staff failed to ensure that an individual with intellectual disability, care and services incorporated the recommendations from the PASRR level II determination and to ensure further Community Service Board services were incorporated into the resident's assessments and care plan for 1 of 35 residents (Resident #17), in the survey sample. The findings included; Resident #17 was originally admitted to the facility 4/8/08 and readmitted 4/4/16 after an acute hospitalization. The current diagnoses included intellectual disability, cerebral palsy, and a seizure disorder. The Annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/1/17 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview indicated the resident was with long and short term memory problems and severely impaired decision making abilities. Review of the 5/1/17 MDS assessment revealed at "A1500" a response of "no" to the question Is this resident currently considered by the state level PASRR process to have serious mental illness and/or intellectual disability ("mental	F 285	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 285	Continued From page 24 retardation" in federal regulation) or a related condition? The Virginia Level II Preadmission Screening and Resident Review (PASRR) summary of findings completed 9/14/08 revealed Resident #17's disability was severe mental retardation with related conditions of cerebral palsy and a seizure disorder. The assessor further stated the resident does not communicate verbally and her orientation level was unable to be determined. The PASRR Determination Summary read "... sensory stimulation is recommended to involve the resident with her environment and provide a medium for interaction." PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, Olmstead vs L.C. (1999), under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care. (https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html) The current and active person-centered care plan which was updated 8/7/17 did not address the intellectual disability diagnosis, neither did it	F 285	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 285	Continued From page 25 address coordination of care and services with the Community Services Board to include participation in planning person centered care. The Resident Assessment Instrument dated October 2016 stated at page A-19; Planning for Care: "*The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State. * The State is responsible for providing specialized services to individuals with MI or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition. * The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care. * Identifies individuals who are subject to Resident Review upon change in condition." On 8/10/17 at approximately 1:40 p.m., an interview was conducted with Social Worker #2, who is assigned to Resident #17. Social Worker #2 stated she did not code section "A1500" of the MDS assessment and after speaking with the	F 285	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 285	Continued From page 26 MDS Coordinators she learned they did not know what PASRR is. Social Worker #2 also stated she has never coordinated with the Community Service Board on Resident #17's behalf and was not aware this was required. As a result the resident had not been followed by the Community Service Board since admission. Social Worker #2 stated the Community Service Board was contacted and an appointment was scheduled for 8/29/17 for someone to come to the nursing facility and update the screening and assign a new caseworker for Resident #17. On 8/10/17 at approximately 5:00 p.m., during the pre-exit briefing the Administrator, Director of Nursing and Corporate Director of Clinical Operations were made aware of the above information. No additional information was presented but the Corporate Consultant stated the only information they have regarding PASRR was what was included in the facility's Mental and Psychosocial Functioning policy with a release dated of 9/28/18. The policy read at #5; "Patients newly diagnosed with mental illness triggers a PASSR review by the state mental health authority." There was no information for the Level II PASSR screening or updates.	F 285	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 315		

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F 315	Continued From page 27 (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to ensure 1 of 35 resident (Resident #8) in the survey sample received necessary equipment to aid in prevention of urinary incontinence episodes. The facility staff failed to provide Resident #8 with a bedpan for use when in bed.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F315 1. Resident #8 care plan has been updated to include the provision of bed pan at bedside to decrease urinary incontinence. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. The Staff Development Coordinator (SDC) in-serviced License Nurses and Certified Nursing Assistant (C.N.A) on 09/20/2017and on-going to ensure the resident's wishes/rights are honored and the information is updated in the plan of care. DNS/designee will perform random audit 3X weekly 1 month and then monthly x 2 months to validate that resident wishes/right are honored. 4. Results of audit will be taken to the monthly Performance Improvement meeting which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, corrective action will be initiated if appropriate.	09/22/2017

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F 315	Continued From page 28 The findings included: Resident #8 was originally admitted to the facility 8/6/16 and readmitted 3/6/17. The current diagnoses included; bilateral below the knee lower extremity amputations, hypertension and heart failure requiring diuretic therapy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/20/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility, transfers and toilet use and in section "H0300" frequently incontinent of bladder. An interview was conducted with Resident #8 on 8/9/17 at approximately 12:05 p.m. The resident stated she loves her room and life in the facility but she had two grievances. The first grievance she expressed was the staff's resistance to provide her with a bed pan when in bed to decrease episodes urinary incontinence. The resident stated she utilized bilateral lower extremity prosthetic legs and she removed them nightly at hour of sleep but when the urge to urinate occurs she has to get up, don the prosthetic legs and transfer to the bedside commode and usually by the time she does that she has already urinated on herself. The resident further stated she requested to have a bedpan for	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 315	Continued From page 29 use when in bed for she felt she could put herself on the bedpan faster than she could don the prosthetic legs and transfer to the bedside commode but the facility staff was not receptive to the idea and they offered no other solutions to her problem. The resident stated the facility staff replied it would not look good to have a bed pan sitting on the over the bed table. The surveyor who conducted the group interview on 8/9/17 stated Resident #8 voiced concern during the group interview that she desired use of a bedpan overnight and she wanted the in-room refrigerator use to be resumed. Resident #8's care plan with a revision dated of 8/16/17 was reviewed. The problem read, "(name of resident) noted to be incontinent of bladder related to impaired mobility and use of diuretic." The goal read; "Patient will remain free of skin breakdown due to incontinence and brief use through the review date 8/29/17." The interventions were; "Check patient frequently and as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence care. Encourage fluids during the day to promote prompted voiding responses. Establish voiding patterns. Monitor/document for signs/symptoms of urinary tract infection; pain, burning, blood tinged urine, cloudiness, no output, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns." An interview was conducted with the Director of Nursing on 8/9/17 at approximately 2:10 p.m., the	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 315	Continued From page 30 Director of Nursing stated Resident #8 could have a bedpan at bedside and she proceeded to inform the staff of such. The Director of Nursing presented a care plan on 8/9/17 at approximately 3:00 p.m., with a new intervention which read (name of resident) may have a bed pan at bedside. The surveyor spoke with Resident #8 on 8/10/17 at approximately 11:40 a.m., the resident was pleased the facility staff had made steps to aid her in decreasing urinary incontinence episodes, they provided her with a bed pan for use. The facility's policy titled "Urinary Incontinence" with a release date of 5/31/15 read; based on the patient's comprehensive assessment, care and treatment are provided to help the patient restore his/her highest level of normal bladder function as possible and to prevent urinary tract infection. Under procedure #4 the policy read; individualize interventions that address the incontinence including the patients capabilities and underlying factors that can be removed, modified, or stabilized and by monitoring the effectiveness of the interventions and modifying them as appropriate. This may include restorative nursing programs. On 8/10/17 at approximately 5:00 p.m., during the pre-exit briefing the Administrator, Director of Nursing and Corporate Director of Clinical Operations were made aware of the above information. No additional information was presented.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 333 SS=E	Continued From page 31 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its-	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	09/22/2017

(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure 1 of 35 residents in the survey sample, Resident #9, was free of significant medication error .

The facility staff failed to administer the correct dosage of Eliquis (1) tablet for Resident #9. Eliquis tablet 5 mg (milligrams) two times a day was administered by the nurses for 5 1/2 days instead of Eliquis 10 mg two times a day, as ordered by the physician.

The findings included:

Resident #9 was admitted to the facility on 7/30/17. Diagnoses for Resident #9 included but not limited to, muscle weakness, UTI (urinary tract infection), high blood pressure, depression, anxiety disorder, and post-surgical care.

The most recent Minimum Data Set with an assessment reference date of 8/6/17, coded Resident #9 with a score of 15 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #9's cognitive abilities for daily decision making are intact.

F333

1. MAR and physician order sheet for resident #9 reviewed by DNS for accuracy. Med variance report completed 08/09/2017. The physician and family member were notified of the medication variance on 08/09/2017. Performance Improvement and reeducation done with license nurse on 09/20/2017and on-going.

2. All residents residing in the facility have been identified as having the potential to be affected. (what did do to assure all

3. All licensed nurses were in-serviced/reeducated by Staff Development Coordinator (SDC) on the five (5) rights of medication administration and on policy and procedure for event reporting of medication errors, documentation and monitoring on 09/20/2017and on-going.

4. All licensed nurses will have Medication Competency completed by Staff Development Coordinator

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F 333	Continued From page 32 On 8/8/17 at approximately 5:00 PM, during the medication pass observation, LPN (Licensed Practical Nurse) #2 administered the Eliquis 5 mg. tablet (one tablet) to Resident #9. The Medication Administration Record (MAR) indicated, "Eliquis 5 mg Tablet EA (each); Give 10 mg by mouth two times a day for 7 days". The medication pack of Eliquis contained 5 mg tablets. LPN #2 should have given Resident #9 two 5 mg tablets to give a total of 10 mg, as ordered. The medication cart used by LPN #2 stored two packs of Eliquis 5 mg tablets for Residents #9. Each pack had a total number of 28 tablets; this equaled to 56 tablets. One pack showed 4 tablets were used with 24 tablets remaining; the other pack showed 7 tablets were used with 21 tablets remaining; therefore, a total of 11 tablets were used. It was evident that Eliquis 5 mg was only given as 1 tablet, instead 2 tablets, for 5 1/2 days (11 doses). If administered correctly per physician's order, a total of 22 tablets should have been given, not 11 tablets. The Pharmacy Shipment Order # R2772004 indicated 28 Eliquis 5 mg tablets were filled, shipped and delivered to the facility on 7/31/17 for Resident #9. The second shipment order # R2772100 indicated 28 Eliquis 5 mg tablets were filled on 7/31/2017, shipped and delivered on 8/5/2017. On 8/9/17 at 11:00 am, LPN #1, who worked 7-3 shift, was interviewed and was asked how many tablets of Eliquis Resident #9 had received on his shift and he stated, "I gave two tablets this am. She gets two tablets of 5 mg tablets, which totals	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* (SDC) on med pass administration, and during orientation then annually thereafter. Any nurse with > 5% med error rate will have further in-servicing from SDC/designee. 5. Medication pass will be randomly monitored weekly X4 weeks, monthly x 2 months, then quarterly thereafter by DNS/ designee and pharmacy nurse consultant quarterly. Findings will be presented to the Performance Improvement Committee which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy X3 months, quarterly for further recommendations. Corrective action will be initiated if required.	09/22/2017

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F 333	Continued From page 33 to 10 mg." On 8/10/17 at 12:05 PM, RN (Registered Nurse) #1 was interviewed regarding the incorrect administration of Eliquis. She stated that she was aware of the incident and the physician had been notified. The physician had ordered to move forward with the current order and have the orthopedic (2) surgeon decide as to when to discontinue the current order. RN #1 had investigated the incident and she stated, "Two tabs (tablets) should have been given". She had checked with all three shifts and found that Resident #9 had no signs and symptoms of bleeding. She stated that, in coordination with the staff development coordinator, nurses will be educated and will be observed during medication pass. RN #9 was asked what could be the outcome for giving Resident #9 incorrect doses of the medication and she stated, "...not enough coagulation for clotting." On 8/10/17 at 12:45 PM, an interview was conducted with the Director of Nursing (DON) and she stated that she already saw the two packs of Eliquis and stated that two tablets should have been given. A medication error report had been filled out, according to the DON, and she added, "The Nurse Manager is doing medication pass observation with nurses now". She was asked what could be the outcome of this medication error and she stated, "There's no outcome of harm now but if it continues, that would put her more at risk for blood clots." The clinical records were reviewed and the Physician Order Sheet indicated the following orders: "1. Eliquis Tablet. Give 10 mg by mouth two times a day for DVT (3) prophylaxis (4) for 7	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 333	Continued From page 34 days. Start date: 8/4/2017 0900; 2. Eliquis Tablet 5 mg. Give 1 tablet by mouth 2 times a day for DVT prophylaxis. Start date: 8/12/2017 0900." The Medication Administration Record (MAR) for Eliquis Tablet 10 mg by mouth two times a day for 7 days, dated 08/01/2017 - 08/31/2017, showed the nurses initialed the MAR on 8/4/17 through 8/8/17 at 0900 and 1700; on 8/9/17 at 1700. Resident #9's Comprehensive Resident Centered Plan of Care, dated 8/1/17, stated the resident was at risk for bruising, abnormal bleeding, or hemorrhage due to anticoagulant (5) use. The goal for this problem was that the resident "will be free from signs and symptoms of abnormal bleeding through next review date". Interventions/Tasks directed the staff to: "Administer anticoagulants as currently prescribed by the physician; Monitor for and report to nurse any of the following signs and symptoms of bleeding: bleeding gums, nose bleeds, unusual bruising, tarry/black stools, pink or discolored urine; Obtain labs per physician order; Report to physician any signs and symptoms of abnormal bleeding or hemorrhage." Review of the Nurses Notes from 7/30/17 through 8/9/17 revealed no signs and symptoms of bleeding for Resident #9. On 8/9/17, a copy of the Medication Administration Policy was requested from the DON and received a copy of a document titled, "Oral Medication Administration". It was a copy of the Competency Checklist titled, "Oral Medication Administration" dated 4/28/09. The procedure included the following: "...Procedure #7. Practices the five rights before giving the medication: ...c.	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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	495247	A. BUILDING _____ B. WING _____	C 08/10/2017

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F 333	Continued From page 35 Right dose - Checks each medication to verify dosage of medication is correct. Note to Observer: When observing medication administration, verify that the correct dosage of the medication is being prepared. If the incorrect dosage is prepared and the employee intends to administer the medication, intervene with administration of the medication. Count the intent to administer the medication as an "Unsatisfactory Demonstration of Skill" even though the medication was not given." The Administrator, DON and District Director of Clinical Operations were made aware of these findings on 8/10/17 at approximately 4:55 PM. No further information was provided. Definition: (1) Eliquis (Apixaban) - is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. (Source: https://medlineplus.gov/druginfo/meds/a613032.html#why) (2) Orthopedics - a branch of medicine concerned with the correction or prevention of deformities, disorders, or injuries of the skeleton and associated structures (as tendons and ligaments). (Source: http://c.merriam-webster.com/medlineplus/orthopedics) (3) DVT prophylaxis - a condition marked by the formation of a thrombus within a deep vein (as of	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 333	Continued From page 36 the leg or pelvis) that may be asymptomatic or be accompanied by symptoms (as swelling and pain) and that is potentially life threatening if dislodgment of the thrombus results in pulmonary embolism. (Source: http://c.merriam-webster.com/medlineplus/deep%20vein%20thrombosis) (4) Prophylaxis - measures designed to preserve health and prevent the spread of disease : protective or preventive treatment. (Source: http://c.merriam-webster.com/medlineplus/prophylaxis) (5) Anticoagulant - a substance (as a drug) that hinders coagulation and especially coagulation of the blood. (Source: http://c.merriam-webster.com/medlineplus/anticoagulant).	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	09/22/2017
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431	F431 1. A container of ammonium lactate 1% and a bottle of Triamcinolone Acetonide 1% located in resident #14 room on Butler Hall on 08/10/2017 was stored properly per policy and procedure on 08/10/2017. 2. Residents with physician's orders for topical medications have been identified as having the potential to be affected. 8/10/2017 DNS/Staff looked in 100% of rooms for any creams/medications stored in rooms. None were identified. 3. Licensed nursing staffs have been in-serviced by Staff Development Coordinator (SDC) on 09/20/2017 on proper medication storage. ADNS/Unit Managers will conduct observation rounds on each unit weekly X3 weeks, then monthly x2 months to validate that medications are stored appropriately in medication Carts. Results of these observation audits will be documented on an audit tool. 4. Audit tools will be presented to Performance Improvement Committee consists of Executive Director, Medical Director,	

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F 431	Continued From page 37 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review and facility document review the facility staff failed to ensure topical (external)	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy. monthly for three months for review, recommendation and continued need for further monitoring to sustain compliance.	09/22/2017

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F 431	Continued From page 38 medications were properly stored for 1 of 35 residents in the survey sample, Resident #14. A container of ammonium lactate 1% medication cream and a bottle of Triamcinolone 1% medication cream were observed stored inside Resident #14's room. The findings included: Resident #14 was admitted to the facility on 7/25/17 following a hospitalization for a pulmonary (lung) embolism (a blockage in the pulmonary artery) and generalized weakness. The current MDS (Minimum Data Set) an admission with an assessment reference date of 8/1/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. On 8/8/17 an initial tour of the facility was conducted. Resident #14 was observed sitting on the side of the bed. Observed on the bedside drawer were two medication creams. One container of ammonium lactate 1% medication cream and a bottle of Triamcinolone Acetonide 1%. The resident stated these were brought in from home. The Order Summary Report evidenced a physician order dated 7/31/17 for Triamcinolone Acetonide Cream 1% apply to lower extremities topically every day and evening shift for itching. On 8/9/17 at 10:15 a.m., and at 6:36 p.m., the container of ammonium lactate 1% medication cream was observed in the same spot, on the	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 431	Continued From page 39 bedside drawer. The resident stated the bottle of Triamcinolone 1% cream was now inside a second drawer. The second drawer was inspected with permission of the resident. Stored inside one drawer was a pink wash basin, inside the basin was the Triamcinolone 1% cream. On 8/9/17 at approximately 7:00 p.m., the above findings was shared with the Administrator and the Director of Nursing. The DON stated she was unaware of this and would look into it. On 8/10/17 at 5:10 p.m., the DON stated the resident was educated last evening that these medications could not be stored at the bedside and placed them inside her office for safekeeping until the resident was discharged. She stated she did not want to store them inside the medication room as she did not want them to be accidentally sent for disposal to the pharmacy. The DON evidenced the resident had been sent a tube of the Triamcinolone 1% cream from the facility pharmacy that was stored inside the treatment cart. The facility's pharmacy Policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with a revision date of 1/1/03 read, in part: "This Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. 3. General Storage Procedures: 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors."	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	