STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 4/26/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020	E020 1. Facility emergency preparedness plan now includes an alternate form of communication. Facility purchased a 2-way radio. 2. No other concerns noted. 3. Maintenance staff educated on using the 2-way radio during an emergency with no other communication sources are available. 4. Audits of 2-way radio is available will be conducted weekly for four week then monthly for three	5/29/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Shine LNHA — TITLE: Administrator — (X6) DATE: 5/14/18

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

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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E 020	Continued From page 1 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the emergency preparedness plan included policies and procedures for safe evacuation from the facility and that it includes all of the required elements; specifically alternate forms of communication. The findings include: On 4/26/18 at 9:15 AM, a review of the facility's comprehensive emergency preparedness plan was reviewed with the facility Administrator, ASM #1 (Administrative Staff Member). A review of the comprehensive emergency preparedness plan failed to reveal any evidence	E 020	months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.	

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E 020	Continued From page 2 of alternate forms of communication. The plan listed cell phones as primary source. At this time, the Administrator stated that the alternate form of communication would be the internet. When asked what the facility would do if electronic/digital forms of communication such as cell phones and internet were not functioning, and if the facility had alternate forms, i.e. satellite radios or other such means, ASM #1 restated, just the internet. On 4/36/18 at 3:15 PM, a follow up review was conducted, due to ASM #1 was unable to initially locate or identify some parts of the plan secondary to being new at the facility. The question of the alternate forms of communication was asked again. At this time, OSM #6 (Other Staff Member) the Maintenance Director was present in assisting the administrator with the review. When asked if there were other forms of alternate communications the facility used, i.e. satellite radios or similar such devices, in an emergency. OSM #6 stated no. He stated there used to be but that they all disappeared. On 4/26/18 at 5:24 PM at the end of day meeting, the Administrator and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	E 020		
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include	E 031	E031 1. Emergency Officials Contact information has been added to the facility emergency plan. 2. No other concerns noted. 3. Staff educated on emergency officials contact information added to the facility emergency plan.	5/29/18

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E 031	Continued From page 3 all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the emergency preparedness plan included all required Emergency Officials contact information in the communication plan, other than 911. The findings include:	E 031	4. Audits of emergency official contacts information will be conduct to ensure information is current weekly for four weeks then monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.	

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E 031	Continued From page 4 On 4/26/18 at 9:15 AM, a review of the facility's comprehensive emergency preparedness plan was reviewed with the facility Administrator, ASM #1 (Administrative Staff Member). This review failed to reveal any evidence of a listing of contact information for all Federal, State, tribal, regional and local emergency preparedness officials. When asked about the listing, the only number the Administrator was able to identify in the plan was the 911 number. No other Emergency Officials contact information was included. On 4/36/18 at 3:15 PM, a follow up review was conducted, due to ASM #1 being unable to initially locate or identify some parts of the plan secondary to being new at the facility. The question of the listing of contact information for all Federal, State, tribal, regional and local emergency preparedness officials was asked again. Such listing still was not provided or reflected in the comprehensive emergency preparedness plan. On 4/26/18 at 5:24 PM at the end of day meeting, the Administrator and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	E 031		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing.	E 039	E039 1. Facility to conduct a tabletop exercise and a full-scale exercise. 2. No other concerns noted. 3. Staff educated on tabletop and full-scale exercises to include review of analysis of exercises.	5/29/18

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E 039	Continued From page 5 The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039	4. Audits of tabletop and full-scale exercises will be conducted yearly. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.	

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E 039	Continued From page 6 discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's participation in, or efforts to identify and participate in locally, a full-scale exercise, tabletop exercise, or an actual facility event utilized as an exercise in emergency preparedness. The findings include: On 03/09/18 at 9:15 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) #1, the Administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's participation in, or efforts to identify and participate in locally, a full-scale exercise, tabletop exercise, or an actual facility event utilized as an exercise in emergency preparedness. The Administrator stated that she thought the previous Administrator may have	E 039		

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E 039	Continued From page 7 attempted to identify a local full scale exercise but had no evidence of that. On 4/36/18 at 3:15 PM, a follow up review was conducted, due to ASM #1 was unable to initially locate or identify some parts of the plan secondary to being new at the facility. The question of evidence of documentation of the facility's participation in, or efforts to identify and participate in locally, a full-scale exercise, tabletop exercise, or an actual facility event utilized as an exercise in emergency preparedness, was asked again. The Administrator stated she didn't have anything. On 4/26/18 at 5:24 PM at the end of day meeting, the Administrator and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/24/18 through 4/27/18. Five complaints were investigated during survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 165 at the time of the survey. The survey sample consisted of 35 current residents, Resident #118, #142, #267, #119, #86, #150, #318, #90, #95, #157, #88, #97, #2, #8, #110, #116, #46, #41, #38, #417, #53, #369, #16, #20, #33, #144, #8, #60, #87, #81,#105, #35, #111, #94 and #27; and seven closed record reviews #468, #169, #319,	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

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F 000	Continued From page 8 #269, #268, #167 and #71.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to ensure the call bell was within reach for one of 42 residents in the survey sample, Resident # 118. The facility staff failed to ensure Resident #118's call bell was within reach. During multiple observations, Resident # 118's call bell was out of reach. The findings include: Resident # 118 was admitted to the facility on 02/14/18 with diagnoses that included but were not limited to: dysphagia (1), bladder cancer, Down Syndrome (2) and pain. Resident # 118's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/21/18, coded Resident # 118 as scoring a 0 (zero) on the brief interview for mental status (BIMS) of a score of 0 - 15, 0- being severely impaired of cognition for making daily decisions. Resident # 118 was coded as requiring extensive	F 558	F558 1. Resident # 118's call bell was replaced and now is within reach. 2. A review of residents was conducted to ensure call bells were in reach. 3. Staff will be re-educated on ensuring call bells are within reach of the residents. 4. Audits of call bells being in reach of the residents will be conducted weekly for four weeks then monthly for three weeks. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.	5/29/18

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F 558	Continued From page 9 assistance of one staff member for activities of daily living. An observation on 04/24/18 at approximately 1:56 p.m., revealed Resident # 118 was in bed, low to floor, appeared clean. Resident # 118's call bell was observed under Resident # 118's pillow at the head of the bed above Resident # 118's head. When asked if he could reach his call bell Resident # 118 was unable to reach for it. An observation on 04/24/18 at approximately 3:26 p.m., revealed Resident # 118 in bed. The call bell was observed under Resident # 118's pillow at the head of the bed above Resident # 118's head. When asked if he could reach his call bell Resident # 118 was unable to reach for it. An observation on 04/25/18 at approximately 1:55 a.m., revealed Resident # 118 in bed asleep, with the call bell under Resident # 118's pillow at the head of the bed above Resident # 118's head. An observation on 04/25/18 at approximately 8:54 a.m., revealed Resident # 118 in bed asleep and the call bell was observed under Resident # 118's pillow at the head of the bed above Resident # 118's head . An observation on 04/26/18 at approximately 7:56 a.m., revealed Resident # 118 in bed asleep. The call bell was hanging off the frame of the bed under the mattress. The comprehensive care plan dated 03/01/2018 for Resident # 118 documented, Focus. At risk for falls related to: New environment, impaired ROM (range of motion) in BLEs (bilateral lower extremities) and LUE (left upper extremity)."	F 558		

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F 558	Continued From page 10 Under "Interventions" it documented, "Call light or personal items available and in easy reach. Date Initiated: 03/01/2018." On 04/26/18 at approximately 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager C-wing. When informed of the above observations of Resident # 118's call bell being out of reach, LPN # 9 stated, "It should have been put within his reach. The call bells are checked during rounds, every two hours to make sure the residents are able to reach them." On 04/26/18 at approximately 2:40 p.m., an observation of Resident # 118 revealed he was lying in bed and a new call bell was observed lying next to his right hand. On 04/26/18 at approximately 2:40 p.m., an interview was conducted with LPN # 9. When asked about Resident #118's new call bell, LPN # 9 stated, "We put it in right after we spoke. It is a pressure switch. (Resident # 118) is able to squeeze his hand and activate the call bell instead of pressing a button." On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 558		

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F 558	Continued From page 11 (2) A genetic condition in which a person has 47 chromosomes instead of the usual 46. The extra chromosome causes problems with the way the body and brain develop. Down syndrome is one of the most common causes of birth defects. This information was obtained from the website: https://medlineplus.gov/ency/article/000997.htm.	F 558		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580	F580 1. Resident #20 physician was notified of administering midodrine when it should have been held per physician's orders. 2. A review of residents on Midodrine will be conducted to ensure it is given as ordered by the physician. 3. Licensed nursing staff will be re-educated on administering Midodrine as ordered by the physician. 4. Audits of residents who have Midodrine orders will be conducted weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.	5/29/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 580	Continued From page 12 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to notify and consult with the physician regarding a need to alter treatment for one of 42 residents in the survey sample, Resident #20. The facility staff failed to notify and consult Resident #20's physician when the resident's medication Midodrine (1) was administered but should have been held per physician's order. The findings include: Resident #20 was admitted to the facility on 5/20/17. Resident #20's diagnoses included but were not limited to hypotension (low blood pressure), urinary tract infection and bipolar	F 580		

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disorder (2). Resident #20's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/24/18, coded the resident as being cognitively intact.

Review of Resident #20's clinical record revealed a physician's order dated 2/6/18 for Midodrine 2.5 milligrams one time a day, hold the medication for a systolic blood pressure greater than 100 or a diastolic blood pressure greater than 90. Review of Resident #20's April 2018 MAR (medication administration record) revealed the resident was administered Midodrine on the following dates (as evidenced by a check mark and nurses' initials) although the resident's systolic blood pressure was greater than 100 or diastolic blood pressure was greater than 90:
- 4/1/18- blood pressure 141/93
- 4/2/18- blood pressure 122/55
- 4/10/18- blood pressure 124/74
- 4/14/18- blood pressure 106/68
- 4/22/18- blood pressure 148/78

Review of Resident #20's April 2018 MAR and nurses' notes failed to reveal documentation that Resident #20's physician was notified and consulted on the above dates.

Resident #20's comprehensive care plan dated 9/12/17 documented, "Impaired Cardiovascular status related to: Hypotension...Medications as ordered by physician and Observe use and effectiveness..."

On 4/26/18 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9 (Resident #20's unit manager). LPN #9 was asked what a check mark and nurses' initials mean on the MAR. LPN #9 stated, "It means it

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F 580	Continued From page 14	F 580		

was done." LPN #9 was read Resident #20's physician order for Midodrine and asked what should be done if the resident's systolic blood pressure is greater than 100 or diastolic blood pressure is greater than 90. LPN #9 stated, "It should be held and you should contact the MD (medical doctor) because you need to find out the next step for orders." LPN #9 was made aware Resident #20's Midodrine was initialed as administered on the above dates, and was made aware of the resident's blood pressures on the above dates. LPN #9 stated the medication should have been held and the doctor should have been contacted. LPN #9 stated the nurses who administered the Midodrine on those above dates may have contacted the doctor and he may have said to give the medication. LPN #9 confirmed there was no documentation to evidence this.

The nurses who initialed Midodrine administration to Resident #20 on 4/1/18, 4/10/18, 4/14/18 and 4/22/18 were not available for interview.

On 4/26/18 at 4:43 p.m., a telephone interview was conducted with LPN #10 (the nurse who initialed administration of Resident #20's Midodrine on 4/2/18). LPN #10 was asked what should be documented on the MAR if a medication is held. LPN #10 stated, "I don't know the exact number. There is a number on the legend. I don't know if it's a three or a seven. There is a little box that pops up that says hold and we write a note." Resident #20's physician's order for Midodrine was read to LPN #10 and LPN #10 was asked what should be done if the resident's systolic blood pressure is greater than 100 or diastolic blood pressure is greater than 90. LPN #10 stated, "You will hold it." LPN #10 was

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F 580	Continued From page 15 asked if she recalled ever holding Resident #20's Midodrine. LPN #10 stated she recalled holding the medication on several occasions. When asked if she recalled holding the medication in April 2018, LPN #10 stated, "I don't have her consistently. I don't know the last time I had (name of Resident #20) so I can't say for certain." On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 4/27/18 at approximately 8:30 a.m., this surveyor asked ASM #1 for a facility policy regarding physician notification. The facility policy titled, "REPORTING CHANGE OF CONDITION: POA (POWER OF ATTORNEY), RESPONSIBLE PARTY VERSUS EMERGENCY CONTACT" did not document information regarding physician notification. No further information was provided prior to exit. (1) "Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616030.html (2) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and	F 580		

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F 580	Continued From page 16 inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bipolar+disorder&_ga=2.1717494.671965706.1525089773-139120270.1477942321	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	F584 1. The activity room floor is now clean and Resident #33 personal refrigerator is now clean. 2. A review of residents' personal refrigerators has been conducted to ensure refrigerators are clean. 3. Health Care Services housekeeping employees will be re-educated on the proper technique of cleaning floors and personal refrigerators. Nursing Staff will also be re-educated on proper cleaning techniques of personal refrigerators. 4. Audits will be conducted to ensure floors and personal refrigerators are clean weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 584	Continued From page 17 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to maintain a clean environment in the activities room and for one of 42 residents in the survey sample, Resident #33. 1. The facility staff failed to clean cheese and dried liquid from the activities room. 2. The facility staff failed to maintain a safe and clean environment for Resident #33. Her personal refrigerator was not cleaned. The findings include: 1. An observation was made on 4/24/18 at 3:10 p.m. of residents in the activities room The residents were making individual pizzas. The residents were observed sprinkling cheese on top of the pizza. An observation was made on 4/25/18 at 9:30 a.m. of the activities room. There was grated cheese noted on the floor by two chairs. There were	F 584		

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F 584	Continued From page 18 several brown spots noted on the floor. An ant was observed on the floor. An observation was made on 4/25/18 at 3:00 p.m. of the activities room. There was grated cheese noted on the floor by two chairs. There were several brown spots noted on the floor. An observation was made on 4/26/18 at 8:05 a.m. of the activities room. There was grated cheese noted on the floor by two chairs. There were several brown spots noted on the floor. A resident was in the room reading a newspaper. An interview was conducted on 4/26/18 at 10:10 a.m. with OSM (other staff member) #17, a housekeeper. When asked how often the common area rooms are cleaned, OSM #17 stated, "Every day." An interview was conducted on 4/26/18 at 3:00 p.m. with OSM #8, the manager of housekeeping and laundry. When asked how often the activities room was cleaned, OSM #8 stated, "They'll sweep it up every day." When asked what staff did if there were brown spots on the floor, #8 stated it would be cleaned. OSM #8 and this writer observed the cheese and brown spots on the floor in the activities room. OSM #8 stated, "I'll clean this up right away." On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Housekeeping Procedures" did not specifically address cleaning the activities room.	F 584		

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F 584	Continued From page 19 No further information was provided prior to exit. COMPLAINT DEFICIENCY 2. The facility staff failed to maintain a safe and clean environment for Resident #33. Her personal refrigerator was not cleaned. Resident #33 was admitted to the facility on 7/23/14 with diagnoses that included but were not limited to: dementia, vitamin D deficiency, dry eye syndrome, pain and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/31/18, coded the resident as scoring a "8" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. Observation was made of Resident #33's room on 4/24/18 at approximately 11:00 a.m. There was a small refrigerator in the room, next to Resident #33's bed. It had two compartment doors. One for the freezer and one for the refrigerator. The refrigerator contained a bottle of cola. The freezer contained a thermometer and a container of ice cream bites. There was a brown substance frozen all over in the freezer. It appeared to be an exploded soda. This room and refrigerator was observed again on 4/25/18 at 11:50 a.m. 4/26/18 at 10:30 a.m., the refrigerator was observed, again with the brown substance in the freezer. On 4/26/18 at 11:21 a.m., an interview was conducted with CNA (certified nursing assistant)	F 584		

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F 584	Continued From page 20 #23. When asked who is responsible for cleaning the residents' refrigerators, CNA #23 stated, "I believe it's the staff's responsibility." CNA #23 opened Resident #33's refrigerator/freezer and stated, "That's gross. Her family brings her snacks and puts them in there." An interview was conducted with LPN (licensed practical nurse) #14 on 4/26/18 at 11:24 a.m., regarding who is responsible for cleaning a personal refrigerator. LPN #14 stated, "I believe it's the CNA's responsibility." When asked how the temperature could be tested if the only thermometer was located in the freezer, LPN #14 stated, "You got us there. I don't understand why someone would document (temperatures) it if it (thermometer) isn't even there (the refrigerator)." An interview was conducted with LPN #15, the unit manager, on 4/26/18 at 11:27 a.m. When asked if she was aware that Resident #33 had a refrigerator in her room, LPN #15 stated, "Yes." When asked who is responsible for keeping it clean, LPN #15 stated, "The CNAs can do it. If they see it is dirty and should be cleaned out." An interview was conducted with RN (registered nurse) #4, the assistant director of nursing, on 4/26/18 at 11:35 a.m. When asked who is responsible for maintaining a refrigerator in a resident's room, RN #4 stated, "The temperatures are taken by the nurses. Cleaning of it, the outer part the CNAs and housekeeping do. The family maintains the inside. If the family doesn't come in then the staff will do it. We monitor the refrigerator temperatures on all of them in house." The facility policy, "Food: Safe Handling for Foods from Visitors" documented in part, "5.	F 584		

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F 584	Continued From page 21 Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and equipped with thermometers, have temperature monitored daily for refrigerators < (less than) 41 F (Fahrenheit) and freezer < 10 F. Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for > (greater than) 7 days. (Storage of frozen foods and shelf stable items may be retained for 30 days.) Cleaned weekly." The administrator and director of nursing were made aware of the above concern on 4/26/18 at 5:15 p.m. No further information was provided prior to exit.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the	F 600	F600 1. Resident #150 is safe from sexual abuse. Resident #268 and Resident #269 were immediately placed on one on one and no longer reside in the facility. 2. Each residents has the potential of being affected. 3. Staff will be re-educated on facility abuse policy and procedures to ensure residents are free from sexual abuse. 4. Audits will be conducted to ensure staff understanding of abuse policy to include sexual abuse weekly for	5/29/18

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F 600	Continued From page 22 facility staff failed to ensure one of 42 residents in the survey sample, was free from sexual abuse, Resident #150. 1. a. The facility staff failed to ensure Resident #150 was free from sexual abuse by Resident #268. On 11/12/17, Resident # 268 grabbed Resident #150's breast. 1. b. The facility staff failed to ensure Resident #150 was from sexual abuse by Resident # 269. On 12/11/17, staff found Resident #269 with his hand down Resident #150's pants in the dining room. The findings include: 1. a. The facility staff failed to ensure Resident #150 was free from sexual abuse by Resident #268. On 11/12/17, Resident # 268 grabbed Resident #150's breast. Resident #150 was admitted to the facility on 11/4/15 with diagnoses that included but were not limited to: Alzheimer's dementia, diabetes, muscle weakness, depression, and seizures. The MDS (minimum data set) assessment, around the time of the incidents, was a quarterly assessment, with an assessment reference date of 11/7/17, and coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. Resident #150 was coded as wandering one to three days during the look back period. The resident was coded as having behaviors not directed toward others one to three days during the look back period. Resident #150 was coded	F 600	four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 600	Continued From page 23	F 600		

as requiring extensive assistance of one or more staff members for all of her activities of daily living.

Resident #268 was admitted to the facility on 4/13/17 with diagnoses that included but were not limited to: chronic kidney disease, mood disorder, dementia, high blood pressure, stroke and congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys). (1) The MDS (minimum data set) assessment around the time of the incident, 11/12/17, was a quarterly assessment, with an assessment reference date of 12/13/17, and coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score indicating he was cognitively intact to make daily decisions. Resident #268 was coded as requiring extensive assistance for moving in the bed, dressing, and personal hygiene. He was coded as requiring supervision of one staff member for transfers, moving on and off the unit and toileting. The resident was coded as independent for eating. Resident #268 was coded as having restrictions in his range of motion on one side of his one arm and one leg.

The Facility Reported Incident (FRI) dated 11/12/17 documented in part, "Incident Type - Allegation of abuse/mistreatment. Describe incident: It was reported to the Administrator at 11 am that (Resident #268) had grabbed (Resident #150)'s breast. They were immediately separated and (Resident #268) was placed on 1:1 (one to one). Our investigation has begun."

The nurse's note dated, 11/12/18 at 11:09 a.m. documented in part in Resident #150's record,

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 600	Continued From page 24 "Around 10:50 a.m. Staff report to writer that another resident was witnessed feeling on (Resident #150)'s breast area, the other resident did stop the inappropriate touching when the staff member instructed him too (sic). Both residents was (sic) immediately separated. Writer assessed breast area no bruising or abnormality noted, no pain or discomfort noted during assessment. Rp (responsible party) and MD (medical doctor) aware will continue to monitor for changes." Review of Resident #150's comprehensive care plan dated 11/5/15 and revised on 3/8/17, failed to evidence any documentation of the incident on 11/12/17. The social services note in Resident #150's clinical record dated, 11/13/17 at 1:58 p.m., documented, "SS (social service) met with resident for a 1:1 supportive visit. Resident wandering the hall of A wing per usual. No psychosocial distress noted. Husband was in earlier to visit." The next documented social services note was dated, 12/11/17, after the second incident with another resident. Review of the psychiatric notes, revealed Resident #150 was seen by psychiatry on 11/3/17, prior to this incident, and then not until 12/15/17 after a second incident. The witness statement dated, 11/12/17, by the CNA (certified nursing assistant) that witnessed Resident #268 and Resident #150, documented in part, "I (name of CNA) was walking (name of another resident) and seen (Resident #268) rubbing (Resident #150) chest near the bird cage, I asked him to take his hands off her and he did.	F 600		

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Then (another staff member) came down the hall and asked if I had seen (Resident #268) I said yes rt (right) here. I told her what happened an (sic) she asked him to come back to C wing for a Wt (weight). I asked her to tell the charge nurse what happened." This CNA was not available for interview.

An interview was conducted with other staff member (OSM) #7 and OSM #10, the social workers, regarding what was done for (Resident #150) after this incident. OSM #7 stated, "We probably had psych (psychiatry) see her. I probably checked up on her. I spoke with her husband and he was very understanding. When asked if the comprehensive care plan should be updated regarding the sexual abuse that occurred with interventions to keep the resident safe, both OSM #7 and OSM #10 stated, "Yes, it should be." When asked how they thought Resident #150 would feel after this incident being a reasonable person, OSM #7 stated, "Not good." OSM #10 stated, "A victim." OSM #10 stated, "We are patient advocates and we failed her."

An interview was conducted with administrative staff member (ASM) #3, the former administrator, on 4/26/18 at 3:10 p.m., regarding the process followed for protecting Resident #150 after the incident of 11/12/17. ASM #3 stated, "We put the man on 1:1 supervision. We had psych (psychiatry) see him. It was questionable if (Resident #268) was cognitively intact. I spoke with (Resident #150)'s husband and he was not upset." ASM #3 stated, "We had the man put on 1:1 supervision. We wanted her to be able to continue to travel around the facility and we accomplished that by putting the man on 1:1 supervision."

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F 600	Continued From page 26 The facility policy, "Resident Abuse" documented in part, "It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognized these rights and hereby establishes the following statements, policies and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse...An abusive act is any act or omission, which may cause or causes actual physical, psychological or emotional harm or injury to a resident or any act which willfully depressive a resident of his rights by law or as stated herein...Acts of abuse directed against resident are absolutely prohibited. Such acts are cause for disciplinary action, including dismissal and possible criminal prosecution. Furthermore, the Administration of Facility recognized that resident abuse can be committed by other residents, visitors or volunteers...All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing or the administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation...The Abuse Coordinator and/or Director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...The Abuse Coordinator of Facility will refer any or all incidents and reports of resident	F 600		

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F 600	Continued From page 27 abuse to the appropriate state agencies." The administrator and director of nursing were made aware of the above findings on 4/26/18 at 5:15 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 1138. 1. b. The facility staff failed to ensure Resident #150 was from sexual abuse by Resident # 269. On 12/11/17, staff found Resident #269 with his hand down Resident #150's pants in the dining room. Resident #269 was admitted to the facility on 9/28/17 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability).(1), traumatic brain injury and mood disorder. The MDS (minimum data set) assessment completed closest to the incident of 12/11/17, with an assessment reference date of 12/22/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making cognitive daily decisions. The resident was coded as requiring limited assistance or supervisions of one staff member for all of his activities of daily living. In Section E - Behavior, the resident was coded as not having any behaviors during the look back period.	F 600		

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F 600	Continued From page 28 The Facility Reported Incident (FRI) dated 12/9/17 documented in part, "Incident Type - Resident to Resident Abuse. Describe Incident: At approximately 4:15 p.m. on this date, the Administrator received a call that a nurse aide observed (Resident #269)'s hand down (Resident #150)'s pants in the dining room. (Resident #150) was assessed and no injury was observed. (Resident #269) was placed on 1:1. Our investigation has begun." The nurse's note dated, 12/9/17 at 4:15 p.m. documented, "CNA (certified nursing assistant) reported to writer that she saw a male resident on C- wing with his hands inside of this resident' pants. Full body assessment was done. No injuries were noted. So s/s (signs or symptoms) pain or discomfort noted. RP (responsible party) is aware." Review of Resident #150's comprehensive care plan dated 11/5/15 and revised on 3/8/17, failed to evidence any documentation of the incident on 12/9/17. The Social Services notes, for Resident #150, dated, 12/11/17 at 11:48 a.m. documented, "Resident up in hallway propelling her self (sic) around the facility as usual. No psychosocial distress noted. SS will continue to follow and assist with her needs as they arise." Review of the nurse's notes for Resident #269 revealed the following documented on 12/9/17 at 6:49 p.m., "CNA observed residents (sic) hand in another resident's pant, writer was summoned to event site. Writer asked resident what occurred, resident stated you may tell the administration, all	F 600		

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they will do is to kick me out. Immediately writer separated the two parties involved. Supervisor notified immediately. MD (medical doctor) and R/P (responsible party) notified and Administrator made aware. Resident was placed on 1:1 close supervision at this time."

The social services notes for Resident #269 dated, 12/15/17 at 11:30 a.m. documented, "Writer met with resident for a 1:1 supportive visit. Informed resident that he could potentially face charges if he inappropriately touched someone again. Resident understood and expressed that he was sorry. Encouraged appropriate behavior. SS (social services) will continue to follow and assist with his needs as they arise."

An interview was conducted with CNA (certified nursing assistant) #18 on 4/25/18 at 3:09 p.m. When asked to describe what she found on 12/9/17, CNA #18 stated, "I was coming down the hallway on C wing. I looked into the cafeteria (dining room). (Resident #269) wasn't acting right. That's when I noticed he had his hand down her (Resident #150)'s pants. She was in her wheelchair. I said to him, 'Oh my gosh; what are you doing.' He responded, 'Nothing.' I saw him pull his hand away from her. I called for the nurse. She came and she asked him about the situation, he told her,' We're just talking.' I took her back to her unit and passed (LPN #8) on my way back and told her of the incident."

An interview was conducted with LPN (licensed practical nurse) #8 on 4/25/18 at 3:14 p.m. When asked to describe her knowledge of an incident with Resident #150 and Resident #269, LPN #8 stated, "I saw (CNA #18) wheeling (Resident #150) back to her unit. She told me what had

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happened. I went to talk to the nurse. I called (name of director of nursing) and (name of administrator). The administrator said he was on his way. I called both responsible party's (RP) and informed them of the occurrence. Resident #269's RP stated she had noted a difference in him so wanted him to see a psychiatrist. I put (Resident #269) on 1:1." When asked what she did for Resident #150, the victim, LPN #8 stated, "We assessed her for injury. Her demeanor was baseline. It was unclear how it affected her. I asked the staff to keep an eye on her. I was the supervisor that day. I felt so sorry for her that day, because she was a target for those two men." When asked if she were a reasonable person, how that would have affected her, LPN #8 stated, "She would feel violated and angry. She's vulnerable."

An interview was conducted with other staff member (OSM) #7 and OSM #10, the two social workers at the facility, on 4/25/18 at 3:50 p.m. When asked if Resident #269 has any history of sexual abuse, OSM #10 stated, "Not to our knowledge." A copy of his sex offenders registry was requested.

The copy of the sex offenders registry was dated, 9/29/17, documented he was not on the registry. The sex offenders registry was done one day after Resident #269 was admitted to the facility.

An interview was conducted with administrative staff member (ASM) #3, the former administrator, on 4/26/18 at 3:10 p.m. When asked about the process followed for protecting Resident #150 after the incident of 12/9/17, ASM #3 stated, "We put the man on 1:1 supervision. We had psych (psychiatry) see him. I spoke with (Resident

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F 600	Continued From page 31 #150)'s husband and he was not upset. ASM #3 stated, "We had the man put on 1:1 supervision. We wanted her to be able to continue to travel around the facility and we accomplished that by putting the man on 1:1 supervision. We actually kept him on 1:1 until his transfer. We were looking for alternate placement for him at the time of the incident." The administrator and director of nursing were made aware of the above findings on 4/26/18 at 5:15 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 607	F607 1. Facility is following policies and procedures for reporting an allegation of abuse to appropriate state agencies. 2. Each residents has the potential of being affected. 3. Staff will be re-educated on facility abuse policy and procedures to ensure reporting an allegation of abuse to appropriate state agencies. 4. Audits will be conducted to ensure staff understanding of reporting an	5/29/18

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F 607	Continued From page 32 a complaint investigation, it was determined that the facility staff failed to implement and follow the policies for an allegation of abuse for one of 42 residents in the survey sample, Resident # 319. The facility staff failed to implement and follow policies and procedures to report an allegation of abuse to appropriate state agencies after Resident # 319 reported an allegation of abuse to the facility staff. The findings include: Resident # 319 was admitted to the facility on 09/18/17 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), dementia (2), gastroesophageal reflux disease (3), hypertension (4), atrial fibrillation (5), muscular dystrophy (6), depression, dysphagia (7), and post mastectomy (8). Resident # 319's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/18/17, coded Resident # 319 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 319 was coded as requiring extensive assistance of one staff member for activities of daily living. The statement given by Resident # 319 and taken by OSM (other staff member) # 10, social worker dated 09/19/2017 documented, "Last night patient (Resident # 319) reported to SS (social services) that she was having trouble sleeping so she used her call bell to ask for help. The nurse came in	F 607	allegation of abuse to appropriate state agencies weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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and was pleasant and helped patient straighten the bed. Patient stated she called for help again and this time nurse came in and helped again but the third time the nurse came in and made a noise and walked out. Patient stated that the nurse was mad. The nurse came back in the room but about 4 (four) to 5 (five) [one of them was a male] nurse was also with her. Patient stated they grabbed her up and through [sic] her in the wheelchair. According to the patient they were not gentle with her and attack [sic] her. Once she was up at the nurse's station she felt scared because of the nurse looks they were giving her. She asked for a more comfortable chair but nobody would help her so she put herself on the floor to get comfortable. Patient did stated to SS that she has been a victim of abuse in the past (outside of this facility). Patient did state to SS that she told the nurses that she would sue them because of what they did and the nurses just laughed."

On 04/25/18 at 10:30 a.m., an interview was conducted OSM (other staff member) # 10, social worker regarding a complaint by Resident # 319. OSM # 10 stated she recalled who Resident # 319 was. OSM #10 stated that Resident # 319 told her, that night shift staff were verbally and physically abusing her. OSM # 10 stated, "I took (Resident # 319"s) statement and the DON (director of nursing) and the administrator took over the investigation.

On 04/26/18 at 9:50 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing and OSM (other staff member) # 10, social worker regarding a complaint by Resident # 319. When asked why an investigation was initiated regarding Resident

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F 607	Continued From page 34 # 319, ASM # 2 stated, "The resident stated they (staff) grabbed her up and threw her in her wheelchair." When asked if this was an allegation of abuse ASM # 2 stated, "Yes." On 04/27/18 at 7:45 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. ASM #2 was asked if a "Facility Report Incident (FRI)" was completed for Resident #319's allegation of abuse. ASM # 2 stated, "The previous administrator was the abuse coordinator. If we have it would have been filed with your office and we would have a copy in our FRI book." ASM # 2 reviewed the FRI book and stated she wasn't able to locate it. On 04/27/18 at 9:10 a.m., a telephone interview was conducted with ASM # 3, previous administrator. When asked if a FRI was completed regarding Resident # 319's allegation of abuse, ASM # 3 stated he would like to review the case with ASM # 2, director of nursing to refresh his memory and would call back to discuss it. On 04/27/18 at 10:12 a.m., a telephone interview was conducted with ASM # 3, previous administrator regarding Resident # 319's allegation of abuse. ASM # 3 stated, "It was not reported to me as an allegation of abuse." When asked if he reviewed Resident # 319's statement at the time of the incident, ASM # 3 stated, "I didn't review the information until the statements were taken. In retrospect, it was an allegation of abuse or mistreatment. I should have done a report in a timely manner." When asked if the facility's policy regarding abuse was followed ASM # 3 stated no.	F 607		

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F 607	Continued From page 35 The facility's policy "Resident Abuse" documented, "4c. The Abuse Coordinator of Facility will refer any or all allegations and reports of resident abuse to the appropriate state agencies." On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. Complaint deficiency References: (1) Disease that makes it difficult to breathe that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html. (5) A problem with the speed or rhythm of the heartbeat. This information was obtained from	F 607		

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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 607	Continued From page 36 the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (6) A group of more than 30 inherited diseases. They all cause muscle weakness and muscle loss. Some forms of MD appear in infancy or childhood. Others may not appear until middle age or later. The different types can vary in whom they affect, which muscles they affect, and what the symptoms are. All forms of MD grow worse as the person's muscles get weaker. Most people with MD eventually lose the ability to walk. There is no cure for muscular dystrophy. Treatments can help with the symptoms and prevent complications. They include physical and speech therapy, orthopedic devices, surgery, and medications. Some people with MD have mild cases that worsen slowly. Others cases are disabling and severe. This information was obtained from the website: https://medlineplus.gov/musculardystrophy.html. (7) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (8) A surgery to remove the entire breast. Most of the time, some of the skin and the nipple are also removed. The surgery is most often done to treat breast cancer. This information was obtained from the website: https://medlineplus.gov/ency/article/002919.htm.	F 607		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and	F 608	F608 1. Facility will report a reasonable suspicion of a crime. Resident #268 and Resident #269 are no longer residents of the facility.	5/29/18

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	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

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F 608	Continued From page 37 implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to report a reasonable suspicion of a crime for two of 42 residents in the survey sample, Residents #268 and #269. 1. The facility staff failed to report to the police an allegation of sexual abuse by Resident #268.	F 608	2. Each residents has the potential of being affected. 3. Staff will be re-educated on facility abuse policy and procedures to ensure reporting a reasonable suspicion of a crime. 4. Audits will be conducted to ensure staff understanding of reporting a reasonable suspicion of a crime weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 608	Continued From page 38 2. The facility staff failed to report to the police an allegation of sexual abuse by Resident #269. The findings include: 1. The facility staff failed to report to the police an allegation of sexual abuse by Resident #268. Resident #268 was admitted to the facility on 4/13/17 with diagnoses that included but were not limited to: chronic kidney disease, mood disorder, dementia, high blood pressure, stroke and congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (1) The MDS (minimum data set) assessment around the time of the incident, 11/12/17, was a quarterly assessment, with an assessment reference date of 12/13/17, and coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score indicating he was cognitively intact to make daily decisions. Resident #268 was coded as requiring extensive assistance for moving in the bed, dressing, and personal hygiene. He was coded as requiring supervision of one staff member for transfers, moving on and off the unit and toileting. The resident was coded as independent for eating. Resident #268 was coded as having restrictions in his range of motion on one side of his one arm and one leg. Resident #150 was admitted to the facility on 11/4/15 with diagnoses that included but were not limited to: Alzheimer's dementia, diabetes, muscle weakness, depression, and seizures. The MDS (minimum data set) assessment, around the time of the incidents, a quarterly assessment,	F 608		

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F 608	Continued From page 39	F 608		

with an assessment reference date of 11/7/17, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. Resident #150 was coded as wandering one to three days during the look back period. The resident was coded as having behaviors not directed toward others one to three days during the look back period. Resident #150 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The Facility Reported Incident (FRI) dated 11/12/17 documented in part, "Incident Type - Allegation of abuse/mistreatment. Describe incident: It was reported to the Administrator at 11 am that (Resident #268) had grabbed (Resident #150)'s breast. They were immediately separated and (Resident #268) was placed on 1:1 (one to one). Our investigation has begun." The bottom left corner of the form documented which agencies were notified. "Law Enforcement" was not documented as having been notified.

An interview was conducted with other staff member (OSM) #7 and OSM #10, the social workers at the facility, on 4/25/18 at 3:55 p.m., regarding this incident being reported to the police. When asked if this incident should have been reported to the police, OSM #10 stated, "Yes, Ma'am."

An interview was conducted with administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, on 4/25/18 at 4:10 p.m. When asked about the process staff follows for reporting a crime in the building, ASM

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F 608	Continued From page 40 #2 stated, "If there is a suspicion of a crime, the abuse coordinator would initiate an investigation and notify the agencies, including the police, if appropriate." When asked if a resident has been touched on her breast and a male had his hands down her pants, would that constitute sexual abuse and should this be reported to the police, ASM #1 stated, "Yes, it should have been reported." On 4/26/18 at 3:10 p.m. An interview was conducted with ASM #3, the former administrator, regarding the incident with Resident #268 and Resident #150 on 11/12/17. When asked if he notified the police, ASM #3 stated he could not remember. When asked why he would not call the police, ASM #3 stated, "The (name of county) police will not start an investigation or assign it a case number if the residents involved have dementia and/or if the family does not want to press charges." When asked what the regulations document, ASM #3 stated, "We are required to report to the police." The facility policy, "Policy & Procedure for Reporting Suspected Crimes under the Federal Elder Justice Act." documented in part, "Procedure: Staff Reporting Requirements: When staff suspect a crime has occurred against a resident at the Facility, they must report the incident to SSA (state survey agency) and local law enforcement. Staff must report a suspicion of a crime to the state survey agency and at least one local law enforcement entity with in a designated time frame by e-mail, fax or telephone. The individual does not need to determine which local law enforcement entity to report a suspicion of crime; but must report to at least one local law enforcement entity. This will	F 608		

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F 608	Continued From page 41 meet the individual's obligation to report." The administrator, ASM #1 and director of nursing, ASM #2 were made aware of the above findings on 4/26/18 at 5:15 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. 2. The facility staff failed to report to the police an allegation of sexual abuse by Resident #269. Resident #269 was admitted to the facility on 9/28/17 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability).(1), traumatic brain injury and mood disorder. The MDS (minimum data set) assessment completed closest to the incident of 12/11/17, with an assessment reference date of 12/22/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making cognitive daily decisions. The resident was coded as requiring limited assistance or supervisions of one staff member for all of his activities of daily living. In Section E - Behavior, the resident was coded as not having any behaviors during the look back period. The Facility Reported Incident (FRI) dated	F 608		

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12/9/17 documented in part, "Incident Type - Resident to Resident Abuse. Describe Incident: At approximately 4:15 p.m. on this date, the Administrator received a call that a nurse aide observed (Resident #269)'s hand down (Resident #150)'s pants in the dining room. (Resident #150) was assessed and no injury was observed. (Resident #269) was placed on 1:1. Our investigation has begun." The bottom left corner of the form documented which agencies were notified. "Law Enforcement" was not documented as having been notified.

An interview was conducted with LPN (licensed practical nurse) #8 on 4/25/18 at 3:14 p.m. When asked if the above occurrence is considered sexual abuse, LPN #8 stated, "Yes." When asked if it should be reported to the local police, LPN #8 stated, "Yes, if it happened outside the facility, it would have been a crime."

An interview was conducted with ASM #3, the former administrator, on 4/26/18 at 3:10 p.m. When asked if he notified the police regarding the incident between Resident 269 and Resident #150 on 12/9/17, ASM #3 stated he couldn't remember. ASM #3 stated, "The (name of county) police will not start an investigation or assign it a case number if the residents involved have dementia and/or if the family does not want to press charges." When asked what the regulations document, ASM #3 stated, "We are required to report to the police."

The administrator, ASM #1 and director of nursing, ASM #2 were made aware of the above findings on 4/26/18 at 5:15 p.m.

No further information was provided prior to exit.

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F 608	Continued From page 43 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 609	F609 1. Resident #319 is no longer a resident at the facility. Facility is reporting allegations of abuse to appropriate state agencies, initial and follow-up reports. 2. Each residents has the potential of being affected. 3. Staff will be re-educated on facility abuse policy and procedures to ensure reporting an allegation of abuse to appropriate state agencies. 4. Audits will be conducted to ensure staff understanding of reporting an allegation of abuse to appropriate state agencies weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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and clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to report an allegation of abuse to the state agency for one of 42 resident's in the survey sample, Resident # 319.

The facility staff failed to file an initial and follow-up report with the state agency within the required five days after a reported allegation of abuse for Resident # 319.

The findings include:

Resident # 319 was admitted to the facility on 09/18/17 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), dementia (2), gastroesophageal reflux disease (3), hypertension (4), atrial fibrillation (5), muscular dystrophy (6), depression, dysphagia (7), and post mastectomy (8).

Resident # 319's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/18/17, coded Resident # 319 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 319 was coded as requiring extensive assistance of one staff member for activities of daily living.

The statement given by Resident # 319 and taken by OSM # 10, social worker dated 09/19/2017 documented, "Last night patient (Resident # 319) reported to SS (social services) that she was having trouble sleeping so she used her call bell to ask for help. The nurse came in and was

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pleasant and helped patient straighten the bed. Patient stated she called for help again and this time nurse came in and helped again but the third time the nurse came in and made a noise and walked out. Patient stated that the nurse was mad. The nurse came back in the room but about 4 (four) to 5 (five) [one of them was a male] nurse was also with her. Patient stated they grabbed her up and through [sic] her in the wheelchair. According to the patient they were not gentle with her and attack [sic] her. Once she was up at the nurse's station she felt scared because of the nurse looks they were giving her. She asked for a more comfortable chair but nobody would help her so she put herself on the floor to get comfortable. Patient did stated to SS that she has been a victim of abuse in the past (outside of this facility). Patient did state to SS that she told the nurses that she would sue them because of what they did and the nurses just laughed."

On 04/25/18 at 10:30 a.m., an interview was conducted OSM (other staff member) # 10, social worker regarding a complaint by Resident # 319. OSM # 10 stated she recalled who Resident # 319 was. She stated that Resident # 319 told her that night shift staff were verbally and physically abusing her. OSM # 10 stated, "I took (Resident # 319"s) statement and the DON (director of nursing) and the administrator took over the investigation.

On 04/26/18 at 9:50 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing and OSM (other staff member) # 10, social worker regarding a complaint by Resident # 319. When asked why an investigation was initiated regarding Resident

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F 609	Continued From page 46 # 319, ASM # 2 stated, "The resident stated they (staff) grabbed her up and threw her in her wheelchair." When asked if this was an allegation of abuse ASM # 2 stated, "Yes." On 04/27/18 at 7:45 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked if a "Facility Report Incident (FRI)" was completed for Resident #319's allegation of abuse, ASM # 2 stated, "The previous administrator was the abuse coordinator. If we have it would have been filed with your office and we would have a copy in our FRI book." ASM # 2 reviewed the FRI book and stated she wasn't able to locate it. On 04/27/18 at 9:10 a.m., a telephone interview was conducted with ASM # 3, previous administrator. When asked if a FRI was completed regarding Resident # 319's allegation of abuse, ASM # 3 stated he would like to review the case with ASM # 2, director of nursing to refresh his memory and would call back to discuss it. On 04/27/18 at 10:12 a.m., a telephone interview was conducted with ASM # 3, previous administrator regarding Resident # 319's allegation of abuse. ASM # 3 stated, "It was not reported to me as an allegation of abuse." When asked if he reviewed Resident # 319's statement at the time of the incident, ASM # 3 stated, "I didn't review the information until the statements were taken. In retrospect, it was an allegation of abuse or mistreatment. I should have done a report in a timely manner." The facility's policy "Resident Abuse" documented, "4c. The Abuse Coordinator of	F 609		

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F 609	Continued From page 47 Facility will refer any or all allegations and reports of resident abuse to the appropriate state agencies." On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. Complaint deficiency References: (1) Disease that makes it difficult to breathe that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html. (5) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.	F 609		

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F 609	Continued From page 48 (6) A group of more than 30 inherited diseases. They all cause muscle weakness and muscle loss. Some forms of MD appear in infancy or childhood. Others may not appear until middle age or later. The different types can vary in whom they affect, which muscles they affect, and what the symptoms are. All forms of MD grow worse as the person's muscles get weaker. Most people with MD eventually lose the ability to walk. There is no cure for muscular dystrophy. Treatments can help with the symptoms and prevent complications. They include physical and speech therapy, orthopedic devices, surgery, and medications. Some people with MD have mild cases that worsen slowly. Others cases are disabling and severe. This information was obtained from the website: https://medlineplus.gov/musculardystrophy.html. (7) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (8) A surgery to remove the entire breast. Most of the time, some of the skin and the nipple are also removed. The surgery is most often done to treat breast cancer. This information was obtained from the website: https://medlineplus.gov/ency/article/002919.htm.	F 609		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or	F 622	F622 1. Facility will provide documentation in the residents' medical record and communicate appropriate information to the receiving health care institution or provider including care plan goals.	5/29/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

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F 622	Continued From page 49 discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) 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; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) 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. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation.	F 622	2. Each residents has the potential of being affected. 3. Licensed nurses will be re-educated on documenting in the residents medical record and communicating appropriate information to the receiving health care institution or provider including care plan goals. 4. Audits will be conducted to ensure licensed staff document in the residents' medical record and communicate appropriate information to the receiving health care institution or provider including care plan goals has been completed weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 622	Continued From page 50 When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and	F 622		

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F 622	Continued From page 51 any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to meet the appropriate transfer requirements for seven of 42 residents in the survey sample, Resident #157, 110, 81, 468, 142, 318, and 46. 1. For Resident #157, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 4/6/18. 2. For Resident #110, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 2/21/18. 3. For Resident #81, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 12/28/18. 4. For Resident #468, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 3/16/18. 5. The facility staff failed to ensure Resident # 142's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 3/9/18. 6. The facility staff failed to provide the receiving facility a copy of Resident # 318's care plan goals for a facility initiated transfer.	F 622		

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F 622	Continued From page 52 7. The facility staff failed to provide the receiving facility a copy of Resident # 46's care plan goals for a facility initiated transfer. The findings include: 1. Resident #157 was admitted to the facility on 3/23/18 with diagnoses that included but were not limited to Non-Alzheimer's dementia, depression, encephalopathy, mood disorder and muscle weakness. Resident #157's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 3/30/18. Resident #157 was coded as being impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status Exam). Resident #157 was coded as requiring extensive assistance from two or more staff members with ADL (Activities of Daily Living). Review of Resident #157's clinical record revealed that she had been transferred to the hospital on 4/6/18. The following nursing note was documented: "Resident Lethargic. Skin hot and clammy. Temp (temperature) 102.7 and climbing...Resident more lethargic than usual. Cannot hold self upright. Temp is elevated and continuing to go up. Responsive to questions. Pupils not dilated. Lung sounds clear. Respirations even and unlabored. VS (vital signs) 110/48,-102.7-117 (pulse)-18 (respirations) - 93% (percent) (oxygen)." Further review of the clinical record revealed that Resident #157 was admitted back to the facility on 4/11/18 with a diagnosis of Sepsis.	F 622		

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F 622	Continued From page 53 There was no evidence that all the required information; Resident #157's advanced directives, responsible party contact information, and Resident #157's care plan was provided to the hospital for the facility-initiated transfer on 4/6/18. On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him aware of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the resident for a transfer to the hospital, LPN #4 stated that the face sheet, physician orders, and the transfer sheet would be sent with the residents. When asked if the care plan is ever sent with residents', LPN #4 stated that the nurses do not send the care plan. When asked if the nurses document a note regarding the documentation that was sent with the resident for a transfer, LPN #4 stated, "No, we don't normally document paper work sent with them. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 2. For Resident #110, facility staff failed to	F 622		

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F 622	Continued From page 54 evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 2/21/18. Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most recent MDS (minimum data set assessment) was a quarterly assessment with and ARD (assessment reference date) of 1/24/18. Resident #110 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #110's nursing notes revealed that she had been transferred to the hospital on 2/21/18, the following nursing note was documented, "Resident sent out to ER (Emergency room) due to difficulty breathing and 02 (oxygen) sat (saturation) was 81 with 4 lit (liters) of oxygen via N/C (nasal cannula). HOB (head of bead) elevated to assist with breathing. Resident encouraged to breath in deep through her nose and out her mouth (with lips and small opening). Resident has no SOB (shortness of breath) noted but does have some anxiety and refused all interventions. Response: On call notified, ordered to send out. (sic) Around (sic) 4.45 (sic) am resident was transported through (Name of ambulance) to (Name of Hospital). RP (responsible party) called and notified." Further review of the clinical record revealed that Resident #110 was admitted back to the facility on 2/22/18 with a diagnosis of shortness of	F 622		

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F 622	Continued From page 55 breath. There was no evidence that all the required information; Resident #110's advanced directives, responsible party contact information, and Resident #110's care plan was provided to the hospital for the facility-initiated transfer on 2/21/18. On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him aware of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the resident for a transfer to the hospital, LPN #4 stated that the face sheet, physician orders, and the transfer sheet would be sent with the residents. When asked if the care plan is ever sent with residents', LPN #4 stated that the nurses do not send the care plan. When asked if the nurses document a note regarding the documentation that was sent with the resident for a transfer, LPN #4 stated, "No, we don't normally document paper work sent with them. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 622		

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F 622	Continued From page 56 3. For Resident #81, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 12/28/18. Resident #81 was admitted to the facility on 11/18/16 with diagnoses that included but were not limited to high blood pressure, thyroid disorder, arthritis, osteoporosis, Non-Alzheimer's dementia, depression, and muscle weakness. Resident #81's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/19/18. Resident #81 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #81's clinical record revealed that he had been transferred to the hospital on 12/28/18. The following nursing note was written: "Resident has dark purple bruising to right and left side of jaw and left elbow... Resident is S/P (status/post) fall day 2 noted dark purple bruising to right and left mandible right side bruise is 2 cm (centimeters) x 3.5 cm (centimeters) and bruise on left side 1.5 cm by 1.5 cm. left elbow 2cm by 3.5 cm. Resident had X Ray that showed high suspicion of an anterior right mandibular fracture with minimal separation. Resident sent out to (Name of hospital) for CT (computed tomography scan) scan. MD (medical doctor/RP (responsible party) made aware." Further review of the clinical record revealed that Resident #81 arrived back to the facility on 12/29/18 with a diagnosis of a mandibular fracture.	F 622		

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F 622	Continued From page 57 There was no evidence that all the required information; Resident #81's advanced directives, responsible party contact information, and Resident #81's care plan was provided to the hospital for the facility-initiated transfer on 12/28/18. On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him aware of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the resident for a transfer to the hospital, LPN #4 stated that the face sheet, physician orders, and the transfer sheet would be sent with the residents. When asked if the care plan is ever sent with residents', LPN #4 stated that the nurses do not send the care plan. When asked if the nurses document a note regarding the documentation that was sent with the resident for a transfer, LPN #4 stated, "No, we don't normally document paper work sent with them. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 622		

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F 622	Continued From page 58 4. For Resident #468, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 3/16/18. Resident #468 was admitted to the facility on 10/5/06 and readmitted on 5/1/12 with diagnoses that included but were not limited to unspecified dementia, muscle weakness, anorexia, high blood pressure, and atrial fibrillation. Resident #468's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/7/18. Resident #468 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #468's clinical record revealed that she was transferred to the hospital on 3/16/18. The following nursing note was documented, "Resident up for breakfast in jerri (sic.) chair consumed 25 % (percent) with assistance from CNA (certified nursing assistant) (drank all liquids). Resident consumed medication per nurse on duty without any difficulties. A (alert) & O (Oriented) the (sic.) confusion able to answer questions but incoherent with response (per normal baseline). Resident up at nurse station per normal doing normal activities. Resident noted by nurse and aide @ (at)145pm of not responding to verbal or tactile stimuli (sic) NP (nurse practitioner) on floor and assessed resident and gave verbal to send to ER (emergency room) (Resident has her eyes opened and will follow persons with her eyes but no response, pupil reactive to light, not talking however resident is making a snoring like noise) (sic) 02 (oxygen) started at 2l (liters)/min (minute) via non rebreather, HOB (Head of bed) in upright	F 622		

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F 622	Continued From page 59	F 622		

position, Resident moving hands and grasping writers fingers when hand was rubbed but would not grasps on command), + (positive) cap (capillary) refill to hands (sic) skin warm and dry to touch, WNL (within normal limits) of baseline skin tone color. EMT (emergency Medical Technician) arrived within 3 mins (minutes) of being called and took over from there."

Review of Resident #468's hospital record revealed that she had expired in the hospital due to unspecified aspiration pneumonia.

There was no evidence that all the required information; Resident #468's advanced directives, responsible party contact information, and Resident #468's care plan was provided to the hospital for the facility-initiated transfer on 3/16/18.

On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him aware of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the resident for a transfer to the hospital, LPN #4 stated that the face sheet, physician orders, and the transfer sheet would be sent with the residents. When asked if the care plan is ever sent with residents', LPN #4 stated that the nurses do not send the care plan. When asked if the nurses document a note regarding the documentation that was sent with the resident for a transfer, LPN #4 stated, "No, we don't normally document paper work sent

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F 622	Continued From page 60 with them. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 5. The facility staff failed to ensure Resident # 142's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 3/9/18. Resident #142 was admitted to the facility on 08/30/17 with recent readmission on 03/19/18, with diagnoses that included but were not limited to: dementia, urinary tract infection (an infection of the urinary tract that may include the bladder and kidneys) (1), hypokalemia (low potassium level in the blood) (2), anxiety, depression, and low back pain. The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 04/02/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making. The "Nurse Practitioner Progress Note" dated 03/09/18 at 1:06 p.m., documented in part, "Still not eating or drinking much. No c/o (complaints of) pain but his mental status and functioning is not his baseline ...Will send patient out to ER (emergency room) for evaluation and treatment".	F 622		

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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 622	Continued From page 61 The nurse's note dated 03/09/18 at 2:28 p.m. documented in part, "N.O. (new order) received to sent [sic] to ER for evaluation and treatment. RP (responsible party) notified." During an interview with LPN (licensed practical nurse) #14, on 04/26/18 at 2:56 p.m., LPN #14 was asked if care plan goals were sent with a resident upon transfer to the hospital. LPN #14 stated they do not send care plans, but they do send the Resident's medication administration record (MAR) and treatment administration record (TAR) "Which has treatment information and may include goals". A review of Resident #142's MAR/TAR failed to provide documentation of care plan goals. During an interview with ASM (administrative staff member) #2, the director of nursing, on 4/26/18 at 3:20 p.m., ASM #2 was asked to describe the documentation that is sent with a resident upon transfer to the hospital. ASM #2 stated, "We send the MD (medical doctor) orders, the transfer sheet, recent labs, and any pertinent information about [Resident's] condition". When asked if the care plan or care plan goals are sent with the Resident, ASM #2 stated "It might be on the transfer sheet". ASM #2 stated she would check and provide any documentation that care plan goals are sent with the Resident upon transfer. ASM #1, the administrator, and ASM #2 were made aware of the above findings on 4/26/18 at 5:15 p.m. No further information was obtained prior to exit.	F 622		

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	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

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F 622	Continued From page 62 (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000521.htm (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000479.htm 6. The facility staff failed to provide the receiving facility a copy of Resident # 318's care plan goals for a facility initiated transfer. Resident # 318 was admitted to the facility on 02/28/17 with a readmission of 04/24/18 with diagnoses that included but were not limited to peripheral vascular disease (1), type 2(two) diabetes without complication (2), epilepsy (3) gastroesophageal reflux disease (4), and hypertension (5). Resident # 318's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/28/18, coded Resident # 318 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 318 was coded as requiring extensive assistance of one staff member for activities of daily living. The nurse's "Progress Notes," dated 04/08/2018 for Resident # 318 documented, "8:19 a.m., "Informed by staff resident was not 'looking good' upon entering the room, resident noted to have eyes open but not verbally coherent. Some droopiness noted to R (right) side of face on assessment. V/S (vital signs) obtained on resident documented and reported to MD (medical doctor) upon calling, also blood sugars 114 on nurse assessment, MD phoned, [ASM	F 622		

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(administrative staff member) # 4, physician] informed writer to transport resident OOF (out of facility) to an acute care setting for further evaluation r/t (related to) change in status. Family aware, resident transported to (Name of Hospital) per preferential request of patient and family."

The nurse's "Progress Notes," dated 04/08/2018 for Resident # 318 documented, "11:24 a.m. Change of Condition. Situation: Resident was sent out to (Name of Hospital) for ER (emergency room) evaluation per [ASM (administrative staff member) # 4, physician] due to increased confusion and weakness noted to resident's right side of body as well as droop noted to right side of resident's mouth. VS (vital signs: BP (blood pressure) 156/94, P (pulse) - 95, O2 sats (oxygen saturation) 97% (percent) Temp - (temperature) 98.6, R (respiration)-17."

On 04/26/18 at 3:50 p.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. When asked to describe what paperwork is sent with the resident upon a facility initiated transfer or discharge LPN # 9 stated, "We send the resident's emergency contact information, physician contact information, diagnoses, social security number, insurance information, facility information, resident's condition, vitals, current physician order sheet and history and physical." When asked if they send the resident's care plan goals to the receiving facility when transferring or discharging a resident to the hospital, LPN # 9 stated, "No."

On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing

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were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm.

(3) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information

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F 622	Continued From page 65 was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 7. The facility staff failed to provide the receiving facility a copy of Resident # 46's care plan goals for a facility initiated transfer. Resident # 46 was admitted to the facility on 05/24/16 with a readmission of 01/10/18 with diagnoses that included but were not limited to dementia (1), femur fracture (2), chronic obstructive pulmonary disease (3) diabetes (4), and hypertension (5). Resident # 46's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/17/18, coded Resident # 46 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 46 was coded as requiring extensive assistance of one staff member for activities of daily living. The nurse's "Progress Notes," dated 01/07/2018 for Resident # 46 documented, "13:26 (1:26) p.m., Nurse on duty received x-ray results which indicated a right femoral neck fracture. NOO (new order obtained) from on call MD (medical doctor). Resident transported via (by) (Name of	F 622		

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Ambulance Service) and 2 (two) attendants at 1330 (1:30, p.m.). On call MD/RP (medical doctor/responsible party) made aware of event."

On 04/26/18 at 3:50 p.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. When asked to describe what paperwork is sent with the resident upon a facility initiated transfer or discharge, LPN # 9 stated, "We send the resident's emergency contact information, physician contact information, diagnoses, social security number, insurance information, facility information, resident's condition, vitals, current physician order sheet and history and physical." When asked if they send the resident's care plan goals when the resident is transferred or discharged, LPN # 9 stated, "No."

On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was

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F 622	Continued From page 67 obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm. (3) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623	F623 1. Facility will provide written notification to the resident and representative for a facility initiated transfer. 2. Each residents has the potential of being affected. 3. Medical Record staff and Admission staff will be re-educated on providing written notification to the resident and representative for a facility initiated transfer.	5/29/18

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F 623	Continued From page 68 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623	4. Audits will be conducted to ensure written notification to the resident and representative for a facility initiated transfer has been completed weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 623	Continued From page 69 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 70 Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident representative for facility initiated transfers to the hospital for seven out of 42 residents in the survey sample, Resident #157, 110, 81, 468, 142, 318, and 46. 1. For Resident #157, facility staff failed to provide written notification to the resident representative for a facility-initiated transfer on 4/6/18. 2. For Resident #110, facility staff failed to provide written notification to the resident representative for a facility-initiated transfer on 2/21/18. 3. For Resident #81, facility staff failed to provide written notification to the resident representative for a facility-initiated transfer on 12/28/18. 4. For Resident #468, facility staff failed to provide written notification to the resident representative for a facility-initiated transfer on 3/16/18. 5. The facility staff failed to provide written notice to the resident/responsible representative for Resident # 142's facility initiated transfer to the hospital on 3/9/18. 6. The facility staff failed to provide written notification to the responsible party (RP) for the facility initiated transfer of Resident # 318 to the hospital on 4/8/18. 7. The facility staff failed to provide written notification to the responsible party (RP) for the facility initiated transfer fof Resident # 46 to the	F 623		

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hospital on 1/7/2018.

The findings include:

1. Resident #157 was admitted to the facility on 3/23/18 with diagnoses that included but were not limited to Non-Alzheimer's dementia, depression, encephalopathy, mood disorder and muscle weakness. Resident #157's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 3/30/18. Resident #157 was coded as being impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status Exam).

Review of Resident #157's clinical record revealed that she had been transferred to the hospital on 4/6/18. The following nursing note was documented: "Resident Lethargic. Skin hot and clammy. Temp (temperature) 102.7 and climbing...Resident more lethargic than usual. Cannot hold self upright. Temp is elevated and continuing to go up. Responsive to questions. Pupils not dilated. Lung sounds clear. Respirations even and unlabored. VS (vital signs) 110/48,-102.7-117 (pulse)-18 (respirations) - 93% (percent) (oxygen)."

Further review of the clinical record revealed that Resident #157 was admitted back to the facility on 4/11/18 with a diagnosis of Sepsis.

Review of Resident #157's clinical record failed to evidence that the RP (responsible party) was notified in writing for her reason for transfer on 4/6/18.

On 4/26/18 at 2:20 p.m., an interview was

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F 623	Continued From page 72 conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that the resident representative was notified verbally of a resident transfer to the hospital. LPN #4 stated that the nurses did not provide written documentation to the resident representative. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 2. For Resident #110, facility staff failed to provide written notification to the resident representative for a facility-initiated transfer on 2/21/18. Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most recent MDS (minimum data set assessment) was a quarterly assessment with and ARD (assessment reference date) of 1/24/18. Resident #110 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #110's nursing notes revealed that she had been transferred to the hospital on 2/21/18, the following nursing note was documented, "Resident sent out to ER (Emergency room) due to difficulty breathing and	F 623		

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F 623	Continued From page 73 02 (oxygen) sat (saturation) was 81 with 4 lit (liters) of oxygen via N/C (nasal cannula). HOB (head of bead) elevated to assist with breathing. Resident encouraged to breath in deep through her nose and out her mouth (with lips and small opening). Resident has no SOB (shortness of breath) noted but does have some anxiety and refused all interventions. Response: On call notified, ordered to send out. (sic) Around (sic) 4.45 (sic) am resident was transported through (Name of ambulance) to (Name of Hospital). RP (responsible party) called and notified." Further review of the clinical record revealed that Resident #110 was admitted back to the facility on 2/22/18 with a diagnosis of shortness of breath. Review of Resident #110's clinical record failed to evidence that the RP (responsible party) was notified in writing for her reason for transfer on 2/21/18. On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that the resident representative was notified verbally of a resident transfer to the hospital. LPN #4 stated that the nurses did not provide written documentation to the resident representative. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 623		

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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 623	Continued From page 74	F 623		

3. For Resident #81, facility staff failed to provide written notification to the resident representative for a facility-initiated transfer on 12/28/18.

Resident #81 was admitted to the facility on 11/18/16 with diagnoses that included but were not limited to high blood pressure, thyroid disorder, arthritis, osteoporosis, Non-Alzheimer's dementia, depression, and muscle weakness. Resident #81's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/19/18. Resident #81 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #81's clinical record revealed that he had been transferred to the hospital on 12/28/18. The following nursing note was written: "Resident has dark purple bruising to right and left side of jaw and left elbow...Resident is S/P (status/post) fall day 2 noted dark purple bruising to right and left mandible right side bruise is 2 cm (centimeters) x 3.5 cm (centimeters) and bruise on left side 1.5 cm by 1.5 cm. left elbow 2 cm by 3.5 cm. Resident had X Ray that showed high suspicion of an anterior right mandibular fracture with minimal separation. Resident sent out to (Name of hospital) for CT scan. MD (medical doctor/RP (responsible party) made aware."

Further review of the clinical record revealed that Resident #81 arrived back to the facility on 12/29/18 with a diagnosis of a mandibular fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 623	Continued From page 75 Review of Resident #81's clinical record failed to evidence that the RP (responsible party) was notified in writing for his reason for transfer on 12/28/18. On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that the resident representative was notified verbally of a resident transfer to the hospital. LPN #4 stated that the nurses did not provide written documentation to the resident representative. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 4. For Resident #468, facility staff failed to provide written notification to the resident representative for a facility-initiated transfer on 3/16/18. Resident #468 was admitted to the facility on 10/5/06 and readmitted on 5/1/12 with diagnoses that included but were not limited to unspecified dementia, muscle weakness, anorexia, high blood pressure, and atrial fibrillation. Resident #468's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/7/18. Resident #468 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 76 Review of Resident #468's clinical record revealed that she was transferred to the hospital on 3/16/18. The following nursing note was documented, "Resident up for breakfast in jerri chair consumed 25 % (percent) with assistance from CNA (certified nursing assistant) (drank all liquids). Resident consumed medication per nurse on duty without any difficulties. A (alert) & O (Oriented) the (sic) confusion able to answer questions but incoherent with response (per normal baseline). Resident up at nurse station per normal doing normal activities. Resident noted by nurse and aide @145pm of not responding to verbal or tactile stimuli (sic) NP (nurse practitioner) on floor and assessed resident and gave verbal to send to ER (emergency room) (Resident has her eyes opened and will follow persons with her eyes but no response, pupil reactive to light, not talking however resident is making a snoring like noise) (sic) 02 (oxygen) started at 2l (liters)/min (minute) via non rebreather, HOB (Head of bed) in upright position, Resident moving hands and grasping writers fingers when hand was rubbed but would not grasps on command), + (positive) cap (capillary) refill to hands (sic) skin warm and dry to touch, WNL (within normal limits) of baseline skin tone color. EMT (emergency Medical Technician) arrived within 3 mins (minutes) of being called and took over from there." Review of Resident #468's hospital record revealed that she had expired in the hospital due to unspecified aspiration pneumonia. Review of Resident #468's clinical record failed to evidence that the RP (responsible party) was notified in writing for her reason for transfer on	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 77 3/16/18. On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that the resident representative was notified verbally of a resident transfer to the hospital. LPN #4 stated that the nurses did not provide written documentation to the resident representative. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. 5. The facility staff failed to provide written notice to resident/responsible representative of facility initiated transfer to hospital for Resident #142 on 3/09/18. Resident #142 was admitted to the facility on 08/30/17 with recent readmission on 03/19/18, with diagnoses that included but were not limited to: dementia, urinary tract infection (an infection of the urinary tract that may include the bladder and kidneys) (1), hypokalemia (low potassium level in the blood) (2), anxiety, depression, and low back pain. The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 04/02/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 78 The "Nurse Practitioner Progress Note" dated 03/09/18 at 1:06 p.m., documented in part, "Still not eating or drinking much. No c/o (complaints of) pain but his mental status and functioning is not his baseline ...Will send patient out to ER (emergency room) for evaluation and treatment". The nurse's note dated 03/09/18 at 2:28 p.m. documented in part, "N.O (new order) received to sent [sic] to ER for evaluation and treatment. RP (responsible party) notified." The nurse's notes dated 03/09/18 at 4:53 p.m. documented in part, "Resident left facility via stretcher ...RP is aware". An interview was conducted with LPN (licensed practical nurse) #15 on 04/26/18 at 1:14 p.m. LPN #15 was asked how the resident/responsible representative was notified of a transfer to the hospital. LPN #15 stated that the "Charge nurse calls to let the family know that the resident is getting transferred". When asked if this is provided in writing to the resident/responsible representative, LPN #15 stated "No". During an interview with ASM (administrative staff member) #2, the director of nursing, on 4/26/18 at 3:20 p.m., ASM #2 was asked how the resident/responsible representative is notified about transfer to the hospital. ASM #2 stated that the staff, "Call the family and document the notification in the nurse's notes". When asked if written notification of the transfer to the hospital is provided to the resident/responsible representative, ASM #2 stated "No". ASM #1, the administrator, and ASM #2 were	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 79 made aware of the above findings on 4/26/18 at 5:15 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000521.htm (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000479.htm 6. The facility staff failed to provide written notification to the responsible party (RP) for the facility initiated transfer of Resident # 318 to the hospital on 4/8/18. Resident # 318 was admitted to the facility on 02/28/17 with a readmission of 04/24/18 with diagnoses that included but were not limited to peripheral vascular disease (1), type 2(two) diabetes without complication (2), epilepsy (3) gastroesophageal reflux disease (4), and hypertension (5). Resident # 318's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/28/18, coded Resident # 318 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. The nurse's "Progress Notes," dated 04/08/2018 for Resident # 318 documented, "8:19 a.m., "Informed by staff resident was not 'looking good' upon entering the room, resident noted to have eyes open but not verbally coherent. Some droopiness noted to R (right) side of face on assessment. V/S (vital signs) obtained on	F 623		

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F 623	Continued From page 80	F 623		

resident documented and reported to MD (medical doctor) upon calling, also blood sugars 114 on nurse assessment, MD phoned, [ASM (administrative staff member) # 4, physician] informed writer to transport resident OOF (out of facility) to an acute care setting for further evaluation r/t (related to) change in status. Family aware, resident transported to (Name of Hospital) per preferential request of patient and family."

The nurse's "Progress Notes," dated 04/08/2018 for Resident # 318 documented, "11:24 a.m. Change of Condition. Situation: Resident was sent out to (Name of Hospital) for ER (emergency room) evaluation per [ASM (administrative staff member) # 4, physician] due to increased confusion and weakness noted to resident's right side of body as well as droop noted to right side of resident's mouth. VS (vital signs: BP (blood pressure) 156/94, P (pulse) - 95, O2 sats (oxygen saturation) 97% (percent) Temp - (temperature) 98.6, R (respiration)-17."

On 04/26/18 at 3:50 p.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager, regarding how the facility staff notify the RP (responsible party) of a facility initated transfer of a resident to the hospital. LPN # 9 stated, "We notify the RP or family by phone." When asked if a written notification is provided to the RP or family, LPN #9 stated, "No."

On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 81	F 623		

References:
(1) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm.

(3) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

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F 623	Continued From page 82 (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 7. The facility staff failed to provide written notification to the responsible party (RP) for the facility initiated transfer of Resident # 46 to the hospital on 1/7/2018. Resident # 46 was admitted to the facility on 05/24/16 with a readmission of 01/10/18 with diagnoses that included but were not limited to dementia (1), femur fracture (2), chronic obstructive pulmonary disease (3) diabetes (4), and hypertension (5). Resident # 46's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/17/18, coded Resident # 46 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. The nurse's "Progress Notes," dated 01/07/2018 for Resident # 46 documented, "13:26 (1:26) p.m., Nurse on duty received x-ray results which indicated a right femoral neck fracture. NOO (new order obtained) from on call MD (medical doctor). Resident transported via (by) (Name of Ambulance Service) and 2 (two) attendants at 1330 (1:30, p.m.). On call MD/RP (medical doctor/responsible party) made aware of event." On 04/26/18 at 3:50 p.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager, regarding how the facility staff	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 83	F 623		

notify the RP (responsible party) of a facility initated transfer of a resident to the hospital. LPN # 9 stated, "We notify the RP or family by phone." When asked if a written notification is provided to the RP or family, LPN #9 stated, "No."

On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

(3) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/

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F 623	Continued From page 84 001214.htm. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625	F625 1. Facility will provide notice of bed hold policy upon transfer to resident/responsible representative. 2. Each residents has the potential of being affected. 3. Licensed nurses, Medical Records Staff and Admission Staff will be re-educated on providing notice of bed hold policy upon transfer to resident/responsible representative. 4. Audits will be conducted to ensure notice of bed hold policy upon transfer to resident/ responsible representative have been completed weekly for four weeks then monthly for three months. Results of the visits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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by:
Based on staff interview, facility documentation review and clinical record review, it was determined the facility staff failed to provide a written bed hold notification/policy to resident/responsible representative at the time of transfer or within twenty four hours for 3 of 42 residents in the survey sample, Residents #142, #318, and #46.

1. The facility staff failed to provide a written bed hold notification/policy to Resident #142's resident/responsible representative upon the residents transfer to hospital on 03/09/18.

2. The facility staff failed to provide a written bed hold notification/policy to Resident #318's resident/responsible representative upon the residents transfer to hospital on 04/08/18.

3. The facility staff failed to provide a written bed hold notification/policy to Resident #46's resident/responsible representative upon the residents transfer to hospital on 07/07/18.

The findings include:

1. The facility staff failed to provide a written bed hold notification/policy to Resident #142's resident/responsible representative upon the residents transfer to hospital on 03/09/18.

Resident #142 was admitted to the facility on 08/30/17 with recent readmission on 03/19/18, with diagnoses that included but were not limited to: dementia, urinary tract infection (an infection of the urinary tract that may include the bladder and kidneys) (1), hypokalemia (low potassium level in the blood) (2), anxiety, depression, and

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 625	Continued From page 86 low back pain. The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 04/02/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status), indicating he had severe cognitive impairment of daily decision making. The "Nurse Practitioner Progress Note" dated 03/09/18 at 1:06 p.m., documented in part, "Still not eating or drinking much. No c/o (complaints of) pain but his mental status and functioning is not his baseline ...Will send patient out to ER (emergency room) for evaluation and treatment". The nurse's note dated 03/09/18 at 2:28 p.m. documented in part, "N.O (new order) received to sent [sic] to ER for evaluation and treatment. RP (responsible party) notified." The nurse's notes dated 03/09/18 at 4:53 p.m. documented in part, "Resident left facility via stretcher ...RP is aware". During an interview with OSM (other staff member) #10, a social worker, on 04/26/18 at 11:39 a.m., OSM #10 was asked who is responsible for providing bed hold information to the resident/responsible representative when a Resident is transferred to the hospital. OSM #10 stated that the "business office calls the family". During an interview with OSM #11, admissions director, on 04/26/18 at 2:15 p.m., she stated that they currently do not have a business office manager, so at this time, it is the responsibility of the admissions department to contact	F 625		

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 625	Continued From page 87 resident/responsible representative about bed holds. OSM #11 stated, "There is not any bed hold information currently in writing that is sent when a Resident is transferred". During an interview with ASM (administrative staff member) #2, the director of nursing, on 4/26/18 at 3:20 p.m., ASM #2 was asked if written notification of a bed hold was provided to resident/responsible representative, ASM #2 stated she would check to see what bed hold documentation the facility provides. ASM #1, the administrator, and ASM #2 were made aware of the above findings on 4/26/18 at 5:15 p.m. On 4/27/18 at 7:30 a.m., the facility provided a copy of the "Notice of Bed Hold Policy". Upon review of the documentation, it was noted that there was nowhere on the document for the resident/responsible representative to sign acknowledgement of the bed hold. During an interview with OSM #11 on 04/27/18 at 9:15 a.m., the "Notice of Bed Hold Policy" was shown to her. She stated that the notice the surveyor showed her is part of the packet that a resident/responsible representative receives upon admission to the facility. She confirmed that it does not represent a bed hold notification and that currently the facility does not provide any written notification to the resident/responsible representative regarding a bed hold when a transfer to the hospital occurs. No further information was obtained prior to exit. (1) This information was obtained from the	F 625		

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following website:
https://medlineplus.gov/ency/article/000521.htm
(2) This information was obtained from the following website:
https://medlineplus.gov/ency/article/000479.htm

2. The facility staff failed to provide Resident # 318's representative written notification of the bed hold policy when the resident was discharged to the hospital on 04/08/18.

Resident # 318 was admitted to the facility on 02/28/17 with a readmission of 04/24/18 with diagnoses that included but were not limited to peripheral vascular disease (1), type 2(two) diabetes without complication (2), epilepsy (3) gastroesophageal reflux disease (4), and hypertension (5).

Resident # 318's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/28/18, coded Resident # 318 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.

The nurse's "Progress Notes," dated 04/08/2018 for Resident # 318 documented, "8:19 a.m., "Informed by staff resident was not 'looking good' upon entering the room, resident noted to have eyes open but not verbally coherent. Some droopiness noted to R (right) side of face on assessment. V/S (vital signs) obtained on resident documented and reported to MD (medical doctor) upon calling, also blood sugars 114 on nurse assessment, MD phoned, [ASM (administrative staff member) # 4, physician] informed writer to transport resident OOF (out of

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facility) to an acute care setting for further evaluation r/t (related to) change in status. Family aware, resident transported to (Name of Hospital) per preferential request of patient and family."

The nurse's "Progress Notes," dated 04/08/2018 for Resident # 318 documented, "11:24 a.m. Change of Condition. Situation: Resident was sent out to (Name of Hospital) for ER (emergency room) evaluation per [ASM (administrative staff member) # 4, physician] due to increased confusion and weakness noted to resident's right side of body as well as droop noted to right side of resident's mouth. VS (vital signs: BP (blood pressure) 156/94, P (pulse) - 95, O2 sats (oxygen saturation) 97% (percent) Temp - (temperature) 98.6, R (respiration)-17."

Further review of Resident #318's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #318"s representative.

During an interview with OSM #11 on 04/27/18 at 9:15 a.m., the "Notice of Bed Hold Policy" was shown to her. She stated that the notice the surveyor showed her is part of the packet that a resident/responsible representative receives upon admission to the facility. She confirmed that it does not represent a bed hold notification and that currently the facility does not provide any written notification to the resident/responsible representative regarding a bed hold when a transfer to the hospital occurs.

On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing

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F 625	Continued From page 90 were made aware of the findings. No further information was provided prior to exit. References: (1) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. (3) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. (4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information	F 625		

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was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

3. The facility staff failed to provide Resident # 46's representative written notification of the bed hold policy when the resident was discharged to the hospital on 01/07/18.

Resident # 46 was admitted to the facility on 05/24/16 with a readmission of 01/10/18 with diagnoses that included but were not limited to dementia (1), femur fracture (2), chronic obstructive pulmonary disease (3) diabetes (4), and hypertension (5).

Resident # 46's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/17/18, coded Resident # 46 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 46 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 01/07/2018 for Resident # 46 documented, "13:26 (1:26) p.m., Nurse on duty received x-ray results which indicated a right femoral neck fracture. NOO (new order obtained) from on call MD (medical doctor). Resident transported via (by) (Name of Ambulance Service) and 2 (two) attendants at

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1330 (1:30, p.m.). On call MD/RP (medical doctor/responsible party) made aware of event."

Further review of Resident #46's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident # 46"s representative.

During an interview with OSM #11 on 04/27/18 at 9:15 a.m., the "Notice of Bed Hold Policy" was shown to her. She stated that the notice the surveyor showed her is part of the packet that a resident/responsible representative receives upon admission to the facility. She confirmed that it does not represent a bed hold notification and that currently the facility does not provide any written notification to the resident/responsible representative regarding a bed hold when a transfer to the hospital occurs.

On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a

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F 625	Continued From page 93 cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm. (3) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 625		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(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;	F 645	F645 1. Facility will obtain PASARR screening prior to residents admitting to the facility. PASARRs have been completed on residents #90, #20, #60 and #53 2. A review of residents will be conducted to initiate the completion of PASARRs on residents. 3. Admissions staff will be re-educated on obtaining PASARR screening prior to residents	5/29/18

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F 645	Continued From page 94 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. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a 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.	F 645	admitting to the facility. PASARRs will be completed 4. Audits will be conducted to ensure PASARR screenings have been obtained prior to residents admitting to the facility weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 645	Continued From page 95 §483.20(k)(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. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed for four of 42 residents in the survey sample, Residents # 90, # 20, # 60, and # 53. 1. The facility staff failed to ensure Resident #90's PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 2. The facility staff failed to ensure Resident #20's PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 3. The facility staff failed to ensure Resident #60's PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the	F 645		

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F 645	Continued From page 96 resident's needs. 4. The facility staff failed to complete the pre-admission screening and resident review (PASARR) for Resident #53. The findings include: 1. The facility staff failed to ensure Resident #90's PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. Resident # 90 was admitted to the facility on 11/08/13. Resident #90's diagnoses included but were not limited to diabetes (1), bipolar disorder (2), dementia without behavioral disturbances (3), anxiety (4) and depressive disorder (5). Resident #90's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/28/18, coded the resident as cognitively intact. Review of Resident #90's clinical record failed to reveal the resident's PASARR. Resident #90's comprehensive care plan with a revision date of 02/28/18 failed to reveal documentation regarding the PASARR. On 04/25/18 at approximately 8:00 a.m., a request was made to ASM (administrative staff member) # 1, administrator for Resident # 90's PASARR. On 04/25/18 at approximately 11:30 a.m., ASM (administrative staff member) # 1, administrator provided this surveyor with a form	F 645		

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entitled "Medicaid Funded Long Term Care Service Authorization Form" for Resident # 90 dated 11/08/13.

On 4/26/18 at 11:32 a.m., an interview was conducted with OSM (other staff member) #7 (social worker) and OSM #10 (social worker). OSM #7 stated the facility staff usually obtains level two PASARRs from a company based in Tennessee but her understanding was that level one PASARRs are obtained from the hospital. When asked if they check to make sure residents' PASARRs are completed, OSM #10 stated, "No. We have not been checking." When asked who was responsible for ensuring PASARRs are completed, OSM #10 stated, "Can I get back to you?"

On 4/26/18 at 11:52 a.m., OSM #10 stated the admissions department was responsible for PASARRs.

On 4/26/18 at 2:13 p.m., an interview was conducted with OSM #11 (the admissions director who was employed at the facility for approximately one month) regarding the process for ensuring PASARRs are completed. OSM #11 stated, "When we get a referral through our system, the referral is then checked for the clinical information and I contact the case manager at the hospital for the UAI (uniform assessment instrument) and PASARR. Sometimes that information doesn't always come over with the resident at the time of admission but our outside liaison follows up with that in a day or two and we get the information." OSM #11 confirmed the above letter entitled "Medicaid Funded Long Term Care Service Authorization Form" for Resident # 90 dated 11/08/13 provided

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F 645	Continued From page 98 was not a PASARR. OSM #11 stated, "About two weeks ago our corporate office had a conference call with the social workers, business office manager and admissions regarding PASARRs, what they are and why they are needed and we were told that the social worker in a rare case can do them in house. That is the new process as of two weeks ago." On 4/26/18 at 5:32 p.m., ASM #1, (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 4/27/18 at 8:14 a.m., ASM #1 stated the facility did not have a policy regarding PASARRs. On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (2) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was	F 645		

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obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.
2. The facility staff failed to ensure Resident #20's PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

Resident #20 was admitted to the facility on 5/20/17. Resident #20's diagnoses included but were not limited to hypotension (low blood pressure), urinary tract infection and bipolar disorder (1). Resident #20's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/24/18, coded the resident as being cognitively intact.

Review of Resident #20's clinical record failed to reveal the resident's PASARR.

On 4/25/18 at approximately 11:30 a.m., per this surveyor's request for Resident #20's PASARR, ASM (administrative staff member) #1 (the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 OATE
F 645	Continued From page 100	F 645		

administrator) presented a letter dated 12/28/16, signed by Resident #20's physician at another facility. The letter was addressed to an insurance company and documented, "The purpose of this letter is to confirm (name of Resident #20) meets Long Term Care criteria."

On 4/26/18 at 11:32 a.m., an interview was conducted with OSM (other staff member) #7 (social worker) and OSM #10 (social worker). OSM #7 stated the facility staff usually obtains level two PASARRs from a company based in Tennessee but her understanding was that level one PASARRs are obtained from the hospital. When asked if they check to make sure residents' PASARRs are completed, OSM #10 stated, "No. We have not been checking." When asked who was responsible for ensuring PASARRs are completed, OSM #10 stated, "Can I get back to you?"

On 4/26/18 at 11:52 a.m., OSM #10 stated the admissions department was responsible for PASARRs.

On 4/26/18 at 2:13 p.m., an interview was conducted with OSM #11 (the admissions director who was employed at the facility for approximately one month) regarding the process for ensuring PASARRs are completed. OSM #11 stated, "When we get a referral through our system, the referral is then checked for the clinical information and I contact the case manager at the hospital for the UAI (uniform assessment instrument) and PASARR. Sometimes that information doesn't always come over with the resident at the time of admission but our outside liaison follows up with that in a day or two and we get the information." OSM #11

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F 645	Continued From page 101 confirmed the above letter that was provided was not a PASARR. OSM #11 stated, "About two weeks ago our corporate office had a conference call with the social workers, business office manager and admissions regarding PASARRs, what they are and why they are needed and we were told that the social worker in a rare case can do them in house. That is the new process as of two weeks ago." On 4/26/18 at 5:32 p.m., ASM #1, (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 4/27/18 at 8:14 a.m., ASM #1 stated the facility did not have a policy regarding PASARRs. No further information was provided prior to exit. (1) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bipolar+disorder&_ga=2.1717494.671965706.1525089773-139120270.1477942321 3. The facility staff failed to ensure Resident #60's PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the	F 645		

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F 645	Continued From page 102 resident's needs. Resident #60 was admitted to the facility on 4/18/12. Resident #60's diagnoses included but were not limited to schizophrenia (1), bipolar disorder (2) and chronic pain syndrome. Resident #60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/13/18, coded the resident as being cognitively intact. Review of Resident #60's clinical record failed to reveal the resident's PASARR. On 4/25/18 at approximately 11:30 a.m., per this surveyor's request for Resident #60's PASARR, ASM (administrative staff member) #1 (the administrator) presented a Medicaid funded long-term care service authorization form dated 4/24/12. On 4/26/18 at 11:32 a.m., an interview was conducted with OSM (other staff member) #7 (social worker) and OSM #10 (social worker). OSM #7 stated the facility staff usually obtains level two PASARRs from a company based in Tennessee but her understanding was that level one PASARRs are obtained from the hospital. When asked if they check to make sure residents' PASARRs are completed, OSM #10 stated, "No. We have not been checking." When asked who was responsible for ensuring PASARRs are completed, OSM #10 stated, "Can I get back to you?" On 4/26/18 at 11:52 a.m., OSM #10 stated the admissions department was responsible for PASARRs.	F 645		

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F 645	Continued From page 103 On 4/26/18 at 2:13 p.m., an interview was conducted with OSM #11 (the admissions director who was employed at the facility for approximately one month) regarding the process for ensuring PASARRs are completed. OSM #11 stated, "When we get a referral through our system, the referral is then checked for the clinical information and I contact the case manager at the hospital for the UAI (uniform assessment instrument) and PASARR. Sometimes that information doesn't always come over with the resident at the time of admission but our outside liaison follows up with that in a day or two and we get the information." OSM #11 confirmed the above Medicaid funded long-term care service authorization form was not a PASARR. OSM #11 stated, "About two weeks ago our corporate office had a conference call with the social workers, business office manager and admissions regarding PASARRs, what they are and why they are needed and we were told that the social worker in a rare case can do them in house. That is the new process as of two weeks ago." On 4/26/18 at 5:32 p.m., ASM #1, (administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 4/27/18 at 8:14 a.m., ASM #1 stated the facility did not have a policy regarding PASARRs. No further information was provided prior to exit. (1) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves."	F 645		

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F 645	Continued From page 104 This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia (2) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bipolar+disorder&_ga=2.1717494.671965706.1525089773-139120270.1477942321 4. The facility staff failed to complete the pre-admission screening and resident review for Resident #53. Resident #53 was admitted to the facility on 9/3/13 and readmitted on 11/8/17 with diagnoses that included but were not limited to: bipolar disorder (1), dementia, difficulty swallowing and urinary tract infections. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 2/1/18 coded the resident as moderately impaired cognitively. The resident was coded as dependent on staff for all activities of daily living. Review of the clinical record failed to evidence a Preadmission Screening and Resident Review (PASAAR) had been completed for Resident #53.	F 645		

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F 645	Continued From page 105 On 4/26/18 at 11:32 a.m., an interview was conducted with OSM (other staff member) #7 (social worker) and OSM #10 (social worker). OSM #7 stated the facility staff usually obtains level two PASARRs from a company based in Tennessee but her understanding was that level one PASARRs are obtained from the hospital. When asked if they check to make sure residents' PASARRs are completed, OSM #10 stated, "No. We have not been checking." When asked who was responsible for ensuring PASARRs are completed, OSM #10 stated, "Can I get back to you?" On 4/26/18 at 11:52 a.m., OSM #10 stated the admissions department was responsible for PASARRs. On 4/26/18 at 2:13 p.m., an interview was conducted with OSM #11 (the admissions director who was employed at the facility for approximately one month) regarding the process for ensuring PASARRs are completed. OSM #11 stated, "When we get a referral through our system, the referral is then checked for the clinical information and I contact the case manager at the hospital for the UAI (uniform assessment instrument) and PASARR. Sometimes that information doesn't always come over with the resident at the time of admission but our outside liaison follows up with that in a day or two and we get the information." OSM #11 stated, "About two weeks ago our corporate office had a conference call with the social workers, business office manager and admissions regarding PASARRs, what they are and why they are needed and we were told that the social worker in a rare case can do them in house. That	F 645		

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F 645	Continued From page 106 is the new process as of two weeks ago." A request for a copy of Resident #53's PASAAR and the facility's policy on PASARR was made on 4/26/18 at 5:30 p.m. of ASM (administrative staff member) #1, the administrator. On 4/27/18 at 7:45 a.m. ASM #1, the administrator stated, "They're looking for it (the PASAAR) but I don't think she (Resident #53) has one." ASM #1 returned at 9:00 a.m. and stated the resident did not have a PASAAR completed. On 4/27/18 at 8:14 a.m., ASM #1 stated the facility did not have a policy regarding PASARRs. No further information was provided prior to exit. 1. Bipolar disorder -- Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from: https://medlineplus.gov/bipolardisorder.html	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	F656 1. Resident #95's care plan has been revised to reflect resident's choice on height of bed; Residents #88, #6 #20, #35, #81 care plans are being followed.	5/29/18

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F 656	Continued From page 107 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop and implement the comprehensive care plan for six of 42 residents in	F 656	2. A review of residents care planned with bed in low position, lids on cups containing hot liquids, administration of blood pressure medication per physician orders, catheter care and activities was conducted to ensure the care plan is implemented and followed. 3. Nursing staff and Activity Director will be re-educated on implementing and following comprehensive care plans for bed in low position, lids on cups containing hot liquids, administration for blood pressure medication per physician orders, catheter care and activities. 4. Audits will be conducted to ensure implementing and following comprehensive care plans for bed in low position, lids on cups containing hot liquids, administration of blood pressure medication per physician orders, catheter care and activities weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 656	Continued From page 108 the survey sample, Residents #95, #88, #6, #20, #35 and #81. 1. The facility staff failed to implement and follow the comprehensive care plan to maintain the bed in the low position for Resident #95. 2. The facility staff failed to implement and follow the comprehensive care plan to ensure a lid was on the hot liquid cup for Resident #88. 3. The facility staff failed to implement and follow the comprehensive care plan to ensure a lid was on the hot liquid cup for Resident #6. 4. The facility staff failed to implement and follow Resident #20's comprehensive care plan for the administration of blood pressure medication per physician's order. 5. The facility staff failed to implement and follow Resident #35's comprehensive care plan for catheter care. 6. The facility staff failed to provide activities per the comprehensive plan of care for Resident #81. The findings include: 1. The facility staff failed to implement and follow the comprehensive care plan to maintain the bed in the low position for Resident #95. Resident #95 was admitted to the facility on 2/12/18 with diagnoses that included but were not limited to multiple sclerosis (1), anemia, and depression and pressure ulcers. The most recent MDS (minimum data set), a	F 656		

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significant change assessment, with an ARD (assessment reference date) of 3/8/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as being dependent on staff for all activities of daily living.

An observation was made on 4/24/18 at 3:15 p.m. of Resident #95. The resident was lying in the bed. The bed's height was at waist level or approximately 42 inches.

An observation was made on 4/25/18 at 3:50 p.m. of Resident #95. The resident was in bed, awake and conversant. The bed's height was at waist level or approximately 42 inches.

An observation was made on 4/26/18 at 8:15 a.m. of Resident #95. The resident was in bed sleeping. The bed's height was at waist level or approximately 42 inches.

Review of the resident's fall risk report dated 2/12/18 scored the resident as having a total fall risk score of three.

Review of the resident's care plan initiated on 3/1/18 documented, "Focus. At risk for falls related to: New environment, physical impairment. Interventions. Maintain bed in low position."

An interview was conducted on 4/26/18 at 9:50 a.m. with LPN (licensed practical nurse) #13, the resident's nurse. When asked why residents have care plans, LPN #13 stated, "So we can meet all their needs and take care of them." When asked who developed the care plans, LPN #13 stated,

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"The nurses, or the unit manager or the director of nursing or social worker or MDS nurse works on them as well." When asked who used the care plan, LPN #13 stated, "All of us." When asked if the care plan was to be implemented and followed, LPN #13 stated, "Yes." When asked when a care plan would not be followed, LPN #13 stated, "If whatever we had doesn't work or it doesn't apply to that resident anymore." When asked what height Resident #95's bed was at, LPN #13 gestured with her hand to above waist level or approximately 42 inches. When asked if that was the low position, LPN #13 stated, "No." When made aware of the intervention on the comprehensive care plan to keep the bed in low position, LPN #13 stated, "I didn't know that. We need to change that on the care plan."

An interview was conducted on 4/26/18 at 1:05 p.m. with LPN #4, the unit manager. When asked why residents had care plans, LPN #4 stated, "Basically they have care plans to make us aware of what they have and put into place." When asked who used the care plans, LPN #4 stated, "The nurses. Basically everyone does actually." When asked if staff were expected to follow the care plan, LPN #4 stated, "Yes." LPN #4 was made aware of the findings at that time. LPN #4 stated, "The resident wants the bed at that height." When asked what staff should do then, LPN #4 stated the care plan would be revised.

On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. ASM #2 stated the resident preferred the bed to be raised. When asked if the care plan would be revised in that case, ASM #2 stated yes it should.

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F 656	Continued From page 111 On 4/27/18 at 8:45 a.m., ASM #2 was asked what a fall risk score of three indicated, ASM #2 stated that was a low risk. Review of the facility's policy titled, "CARE PLAN PREPARATION" documented, "A care plan directs the patient's nursing care from admission to discharge. Their written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process..." No further information was provided prior to exit. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome	F 656		

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 656	Continued From page 112 criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 1. Multiple Sclerosis -- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from: https://medlineplus.gov/multiplesclerosis.html 2. The facility staff failed to implement and follow the comprehensive care plan to ensure a lid was on the hot liquid cup for Resident #88. Resident #88 was admitted to the facility on 3/15/13 with diagnoses that included but were not limited to: muscle weakness, dementia, high blood pressure, paralysis of the left arm and leg and stroke. The resident's neck was severely contractured so that her head was always bent to the right and rested on her shoulder. The most recent MDS (minimum data set), a	F 656		

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F 656	Continued From page 113	F 656		

quarterly assessment, with an ARD (assessment reference date) of 2/28/18 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform independently after the tray was set up.

An observation was made on 4/25/18 at 9:15 a.m., of Resident #88. The resident was sitting up in her wheelchair eating breakfast. There was a half-full cup of coffee with a straw in it on the resident's table. There was no lid on the cup.

Review of the hot liquid safety evaluation dated 2/6/18 documented, "This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: #6. altered ROM (range of motion) or contracture of joint(s) to dominant side of (blank line) which cause difficulty in handling regular cup or glass. 1. Shoulder (was checked). 11. If any boxes are checked yes, indicate which interim measures put in place to enhance safety while rehab (rehabilitation) screen is pending: 1. Cup with lid or other adaptive cup (was checked)."

Review of the resident's care plan initiated on 2/8/18 documented, "Focus. Resident has been evaluated and has been identified for risk of injury while handling and drinking hot beverages. Interventions. Provide cup with lid or other adaptive cup."

An interview was conducted on 4/26/18 at 1:05 p.m. with LPN (licensed practical nurse) #4, the

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F 656	Continued From page 114 unit manager. When asked why residents had care plans, LPN #4 stated, "Basically they have care plans to make us aware of what they have and put into place." When asked who used the care plans, LPN #4 stated, "The nurses. Basically everyone does actually." When asked if staff were expected to implement and follow the care plan, LPN #4 stated, "Yes." LPN #4 was made aware of the findings at that time. An interview was conducted on 4/26/18 at 2:45 p.m. with CNA (certified nursing assistant) #14, the resident's aide. When asked how the resident's coffee was served, CNA #14 stated, "I put milk and sugar in it." When asked if the resident had a special cup or had a lid on her coffee cup, CNA #14 stated, "No. She doesn't like it." When asked why a resident would have a lid on their hot liquids, CNA #14 stated, "So it doesn't spill." When asked how staff were made aware that a resident was to have lid on their hot liquids, CNA #14 stated, "I don't know. That's a good question." When asked if the information was on the CNA's care card, CNA #14 stated, "No." Review of Resident #88's care card documented, "lid on cup for hot liquids." On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 3. The facility staff failed to implement and follow the comprehensive care plan to ensure a lid was	F 656		

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F 656	Continued From page 115 on the hot liquid cup for Resident #6. Resident #6 was admitted to the facility on 11/3/17 and readmitted on 12/27/18 with diagnoses that included but were not limited to: dementia, cancer to left side of face, muscle weakness, depression and anxiety. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/15/18 coded the resident as having scored a four out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. An observation was made on 4/25/18 at 9:00 a.m., of Resident #6. The resident was in bed having breakfast. There was a cup of hot coffee on the table without a lid. Review of the resident's hot liquid safety evaluation dated, 2/6/18 documented, "This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: 1. Has a cognitive impairment or drowsiness that impacts the resident's perception and awareness to hot liquids and safety measure included but not limited to : altered comprehension and/or memory impairment (was checked). 8. Episodes of behavior which could cause injury if occurring while the resident is handling hot liquids... (was checked). 11. If any boxes are checked yes, indicate which interim measures were put in place to enhance safety while rehab (rehabilitation) screen is pending. 1. Cup with lid or other	F 656		

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F 656	Continued From page 116 adaptive cup...4. To drink hot liquids at table only. (were checked)." Review of the resident's care plan initiated on: 2/8/18 documented, "Focus. Resident has been evaluated and has been identified for risk of injury while handling and drinking hot beverages. Interventions. Provide cup with lid or other adaptive cup." An interview was conducted on 4/26/18 at 1:05 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked why residents had care plans, LPN #4 stated, "Basically they have care plans to make us aware of what they have and put into place." When asked who used the care plans, LPN #4 stated, "The nurses. Basically everyone does actually." When asked if staff were expected to follow the care plan, LPN #4 stated, "Yes." LPN #4 was made aware of the findings at that time. An interview was conducted on 4/26/18 at 2:45 p.m. with CNA (certified nursing assistant) #14, the resident's aide. When asked how the resident's coffee was served, CNA #14 stated, "I put the cup on the table." When asked if Resident #6 had a lid on her coffee cup, CNA #14 stated, "I've never seen her with one." When asked why a resident would have a lid on their hot liquids, CNA #14 stated, "So it doesn't spill." When asked how staff were made aware that a resident was to have lid on their hot liquids, CNA #14 stated, "I don't know. That's a good question." When asked if the information was on the CNA's care card, CNA #14 stated, "No." Review of Resident #6's care card documented, "lid on cup for hot liquids."	F 656		

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F 656	Continued From page 117 On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 4. The facility staff failed to implement and follow Resident #20's comprehensive care plan for the administration of blood pressure medication per physician's order. Resident #20 was admitted to the facility on 5/20/17. Resident #20's diagnoses included but were not limited to hypotension (low blood pressure), urinary tract infection and bipolar disorder (1). Resident #20's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/24/18, coded the resident as being cognitively intact. Review of Resident #20's clinical record revealed a physician's order dated 2/6/18 for Midodrine (2) 2.5 milligrams one time a day and to hold the medication for a systolic blood pressure greater than 100 or a diastolic blood pressure greater than 90. Review of Resident #20's April 2018 MAR (medication administration record) revealed the resident was administered Midodrine on the following dates (as evidenced by a check mark and nurses' initials) although the resident's systolic blood pressure was greater than 100 or diastolic blood pressure was greater than 90: - 4/1/18- blood pressure 141/93 - 4/2/18- blood pressure 122/55 - 4/10/18- blood pressure 124/74 - 4/14/18- blood pressure 106/68	F 656		

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F 656	Continued From page 118 - 4/22/18- blood pressure 148/78 Resident #20's comprehensive care plan dated 9/12/17 documented, "Impaired Cardiovascular status related to: Hypotension...Medications as ordered by physician and Observe use and effectiveness..." On 4/26/18 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9 (Resident #20's unit manager). LPN #9 was asked what is meant when by a check mark and nurses' initials on the MAR. LPN #9 stated, "It means it was done." LPN #9 was read Resident #20's physician order for Midodrine and asked what should be done if the resident's systolic blood pressure is greater than 100 or diastolic blood pressure is greater than 90. LPN #9 stated, "It (Midodrine) should be held and you should contact the MD (medical doctor) because you need to find out the next step for orders." LPN #9 was made aware Resident #20's Midodrine was initialed as administered on the above dates and made aware of the resident's blood pressures on the above dates. LPN #9 was asked if the medication should have been held on those dates. LPN #9 stated the medication should have been held and the doctor should have been contacted. LPN #9 stated the nurses who administered the Midodrine on those above dates may have contacted the doctor and he said to give the medication but confirmed there was no documentation to evidence this. On 4/26/18 at 2:28 p.m., another interview was conducted with LPN #9. LPN #9 was asked the purpose of the care plan. LPN #9 stated, "To keep everybody knowledgeable about what's going on with the patient and why. Information	F 656		

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that can be given to the next person taking care of the patient. There are a lot of different purposes. Also so we can take care of them." When asked if nurses are supposed to follow the care plan, LPN #9 stated, "Yes."

The nurses who initialed Midodrine administration to Resident #20 on 4/1/18, 4/10/18, 4/14/18 and 4/22/18 were not available for interview.

On 4/26/18 at 4:43 p.m., a telephone interview was conducted with LPN #10 (the nurse who initialed administration of Resident #20's Midodrine on 4/2/18). LPN #10 was asked what should be documented on the MAR if a medication is held. LPN #10 stated, "I don't know the exact number. There is a number on the legend. I don't know if it's a three or a seven. There is a little box that pops up that says hold and we write a note." Resident #20's physician's order for Midodrine was read to LPN #10 and LPN #10 was asked what should be done if the resident's systolic blood pressure is greater than 100 or diastolic blood pressure is greater than 90. LPN #10 stated, "You will hold it." LPN #10 was asked if she recalled ever holding Resident #20's Midodrine. LPN #10 stated she recalled holding the medication on several occasions. When asked if she recalled holding the medication in April 2018, LPN #10 stated, "I don't have her consistently. I don't know the last time I had (name of Resident #20) so I can't say for certain."

On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document regarding care plans

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F 656	Continued From page 120 documented, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation, and evaluation." No further information was provided prior to exit. (1) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bipolar+disorder&_ga=2.1717494.671965706.1525089773-139120270.1477942321 (2) "Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616030.html 5. The facility staff failed to implement and follow Resident #35's comprehensive care plan for	F 656		

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F 656	Continued From page 121 catheter (1) care. Resident #35 was admitted to the facility on 10/1/16. Resident #35's diagnoses included but were not limited to difficulty swallowing, muscle weakness and major depressive disorder. Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/2/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded Resident #35 as requiring extensive assistance of one staff with bed mobility and requiring extensive assistance of two or more staff with transfers. Section H coded the resident as having an indwelling catheter. Review of Resident #35's clinical record revealed a physician's order for a Foley catheter for a diagnosis of urinary retention. Resident #35's comprehensive care plan dated 10/18/16 documented, "Alteration in elimination of bowel and bladder and am (sic) risk for UTI's (urinary tract infections) r/t (related to) History of UTI's Indwelling Urinary Catheter, Urinary Retention...Keep drainage bag of catheter below the level of the bladder at all times and off floor..." On 4/24/18 at 2:38 p.m., Resident #35 was observed sitting in a wheelchair. The catheter tubing was observed touching the floor. On 4/25/18 at 7:45 a.m., Resident #35 was observed lying in bed. The bottom of the catheter drainage bag was observed touching the floor. On 4/26/18 at 9:55 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked where a resident's catheter	F 656		

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tubing and drainage bag should be positioned. LPN #5 stated, "Below waste level." When asked if the bag and tubing should touch the floor, LPN #5 stated, "No." When asked why, LPN #5 stated, "Contamination."

On 4/26/18 at 10:27 a.m., an interview was conducted with LPN #9. LPN #9 was asked where a resident's catheter tubing and drainage bag should be positioned. LPN #9 stated, "It should be in a dignity bag and the bag should be hooked to the bed and lower than the waist." When asked if the tubing or drainage bag should touch the floor, LPN #9 stated, "No."

On 4/26/18 at 2:28 p.m., another interview was conducted with LPN #9. LPN #9 was asked the purpose of the care plan. LPN #9 stated, "To keep everybody knowledgeable about what's going on with the patient and why. Information that can be given to the next person taking care of the patient. There are a lot of different purposes. Also so we can take care of them." When asked if nurses are supposed to follow the care plan, LPN #9 stated, "Yes."

On 4/27/18 at 7:45 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document regarding care plans documented, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation, and

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F 656	Continued From page 123 evaluation." No further information was presented prior to exit. (1) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm 6. The facility staff failed to provide activities per the comprehensive plan of care for Resident #81. Resident #81 was admitted to the facility on 11/18/16 with diagnoses that included but were not limited to high blood pressure, thyroid disorder, arthritis, osteoporosis, Non-Alzheimer's dementia, depression, and muscle weakness. Resident #81's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/19/18. Resident #81 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #81 was coded in section B (Hearing, Speech and Vision) as usually understanding others and usually being understood by others. Section F (Preferences for Customary Activities) documented that is was very important for Resident #81 to have newspapers, books, and magazines to read; keep up with the news, and participate in religious activities. It was documented that it was somewhat important for Resident #81 to go outside to get fresh air when the weather was good. On 4/24/18 at 11:50 a.m., an observation was made of Resident #81. He was awake lying in bed watching television.	F 656		

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On 4/25/18 at 8:24 a.m., an observation was made of Resident #81. He was awake lying in bed watching television.

On 4/25/18 at 10:47 a.m., an observation was made of Resident #81. He was sleeping in bed.

On 4/25/18 at 12:50 p.m., an observation was made of Resident #81. He was lying up in bed eating lunch.

On 4/26/18 at 10:36 a.m., wound care observation was conducted with the wound care nurse. The wound care nurse stated that the resident hadn't been out of bed yet that day.

On 4/26/18 at 12:49 p.m., an interview was conducted with Resident #81. He was lying in bed. The television was on but he was looking at the ceiling. When Resident #81 was asked if anyone had offered him to do any activities that week, Resident #81 stated, "No." Resident #81 stated that he would like to do more.

Review of Resident #81's activity care plan dated 10/20/17 documented the following: "I prefer independent activities or spending time with my family rather than doing things in groups...I will participate in one independent activity a day...Invite clergy or people from my church to come and visit with me, Invite me to "sit in" during activity programs you think I might enjoy, allowing me to join at my own comfort level, Monitor my participation level in my independent activities with me to ensure that I can still participate at a high level with no signs of decline, Offer me activities and supplies for things I can do in my room, such as the newspaper, I enjoy reading the

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	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

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F 656	Continued From page 125	F 656		

paper, Please assist me in participating in my favorite activities at my highest level, such as sitting outside and reading the newspaper."

On 4/26/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) #20, the activities director. When asked how residents are made aware of activities going on in the facility, OSM #20 stated that each resident will receive a large print activity calendar to put up in their room. OSM #20 stated that all residents are offered to go to an activity. When asked if she personally asks every single resident if they want to attend an activity, OSM #20 stated that she would expect nursing staff to help the activities department by assisting residents to the activity. OSM #20 stated that there were only two activity staff for the building. When asked how she or other staff know what a resident likes to do for activities, OSM #20 stated that it should be documented on their care plan or activities assessment. When asked what Resident #81 liked to do for activities, OSM #20 stated that he liked to read the paper that he receives once a week from his home-town. OSM #20 stated that when it is warm outside, Resident #81 liked to sit outside. When asked if it was warm outside that day, OSM #20 agreed that it was. OSM #20 stated that Resident #81's family also visited 2-3 times per week. When asked what activities Resident #81 did that week, OSM #20 stated that she took him his mail. OSM #20 stated, "I asked if he wanted to get up and do something and he said no." OSM #20 could not remember when she asked Resident #81 when he wanted to get up. When asked if she documented his refusal anywhere, OSM #20 stated, no. This writer then accompanied OSM #20 to the activities department to view Resident #81's activity log for

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F 656	Continued From page 126 April 2018. Resident #81's April activity log was completely blank. OSM # 20 stated that after an activity she is supposed to document what was done immediately. OSM #20 stated that the activities she did with Resident #81 must have been documented in her notes. When asked where her notes were located, OSM #20 stated, "I can't find my notes." Review of Resident #81's clinical record failed to evidence any notes for the activities department. On 4/26/18 at 3:57 p.m., further interview was conducted with Resident #81. Resident #81 stated that facility staff took him outside later that afternoon. Resident #81 stated, "I feel so much better." On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657	F657 1. Resident #150 care plan has been updated to address two incidents of resident to resident sexual abuse. 2. No other residents affected. 3. Social Services staff will be re-educated to updated care plans for residents involved in resident to resident altercations.	5/29/18

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F 657	Continued From page 127 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of 42 residents in the survey sample, Resident #150. Resident #150 was involved in two resident-to-resident-sexual abuse incidents and the facility staff failed to update her care plan to address these incidents. The findings include: Resident #150 was admitted to the facility on 11/4/15 with diagnoses that included but were not limited to: Alzheimer's dementia, diabetes, muscle weakness, depression, and seizures. The MDS (minimum data set) assessment, around the time of the incidents, a quarterly	F 657	4. Audits will be conducted to ensure care plans are updated for resident involved in resident to resident altercations weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 657	Continued From page 128	F 657		

assessment, with an assessment reference date of 11/7/17, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. Resident #150 was coded as wandering one to three days during the look back period. The resident was coded as having behaviors not directed toward others one to three days during the look back period. Resident #150 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The Facility Reported Incident (FRI) dated 11/12/17 documented in part, "Incident Type - Allegation of abuse/mistreatment. Describe incident: It was reported to the Administrator at 11 am that (Resident #268) had grabbed (Resident #150)'s breast. They were immediately separated and (Resident #268) was placed on 1:1 (one to one). Our investigation has begun." The bottom left corner of the form documented which agencies were notified. "Law Enforcement" was not documented as having been notified.

Resident #268 was admitted to the facility on 4/13/17 with diagnoses that included but were not limited to: chronic kidney disease, mood disorder, dementia, high blood pressure, stroke and congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)). The MDS (minimum data set) assessment around the time of the incident, 11/12/17, quarterly assessment, with an assessment reference date of 12/13/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score indicating he was cognitively

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intact to make daily decisions. Resident #268 was coded as requiring extensive assistance for moving in the bed, dressing, and personal hygiene. He was coded as requiring supervision of one staff member for transfers, moving on and off the unit and toileting. The resident was independent for eating. Resident #268 was coded as having restrictions in his range of motion on one side of his one arm and one leg.

Review of Resident #150's comprehensive care plan dated 11/5/15 and revised on 3/8/17, failed to evidence any documentation of the incident on 11/12/17.

The Facility Reported Incident (FRI) dated 12/9/17 documented in part, "Incident Type - Resident to Resident Abuse. Describe Incident: AT approximately 4:15 p.m. on this date, the Administrator received a call that a nurse aide observed (Resident #269)'s hand down (Resident #150)'s pants in the dining room. (Resident #150) was assessed and no injury was observed. (Resident #269) was placed on 1:1. Our investigation has begun."

Resident #269 was admitted to the facility on 9/28/17 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability).(2), traumatic brain injury and mood disorder. The MDS (minimum data set) assessment completed closest to the incident of 12/11/17, with an assessment reference date of 12/22/17, coded the resident as scoring a 15 on the BIMS (brief

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F 657	Continued From page 130	F 657		

interview for mental status) score, indicating the resident was capable of making cognitive daily decisions. The resident was coded as requiring limited assistance or supervisions of one staff member for all of his activities of daily living. In Section E - Behavior, the resident was coded as not having any behaviors during the look back period.

Review of Resident #150's comprehensive care plan dated 11/5/15 and revised on 3/8/17, failed to evidence any documentation of the incident on 12/9/17.

An interview was conducted with LPN (licensed practical nurse) #8 on 4/25/18 at 3:09 p.m. When asked who updates the care plans, LPN #8 stated, "It's usually the unit managers."

An interview was conducted with other staff member (OSM) # 7 and OSM #10, the social workers at the facility, on 4/25/18 at 3:55 p.m. When asked if the care plan should be updated for an incident of sexual abuse, both OSM #7 and OSM #10 stated the care plan should have addressed the incident. OSM #7 and OSM #8 were shown the care plan for Resident #150, neither could find locate any documentation on the care plan for the above documented incidents. OSM #10 stated, "We are the resident advocates, and we failed her."

An interview was conducted with administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, on 4/25/18 at 4:10 p.m. The process for investigating abuse allegations was discussed. When asked if the victim of the abuse should have their care plan updated after an incident such as sexual abuse,

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F 657	Continued From page 131 ASM #2 stated, "Yes, it should be updated." An interview was conducted with ASM #3, the former administrator, on 4/26/18 at 3:10 p.m. When asked if the care plan of Resident #150 should have been updated after both allegation of sexual abuse, ASM #3 stated, "I asked the social worker to follow up on this." ASM #3 was informed the care plan was not updated with these incidents. ASM #3 stated, "The social worker should have addressed that in the care plan." The facility policy, "Care Plan Preparation" documented in part, "Nurses update and revise the plan throughout the patient's stay and the document becomes part of the permanent patient record." The administrator and director of nursing were made aware of the above findings on 4/26/18 at 5:15 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658	F658 1. Resident #94 order for a splint has been discontinued. Therapy order has been obtained.	5/29/18

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F 658	Continued From page 132 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 42 residents in the survey sample, Resident #94. The facility staff failed to clarify Resident #94's physician order for a splint. The findings include: Resident #94 was admitted to the facility on 8/3/16. Resident #94's diagnoses included but were not limited to multiple sclerosis (1), contracture of muscle (multiple sites) and high blood pressure. Resident #94's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/8/18, coded the resident as being cognitively intact. Section G coded Resident #94 as being totally dependent on one staff with bed mobility and as being totally dependent on two or more staff with transfers. Review of Resident #94's clinical record revealed a physician's order dated 1/11/17 that documented, "Resident to wear Velcro splint to left forearm to prevent worsening contractures." Resident #94's comprehensive care plan dated 2/2/17 failed to document information about a left forearm splint. On 4/24/18 at 12:00 p.m. and 4/25/18 at 10:43 a.m., Resident #94 was observed lying in bed.	F 658	2. A review of residents receiving splints was conducted to ensure orders reflect the current care of plan ordered by the physician. 3. Licensed Nurse will be re-educated on ensuring resident receiving splints reflect the current plan of care ordered by the physician. 4. Audits will be conducted on ensuring resident receiving splints reflect the current plan of care ordered by the physician weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 658	Continued From page 133 No splint was observed on the resident's left forearm. On 4/26/18 at 2:28 p.m., an interview was conducted with LPN (licensed practical nurse) #9 (unit manager). LPN #9 stated the facility had splints with Velcro closures but did not have Velcro splints. LPN #9 stated the nurse that wrote the physician's order for Resident #94's splint was no longer employed at the facility. LPN #9 stated she had not seen the splint. When asked if the physician's order should have been clarified, LPN #9 stated, "I look through orders and somehow I missed it." On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. When asked what standard of practice the facility staff follows, ASM #2 stated the facility staff follows Lippincott. ASM #1 and ASM #2 were asked to provide the facility standard of practice regarding the clarification of physician's orders. The facility document titled, "NON-CONTROLLED MEDICATION ORDERS" documented, "3. Complete documentation by clarifying orders as necessary..." No further information was presented prior to exit. (1) "Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS..." This information was	F 658		

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F 658	Continued From page 134 obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=multiple+sclerosis	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide activities to meet the residents' needs for one 42 residents in the survey sample, Resident #81. The facility staff failed to provide evidence that activities were offered and provided to meet Resident #81's needs for the month of April (2018). The findings include: Resident #81 was admitted to the facility on 11/18/16 with diagnoses that included but were not limited to high blood pressure, thyroid disorder, arthritis, osteoporosis, Non-Alzheimer's	F 679	F679 1. Activities are being offered, documented and provided to meet Resident #81 needs. 2. Each resident who prefers independent activities has the potential of being affected. 3. Activity staff will be re-educated on ensuring activities are being offered and provided to meet each residents' needs who prefers independent activities. 4. Audits will be conducted to ensure residents' needs are met who prefers independent activities weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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dementia, depression, and muscle weakness. Resident #81's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/19/18. Resident #81 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #81 was coded in section B (Hearing, Speech and Vision) as usually understanding others and usually being understood by others. Section F (Preferences for Customary Activities) documented that is was very important for Resident #81 to have newspapers, books, and magazines to read; keep up with the news, and participate in religious activities. It was documented that it was somewhat important for Resident #81 to go outside to get fresh air when the weather was good.

On 4/24/18 at 11:50 a.m., an observation was made of Resident #81. He was awake lying in bed watching television.

On 4/25/18 at 8:24 a.m., an observation was made of Resident #81. He was awake lying in bed watching television.

On 4/25/18 at 10:47 a.m., an observation was made of Resident #81. He was sleeping in bed.

On 4/25/18 at 12:50 p.m., an observation was made of Resident #81. He was lying up in bed eating lunch.

On 4/26/18 at 10:36 a.m., wound care observation was conducted with the wound care nurse. The wound care nurse stated that the resident hadn't been out of bed yet that day.

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F 679	Continued From page 136 On 4/26/18 at 12:49 p.m., an interview was conducted with Resident #81. He was lying in bed. The television was on but he was looking at the ceiling. When asked Resident #81 if anyone had offered him to do any activities that week, Resident #81 stated, "No." Resident #81 stated that he would like to do more. Review of Resident #81's activity care plan dated 10/20/17 documented the following: "I prefer independent activities or spending time with my family rather than doing things in groups...I will participate in one independent activity a day...Invite clergy or people from my church to come and visit with me, Invite me to "sit in" during activity programs you think I might enjoy, allowing me to join at my own comfort level, Monitor my participation level in my independent activities with me to ensure that I can still participate at a high level with no signs of decline, Offer me activities and supplies for things I can do in my room, such as the newspaper, I enjoy reading the paper, Please assist me in participating in my favorite activities at my highest level, such as sitting outside and reading the newspaper." On 4/26/18 at 2:00 p.m., an interview was conducted with OSM (other staff member) #20, the activities director. When asked how residents are made aware of activities going on in the facility, OSM #20 stated that each resident will receive a large print activity calendar to put up in their room. OSM #20 stated that all residents are offered to go to an activity. When asked if she personally asks every single resident if they want to attend an activity, OSM #20 stated that she would expect nursing staff to help the activities department by assisting residents to the activity.	F 679		

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F 679	Continued From page 137 When asked if residents ever get missed and are not able to attend an activity, OSM #20 stated, "I am not going to say that is not going to happen, if something comes up it could happen." OSM #20 stated that there were only two activity staff for the building. When asked how she or other staff know what a resident likes to do for activities, OSM #20 stated that it should be documented on their care plan or activities assessment. When asked what Resident #81 liked to do for activities, OSM #20 stated that he liked to read the paper that he receives once a week from his home-town. OSM #20 stated that when it is warm outside, Resident #81 liked to sit outside. When asked if it was warm outside that day, OSM #20 agreed that it was. OSM #20 stated that Resident #81's family also visited 2-3 times per week. When asked what activities Resident #81 did that week, OSM #20 stated that she took him his mail. OSM #20 stated, "I asked if he wanted to get up and do something and he said no." OSM #20 could not remember when she asked Resident #81 when he wanted to get up. When asked if she documented his refusal anywhere, OSM #20 stated, no. This writer then followed OSM #20 to the activities department to view Resident #81's activity log for April 2018. Resident #81's April activity log was completely blank. OSM # 20 stated that after an activity she is supposed to document what was done immediately. OSM #20 stated that the activities she did with Resident #81 must have been documented in her notes. When asked where her notes were, OSM #20 stated, "I can't find my notes." Review of Resident #81's clinical record failed to evidence any notes for the activities department.	F 679		

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F 679	Continued From page 138 On 4/26/18 at 3:57 p.m., further interview was conducted with Resident #81. Resident #81 stated that facility staff took him outside later that afternoon. Resident #81 stated, "I feel so much better." On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide treatments and care in accordance with professional standard of practice and the comprehensive person-centered care plan for one of 42 residents in the survey sample, Resident #95. The facility staff failed to administer ibuprofen to Resident #95 as ordered by the physician.	F 684	F684 1. Resident #95's ibuprofen was clarified and administered per physicians orders. 2. A review of resident receiving ibuprofen was conducted to ensure administered per physician's order. 3. Licensed nurse will be re-educated on administering ibuprofen per physician's orders. 4. Audits will be conducted on ensuring resident receiving ibuprofen is administered per physician's orders weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 684	Continued From page 139	F 684		

The findings include:

Resident #95 was admitted to the facility on 2/12/18 with diagnoses that included but were not limited to: multiple sclerosis (1), anemia, depression and pressure ulcers.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 3/8/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as being dependent on staff for all activities of daily living.

Review of the resident's comprehensive care plan initiated on 4/11/18 documented, "Focus. Elevated temp (temperature). Interventions. Administer Pain (sic) medication as ordered."

Review of the April 2018 physician's orders documented, "Ibuprofen Table 400 MG (milligrams) by mouth every 8 hours as needed for Fever. Start date 3/22/18."

Review of the April 2018 MAR (medication administration record) documented, "Ibuprofen Table 400 MG (milligrams) by mouth every 8 hours as needed for Fever. Start date 3/22/18." The medication was documented as being given on 4/17/18 at 8:30 p.m. for a temperature of 98.7 and on 4/18/18 at 5:48 a.m. for a temperature of 98.4.

An interview was conducted on 4/26/18 at 1:05 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked what was considered a fever, LPN #4 stated, "I'd say a hundred plus is

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F 684	Continued From page 140 a fever." LPN #4 was asked to review Resident #95's April 2018 MAR. When asked if the staff had followed the physician order when they gave the ibuprofen for a temperature of 98.7 and 98.4, LPN #4 stated they had not. An interview was conducted on 4/26/18 at 1:30 p.m. with RN (registered nurse) #3, the nurse who gave the ibuprofen on 4/17/18. When asked what was considered a fever, RN #3 stated, "One hundred point four." When asked if she considered 98.7 to be a fever. RN #3 stated, "No." When asked to review the April 2018 MAR for the resident, RN #3 stated, "She asked me for it." When asked what she should have done at that time, RN #3 stated, "I should have contacted the physician and see if I could get an order for it." On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. A request for a copy of the facility's policy for following physician orders was made at that time. No policy was received. No further information was provided prior to exit. 1. Multiple Sclerosis -- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from: https://medlineplus.gov/multiplesclerosis.html	F 684		
F 685	Treatment/Devices to Maintain Hearing/Vision	F 685		

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F 685 SS=D	Continued From page 141 CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide hearing treatment and services for one of 42 residents in the survey sample, Resident #110. The facility staff failed to follow up on Resident #110's request for hearing aids. The findings include: Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most recent MDS (minimum data set assessment) was a quarterly assessment with and ARD (assessment reference date) of 1/24/18. Resident #110 was coded as being intact in	F 685	F685 1. An appointment has been scheduled with the audiologist for Resident #110. 2. A review of residents needing treatment for hearing and vision was conducted to ensure proper assistance was received. 3. Social service staff will be re-educated on assisting residents in receiving proper treatment and assistive devices to maintain hearing and vision. 4. Audits will be conducted to ensure residents receive assistance in receiving proper treatment and assistive devices to maintain hearing and vision weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 685	Continued From page 142	F 685		

cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Section B (Hearing, Speech and Vision) documented Resident #110 as having adequate hearing.

On 4/24/18 at 3:03 p.m., an interview was conducted with Resident #110. Resident #110 had some concerns regarding her hearing. While questions were being asked, Resident #110 had to ask "what?" on several occasions because she could not hear this writer. Resident #110 stated that the social worker was aware of her need for hearing aids. Resident #110 stated, "I had a hearing test done and no one followed up on it. ENT (Ear, Nose and Throat) stated that I failed the test." When asked how long ago she had her hearing test, Resident #110 stated, "Six months ago. It may have been longer." Resident #110 stated that the social worker was made aware around the same time of the hearing test.

Review of Resident #110's clinical record revealed no evidence of her hearing test.

Further review of the clinical record failed to evidence notes from the social worker regarding Resident #110's hearing aids.

Review of Resident #110's communication care plan dated 4/28/17, documented in part, the following: " At risk for impaired communication r/t (related to) Impaired hearing. Goal: (Name of Resident #110) will continue to make her needs known daily thru next review. Interventions: Answer questions as needed and repeat as necessary, Maintain eye contact if possible, provide for quiet setting, speak at appropriate volume to facilitate patient hearing, use simple

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F 685	Continued From page 143	F 685		

and direct communication to promote understanding."

On 4/26/18 at 11:41 a.m., an interview was conducted with OSM (other staff member) #10, the social worker. When asked if she was aware of Resident #110's request for hearing aides, OSM #10 stated that she was aware. OSM #10 stated, "She (Resident #110) said that she had a hearing test done. I asked her when the test was done." OSM #10 stated that she had no record of when the hearing test was done and stated that she still had to get Resident #110 set-up with another appointment for a hearing test. OSM #10 stated that she was working on it; that she had been trying to get in touch with (name of hospital [Virginia Commonwealth University]) audiologist. OSM #10 could not remember when Resident #110 had initially requested hearing aides but that it had been some time. OSM #10 stated that she had no evidence or documentation that she was trying to get Resident #110 and appointment with VCU audiologist.

On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Vision and Hearing Guidance," documents in part, the following: "Vision and hearing guidance to ensure that residents receive proper treatment and assistive (sic) devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- in making appointments, and - By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a

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F 685	Continued From page 144 professional specializing in the provision of vision or hearing assistive devices...The facility's responsibility is to assist residents and their representatives in locating and utilizing any available resources (e.g. Medicare or Medicaid program payment, local health organizations offering items and services which are available free to the community) for the provision of the services the residents needs...Social services will be actively involved with providing these resources and coordinating efforts with the clinical team." No further information was presented prior to exit.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide treatment and services to promote the healing of	F 686	F686 1. Resident #157 right heel pressure sore is healed. 2. A review of residents identified with pressure sore was conducted and all areas have treatment orders. 3. Licensed Nurse will be re-educated on ensuring any resident identified with pressure sore receive treatment orders immediately. 4. Audits will be conducted to ensure resident identified with pressure sores receive treatment immediately weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 686	Continued From page 145 a pressure sore for one of 42 residents in the survey sample, Resident #157. Resident #157 was identified as having a right heel unstageable pressure sore (1) on 3/23/18. Treatment orders were not obtained and treatment was not provided to Resident #157's right heel pressure sore until 3/36/18 (three days after the wound had been identified). The findings include: Resident #157 was admitted to the facility on 3/23/18 with diagnoses that included but were not limited to Non-Alzheimer's dementia, depression, encephalopathy, mood disorder and muscle weakness. Resident #157's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 3/30/18. Resident #157 was coded as being impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status Exam). Resident #157 was coded as requiring extensive assistance from two or more staff members with ADL (Activities of Daily Living). Review of Resident #157's initial pressure injury record revealed that an unstageable pressure sore (1) was identified to her right heel on 3/23/18 (On admission). The following was documented: "Date first observed: 3/23/18, Location: right heel, Stage: UTS (unstageable), Length in CM (centimeters) 2, Width in CM 2, Depth 0, Drainage: none...Describe treatment plan: skin prep." Review of Resident #157's baseline care plan documented the following: R (right) heel red and mushy, skin prep."	F 686		

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F 686	Continued From page 146 Review of Resident #157's physician order sheet revealed that the order for skin prep was not initiated until 3/26/18 (three days after the wound was found). Review of Resident #157's March 2018 TAR (treatment administration record) revealed that the order for skin prep was not initiated until 3/26/18 (three days after the wound was found). Review of Resident #157's clinical record documented the unstagebale to her right heel as healed on 4/17/18. On 4/26/18 at 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) #6, the wound care nurse. When asked if an order should be in place for skin prep, LPN #6 stated, "Yes, if we are applying skin prep, there should be an order." LPN #6 was asked when Resident #157's unstageable wound was identified. LPN #6 stated that the wound was identified on 3/23/18. When asked when the skin prep treatment was initiated, LPN #6 looked at the physician order sheet and confirmed that the order was written on 3/26/18. LPN #6 was then asked to provide evidence that the treatment (skin prep) to Resident #157's heel was completed on 3/23/18 through 3/25/18. On 4/26/18 at 1:36 p.m., further interview was conducted LPN #6. LPN #6 stated that she could not find evidence that the skin prep was applied on 3/23/18 through 3/25/18. LPN #6 was asked if treatment to the pressure wound was delayed if there is no evidence the skin prep was applied prior to 3/26/18. LPN #6 stated, "If that's what you call it."	F 686		

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F 686	Continued From page 147 On 4/26/18 at approximately 4:00 p.m., observation was conducted of Resident #157's bilateral heels. Resident #157 had no skin concerns to her heels. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. (1) A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. Unstageable pressure ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural	F 686		

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F 686	Continued From page 148 (biological) cover" and should not be removed. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure a safe environment in one of two oxygen storage rooms, Wing C; and failed to ensure assistance devices to prevent accidents were implemented for two residents in the survey sample of 42 residents, Resident #88 and Resident #8. 1. The facility staff failed to ensure two oxygen tanks were stored in a secure manner in the oxygen storage room on Wing C. 2. The facility staff failed to implement and ensure a lid was on Resident #88's cup containing hot liquids to prevent accidents and injury while handling and drinking hot beverages, per the resident's assessment and comprehensive care plan. 3. The facility staff failed to implement and ensure	F 689	F689 1. Oxygen tanks are store in a secure manner on Wing C. Lids remain on cups containing hot liquids per the resident assessment and comprehensive care plan for Resident #88 and Resident #6. 2. A review of oxygen tanks storage will be completed to ensure oxygen is stored in a secure manner. A review of resident needing lids on cups containing hot liquids per the resident assessment and comprehensive care plan was conducted to ensure the lids remains on the cups with hot liquid. 3. Nursing staff will be re-educated on ensuring oxygen is stored in a secure manner. Nursing staff will also be re-educated on ensuring lids remain on cups containing hot liquid per the resident assessment and comprehensive care plan.	5/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 689	Continued From page 149 a lid was on Resident #6's cup that contained hot liquid to prevent accidents and injury while handling and drinking hot beverages, per the resident's assessment and comprehensive care plan. The findings include: On 4/25/18 at 3:29 a.m., observation of oxygen tank storage was conducted in the locked medication storage room on Wing C. Two freestanding oxygen tanks were observed standing in an upright position on the floor beside other tanks that were secured in a metal rack. On 4/25/18 at 5:25 a.m., an interview was conducted with LPN (licensed practical nurse) #12. LPN #12 was asked how oxygen tanks are supposed to be stored. LPN #12 stated oxygen tanks should be stored in a dry area that is not accessible to children or people who are not cognitively intact. When asked how the tanks should be positioned, LPN #12 stated the tanks are supposed to stand up straight. When asked to clarify if the tanks should be stored in a manner where they cannot flip over, LPN #12, "Yes. In a rack like this, where they cannot be tilted or reversed or anything." LPN #12 pointed to the metal rack containing the other oxygen tanks. LPN #12 was shown the two freestanding oxygen tanks and asked if they were stored in a manner where they could not be tilted or flipped. LPN #12 stated, "No. They are not." When asked why oxygen tanks should be stored in a manner where they cannot be tilted or flipped, LPN #12 stated, "To avoid a safety hazard." When asked how much oxygen was in the two freestanding tanks, LPN #12 stated one tank was full and one tank was empty.	F 689	4. Audits will be conducted to ensure oxygen is stored in a secure manner weekly for four weeks then monthly for three months. Audits will also be conducted to ensure lids remain on cups containing hot liquid per the resident assessment and comprehensive care plan weekly for four weeks then month for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 689	Continued From page 150 On 4/25/18 at 5:34 a.m., another interview was conducted with LPN #12. LPN #12 stated he was not aware of the freestanding oxygen tanks in the storage room prior to this surveyor's observation. LPN #12 stated the oxygen tanks were for a Hospice resident and the tanks had been placed in the storage room by Hospice staff. LPN #12 stated he placed the tanks in a metal rack. On 4/25/18 observation at approximately 6:45 a.m., revealed the oxygen tanks were secure. On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document regarding oxygen tank storage documented, "1. Cylinders are: Stored upright with valve outlet seals and valve protection caps in place. Either individually chained OR inserted in metal 'racks...'" No further information was presented prior to exit. 3. The facility staff failed to implement and ensure a lid was on Resident #6's cup that contained hot liquid to prevent accidents and injury while handling and drinking hot beverages, per the resident's assessment and comprehensive care plan. Resident #88 was admitted to the facility on 3/15/13 with diagnoses that included but were not limited to: muscle weakness, dementia, high blood pressure, paralysis of the left arm and leg and stroke. The resident's neck was severely	F 689		

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F 689	Continued From page 151 contractured so that her head was always bent to the right and rested on her shoulder. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/28/18 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform independently after the tray was set up. An observation was made on 4/25/18 at 9:15 a.m., of Resident #88. The resident was sitting up in her wheelchair eating breakfast. There was a half-full cup of coffee with a straw in it on the resident's table. There was no lid on the cup. Review of the hot liquid safety evaluation dated 2/6/18 documented, "This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: #6. altered ROM (range of motion) or contracture of joint(s) to dominant side of (blank line) which cause difficulty in handling regular cup or glass. 1. Shoulder (was checked). 11. If any boxes are checked yes, indicate which interim measures put in place to enhance safety while rehab (rehabilitation) screen is pending: 1. Cup with lid or other adaptive cup (was checked)." Review of the resident's care plan initiated on 2/8/18 documented, "Focus. Resident has been evaluated and has been identified for risk of injury while handling and drinking hot beverages. Interventions. Provide cup with lid or other	F 689		

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F 689	Continued From page 152 adaptive cup." An interview was conducted on 4/26/18 at 2:45 p.m. with CNA (certified nursing assistant) #14, the resident's aide. When asked how the resident's coffee was served, CNA #14 stated, "I put milk and sugar in it." When asked if the resident had a special cup or had a lid on her coffee cup, CNA #14 stated, "No. She doesn't like it." When asked why a resident would have a lid on their hot liquids, CNA #14 stated, "So it doesn't spill." When asked how staff were made aware that a resident was to have lid on their hot liquids, CNA #14 stated, "I don't know. That's a good question." When asked if the information was on the CNA's care card, CNA #14 stated, "No." Review of Resident #88's care card documented, "lid on cup for hot liquids." On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 3. The facility staff failed to implement and ensure a lid was on Resident #6's cup that contained hot liquid to decrease the risk of injury while handling and drinking hot beverages, per the resident's assessment and comprehensive care plan. Resident #6 was admitted to the facility on 11/3/17 and readmitted on 12/27/18 with diagnoses that included but were not limited to: dementia, cancer to left side of face, muscle	F 689		

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F 689	Continued From page 153 weakness, depression and anxiety. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/15/18 coded the resident as having scored a four out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. An observation was made on 4/25/18 at 9:00 a.m., of Resident #6. The resident was in bed having breakfast. There was a cup of hot coffee on the table without a lid. Review of the resident's hot liquid safety evaluation dated, 2/6/18 documented, "This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: 1. Has a cognitive impairment or drowsiness that impacts the resident's perception and awareness to hot liquids and safety measure included but not limited to : altered comprehension and/or memory impairment (was checked). 8. Episodes of behavior which could cause injury if occurring while the resident is handling hot liquids... (was checked). 11. If any boxes are checked yes, indicate which interim measures were put in place to enhance safety while rehab (rehabilitation) screen is pending. 1. Cup with lid or other adaptive cup...4. To drink hot liquids at table only. (were checked)." Review of the resident's care plan initiated on: 2/8/18 documented, "Focus. Resident has been evaluated and has been identified for risk of injury	F 689		

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F 689	Continued From page 154	F 689		

while handling and drinking hot beverages. Interventions. Provide cup with lid or other adaptive cup."

An interview was conducted on 4/26/18 at 1:05 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked why residents had care plans, LPN #4 stated, "Basically they have care plans to make us aware of what they have and put into place." When asked who used the care plans, LPN #4 stated, "The nurses. Basically everyone does actually." When asked if staff were expected to follow the care plan, LPN #4 stated, "Yes." LPN #4 was made aware of the findings at that time.

An interview was conducted on 4/26/18 at 2:45 p.m. with CNA (certified nursing assistant) #14, the resident's aide. When asked how the resident's coffee was served, CNA #14 stated, "I put the cup on the table." When asked if Resident #6 had a lid on her coffee cup, CNA #14 stated, "I've never seen her with one." When asked why a resident would have a lid on their hot liquids, CNA #14 stated, "So it doesn't spill." When asked how staff were made aware that a resident was to have lid on their hot liquids, CNA #14 stated, "I don't know. That's a good question." When asked if the information was on the CNA's care card, CNA #14 stated, "No."

Review of Resident #6's care card documented, "lid on cup for hot liquids."

On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

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F 689	Continued From page 155 No further information was provided prior to exit.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(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. §483.25(e)(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. §483.25(e)(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.	F 690	F690 1. Catheter tubing and drainage bag for Resident #35 remain off the floor. 2. A review of residents with catheter was conducted to ensure the tubing and drainage bags remain off the floor. 3. Nursing staff will be re-educated to ensure catheter tubing and drainage bags remain off the floor. 4. Audits will be conducted to ensure catheter tubing and drainage bags remain off the floor weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 690	Continued From page 156 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to provide catheter services in a manner to prevent infection for one of 42 residents in the survey sample, Resident #35. Resident #35's catheter (1) tubing and drainage bag was observed touching the floor. The findings include: Resident #35 was admitted to the facility on 10/1/16. Resident #35's diagnoses included but were not limited to difficulty swallowing, muscle weakness and major depressive disorder. Resident #35's most recent MDS, a quarterly assessment with an ARD of 2/2/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded Resident #35 as requiring extensive assistance of one staff with bed mobility and requiring extensive assistance of two or more staff with transfers. Section H coded the resident as having an indwelling catheter. Review of Resident #35's clinical record revealed a physician's order for a Foley catheter for a diagnosis of urinary retention. Resident #35's comprehensive care plan dated 10/18/16 documented, "Alteration in elimination of bowel and bladder and am (sic) risk for UTI's (urinary tract infections) r/t (related to) History of UTI's Indwelling Urinary Catheter, Urinary Retention...Keep drainage bag of catheter below the level of the bladder at all times and off floor..." On 4/24/18 at 2:38 p.m., Resident #35 was	F 690		

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F 690	Continued From page 157 observed sitting in a wheelchair. The catheter tubing was observed touching the floor. On 4/25/18 at 7:45 a.m., Resident #35 was observed lying in bed. The bottom of the catheter drainage bag was observed touching the floor. On 4/26/18 at 9:55 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked where a resident's catheter tubing and drainage bag should be positioned. LPN #5 stated, "Below waste level." When asked if the bag and tubing should touch the floor, LPN #5 stated, "No." When asked why, LPN #5 stated, "Contamination." On 4/26/18 at 10:27 a.m., an interview was conducted with LPN #9. LPN #9 was asked where a resident's catheter tubing and drainage bag should be positioned. LPN #9 stated, "It should be in a dignity bag and the bag should be hooked to the bed and lower than the waist." When asked if the tubing or drainage bag should touch the floor, LPN #9 stated, "No." On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document regarding catheter care failed to reveal documentation regarding the above findings. No further information was provided prior to exit. (1) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website:	F 690		

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F 690 F 695 SS=D	Continued From page 158 https://medlineplus.gov/ency/article/003981.htm Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide respiratory services and store respiratory equipment in a sanitary manner. 1. The facility staff failed to store Resident # 152's nasal cannula in a plastic bag when not in use. 2. The facility staff failed to follow physicians orders and administered oxygen at the incorrect rate to Resident #110. The findings include: 1. The facility staff failed to store Resident # 152's nasal cannula in a plastic bag when not in use. Resident # 152 was admitted to the facility on 12/01/12 with diagnoses that included but were not limited to: kidney disease (1), hypertension (2), edema (3), heart failure and pain. Resident # 152's most recent comprehensive	F 690 F 695	F695 1. Resident #152 nasal cannula is stored in a bag when not in use. Resident #110 is receiving oxygen per physician's order. 2. A review of resident with oxygen was conducted to ensure nasal cannulas are in bags when not in use and the oxygen rate is administered per physician's orders. 3. Nursing staff will be re-educated on ensuring oxygen nasal cannula are stored in a bag when not in use. Licensed Nurses will be re-educated on ensuring oxygen rate is administered per physician's ordered. 4. An audit will be conducted to ensure oxygen nasal cannula are stored in a bag when not in use weekly for four weeks then monthly for three months. An audit will also be conducted to ensure oxygen rate is administered per physician's orders weekly for four weeks then monthly for three months. Results of the visits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 695	Continued From page 159	F 695		

MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/03/18, coded Resident # 152 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 152 was coded as being independent to requiring supervision of one staff member for activities of daily living.

The POS (physician's order sheet) dated April 2018 for Resident # 152 documented, " O2 (oxygen) at 3LPM (three liters per minute) NC (nasal cannula) continuous every shift. Maintain sats (saturation) above 90. Start Date 09/20/2017."

An observation on 04/24/18 at approximately 12:06 p.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.

An observation on 04/25/18 at approximately 9:19 a.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.

An observation on 04/26/18 at approximately 7:55 a.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.

An observation on 04/26/18 at approximately 12:00 p.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.

An observation on 04/26/18 at approximately 12:57 p.m. revealed Resident #152's oxygen

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F 695	Continued From page 160 tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag. Observations of the resident on the above dates revealed she was in her wheelchair, with a portable oxygen cylinder attached on the back of the wheelchair and was receiving oxygen via nasal cannula. The O2 (oxygen) from the portable cylinder was set correctly. On 04/26/18 at approximately 1:00 p.m., LPN # 9 was asked to observe Resident # 152's oxygen concentrator, oxygen tubing and nasal cannula. LPN # 9 stated, "All the tubing and nasal cannula should have been bagged. It's checked every shift, this was over looked." On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) Most kidney diseases attack the nephrons. This damage may leave kidneys unable to remove wastes. Causes can include genetic problems, injuries, or medicines. You have a higher risk of kidney disease if you have diabetes, high blood pressure, or a close family member with kidney disease. Chronic kidney disease damages the nephrons slowly over several years. Other kidney problems include: Cancer, Cysts, Stones and Infections. This information was obtained from the website: https://medlineplus.gov/kidneydiseases.html. (2) High blood pressure. This information was	F 695		

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F 695	Continued From page 161 obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. 2. The facility staff failed to follow physician's orders and administered oxygen at the incorrect rate to Resident #110. Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most recent MDS (minimum data set assessment) was a quarterly assessment with and ARD (assessment reference date) of 1/24/18. Resident #110 was coded as being intact for cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #110's most recent physician orders sheet revealed the following order: "4 liters of 02 (oxygen) via N/C (nasal cannula) continuously. May increase to 5 liters via N/C if 02 sats (saturation) 90 percent or less." On 4/26/18 at 9:09 a.m., an observation was made of Resident #110. Resident #110's oxygen flow rate was set above the red ring that was also above the 5 liter mark on her oxygen concentrator. On 4/27/18 at 9:45 a.m., an observation was	F 695		

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made of Resident #110. Resident #110's oxygen flow rate was set above the red ring that was also above the 5 liter mark on her oxygen concentrator.

Review of Resident #110's Respiratory care plan dated 4/28/17 documented the following: "At risk for Respiratory Distress r/t (related to) Dx (diagnoses) of acute/chronic respiratory failure, CHF (congestive heart failure), Obstructive sleep apnea. Goal (Name of Resident #110) will have adequate gas exchange as evidenced (sic) by no adventitious breath sounds, absence of respiratory distress, and absence of shortness of breath thru next review. Interventions: administer oxygen as ordered. Monitor oxygen saturations on room air and/or oxygen as needed. Monitor oxygen flow rate and response."

On 4/27/18 at 9:45 a.m., an interview was conducted with RN (registered nurse) #5. When asked who changes the flow rate on Resident #110's oxygen, RN #5 stated, "Most of the time when I am here I do." When RN #5 was shown the flow rate of Resident #110's oxygen concentrator, RN #5 stated, "No that is not right."

On 4/27/18 at 9:55 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked if Resident #110 changes her own 02 rate, LPN #4 stated that she did not. LPN #4 confirmed that Resident #110's oxygen was not at the right rate.

On 4/27/18 at 10:15 a.m., an interview was conducted with LPN #16. When asked who was able to adjust the oxygen rate on a resident's oxygen tank or concentrator, LPN #16 stated, "A nurse." LPN #16 stated that oxygen was a

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F 695	Continued From page 163 medication or medical treatment. When asked what it meant when the ball was on the red line above the 5 liter mark, LPN #16 stated, 'It's more than 5. I don't think the concentrator can go above 5. You need a special concentrator to go above 5." Review of the manufacturer's instructions for the oxygen concentrator documented in part the following: "Do not set the flow rate above the RED ring. An oxygen flow rate greater than 5 L/min will decrease the oxygen concentration." On 4/27/18 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725	F725 PNC – No POC needed	

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F 725	Continued From page 164 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure sufficient staffing for one of 42 residents in the survey sample, Resident #41. The facility staff failed to ensure sufficient staffing on 3/18/18, resulting in delayed ADL (activities of daily living) assistance for Resident #41. The findings include: Resident #41 was admitted to the facility on 11/7/17. Resident #41's diagnoses included but were not limited to Parkinson's disease (1), urinary retention and anxiety disorder. Resident #41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/1/18, coded the resident as being cognitively intact. Section G coded Resident #41 as requiring supervision with one-person physical assistance with bed mobility/transfers and as requiring extensive assistance of one person with dressing. Section	F 725	Past noncompliance: no plan of correction required.	

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H coded the resident as having an indwelling urinary catheter (2). Resident #41's comprehensive care plan dated 11/27/17 documented, "I have a physical functioning deficit related to: Mobility impairment, ROM (range of motion) limitations, Self care impairment due to involuntary movements secondary to Dx (diagnosis); Parkinson's...Dressing assistance of 1 person. Personal Hygiene assistance of 1 person. Transfer assistance of 1 person. Foley (catheter) bag to be changed to leg bag every a.m..."

On 3/22/18, the Office of Licensure and Certification received a complaint regarding Resident #41. The complainant alleged the facility staff failed to provide ADL (activities of daily living) care in a timely manner on 3/18/18 and the facility was understaffed.

A facility concern form dated 3/18/18 documented, "Describe concern using factual terms: Her mother (name of Resident #41) was coming out of bathroom still in pajamas @ (at) 2 pm when she arrived. Her catheter bag not changed and full. She said 3 people were sitting at nursing station, and was told we are short staffed..."

An email sent from Resident #41's family member to the former administrator of the facility on 3/18/18 documented, "It is 2 pm on Sunday and someone just now came to help my mother get out of her pajammas (sic), And remove her night time Cath (catheter) bag that is attached to her walker. Making my mom Stuck (sic) in her bed all day. She buzzed and buzzed for help. She was told they were busy and only had 3 people working..." An email sent from the former

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administrator to Resident #41's family member on 3/19/18 documented, "Good afternoon to everyone. I sincerely regret this incident occurred yesterday. Upon review, we had a total of six employees call out on 7-3 (7:00 a.m. to 3:00 p.m. shift). We were scheduled to have 16 nurse aides for that shift so to have over a third call out just was unexpected. I have been here for 3.5 years and even during snow storms we have not had that many call out on one shift. I realize this is not an excuse only an explanation. Please know that I personally review attendance every day tracking call outs and tardy's. I write up staff once they reach the number of infractions to warrant a write up and we do terminate staff going through the disciplinary process. Again, I apologize."

Review of the as worked nursing schedule for 3/18/18 revealed 15 CNAs (certified nursing assistants), 1 CNA on light duty and 1 CNA orientee were scheduled for the day shift on 3/18/18. Further review of the schedule revealed four CNAs and the orientee called out and one CNA was no call no show. The schedule documented two CNAs worked Resident #41's unit (a unit containing 60 beds) although staff reported three CNAs worked the unit on that day. The schedule also revealed no CNAs who worked the previous night stayed over and worked on day shift.

On 4/26/18 at 9:55 a.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse caring for Resident #41 during the day shift on 3/18/18). LPN #5 stated she did not remember what time Resident #41's catheter bag was changed on 3/18/18. LPN #5 stated on that day, she went into Resident #41's room with the

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resident's medicine and asked the resident how she was doing. LPN #5 stated the resident stated she was not good because she was still in bed. When asked what time this occurred, LPN #5 stated maybe around 12:00 p.m. or 1:00 p.m. LPN #5 stated, "I think it was afternoon. The aides who were working weren't the usual aides. I think we only had three aides and one of the aides was prn (as needed)." When asked how many aides are typically on the unit during day shift, LPN #5 stated, "There is supposed to be six but usually there is five." When asked what time of day Resident #41 prefers to be assisted with her catheter bag, LPN #5 stated, "Assuming by the way her daughter reacted, I'm guessing earlier in the morning." LPN #5 stated one of the CNAs on the unit that day usually works the 3:00 p.m. to 11:00 p.m. shift, one of the CNAs usually works a different unit and one of the CNAs works as needed. When asked if the lack of staff affected resident care, LPN #5 stated, "Yes because they don't have the time to spend with each resident and they have to speed through things and I have to do more patient care." When asked if the residents' care needs were met, LPN #5 stated, "I think for the most part."

On 4/26/18 at 2:40 p.m., an interview was conducted with CNA #14 (one of the three CNAs that worked on Resident #41's unit during the day shift on 3/18/18). CNA #14 was asked to describe any events regarding Resident #41 that occurred on 3/18/18. CNA #14 stated the resident's family member stated she was going to call someone about staffing because the CNAs were short staffed and there were only three CNAs on the unit that day. When asked to describe the amount of care Resident #41 required, CNA #14 stated she was not sure

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because she had never cared for the resident. CNA #14 stated on 3/18/18 the CNAs worked together to care for residents and no one took a specific resident assignment. CNA #14 said by the time she saw Resident #41 on 3/18/18, the resident was coming down the hall. CNA #14 stated the resident was dressed and she did not see a catheter. When asked what time she saw Resident #41, CNA #14 stated she did not know what time but it was before the resident's family member came to the facility and she saw Resident #41 again around the time she was getting off at 3:00 p.m.

On 4/26/18 at 3:22 p.m., a telephone interview was conducted with ASM (administrative staff member) #3 (the former administrator). ASM #3 was asked to describe the events that took place on 3/18/18 regarding Resident #41. ASM #3 stated on 3/18/18, about a third of the shift called out. ASM #3 stated the shifts had originally been covered but with that many call outs, the schedule was not covered. ASM #3 stated he was sure staff did not assist Resident #41 in a timely manner. ASM #3 stated the director of nursing and he were not made aware of the staffing on 3/18/18 and someone in the nursing department should have called the director of nursing. When asked how many CNAs are usually scheduled for Resident #41's unit, ASM #3 stated six CNAs are usually scheduled for the day shift.

On 4/26/18 at 3:29 p.m., an interview was conducted with OSM (other staff member) #12 (the staffing coordinator). OSM #12 stated she did not think she worked on 3/18/18. OSM #12 stated LPN #10 was the day shift supervisor on that day. OSM #12 was asked what should be done when multiple staff call out. OSM #12

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stated, "They should mandate. The night shift supervisor should have started calling in CNAs to come in and ask 11 to 7 CNAs if they could stay over to work." When asked who was the night shift supervisor on the night of 3/17/18 into the day on 3/18/18, OSM #12 reviewed her records and stated there was no night shift supervisor working that night but there were four nurses working. OSM #12 stated any of those nurses could have mandated CNAs to stay over and called CNAs to come in. When asked why none of the night shift CNAs were mandated to stay over, OSM #12 stated the CNAs were probably gone when LPN #10 arrived to the facility.

On 4/26/18 at 3:56 p.m., an interview was conducted with CNA #15 (one of the three CNAs that worked on Resident #41's unit during the day shift on 3/18/18). CNA #15 stated on 3/18/18 the three CNAs worked together. CNA #15 stated the two female CNAs took care of the female residents and he concentrated on the male residents and assisted the female CNAs with transfers. When asked if he interacted with Resident #41 on 3/18/18, CNA #15 stated he did not think so. When asked how many CNAs usually work on Resident #41's unit on day shift, CNA #15 stated normally there was five to six CNAs. When asked if the lack of CNAs affected resident care on 3/18/18, CNA #15 stated, "I believe it did but unfortunately it's out of your control. We try to do the best we can do." When asked how the lack of CNAs affected resident care that day, CNA #15 stated, "We probably couldn't get to everybody for care and bathing. Three people, we could only do so much. I'm pretty sure care was lacking." When asked if residents were provided morning ADL care in a timely manner, CNA #15 stated, "With three

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people, I don't think so. With three people that is impossible."

On 4/26/18 at 4:02 p.m., another interview was conducted with CNA #14. CNA #14 was asked how many CNAs are usually on each unit. CNA #14 stated there is usually between four and five CNAs on each unit and 3/18/18 was the first time she had ever been on a unit with only two other CNAs. CNA #14 was asked how the lack of CNAs affected resident care on 3/18/18. CNA #14 stated, "It was hard for us to get to everyone in a timely manner- dressed, changed, trays up, out of bed, daily care." CNA #14 stated one of the nurses did help answer call lights.

On 4/26/18 at 4:23 p.m., an interview was conducted with Resident #41. Resident #41 stated she could not specifically remember what occurred on 3/18/18. Resident #41 stated she requires staff assistance with changing her catheter bag over to a leg bag so she can comfortably get dressed. When asked if she has ever had, a delay in assistance with getting her catheter bag changed over, Resident #41 stated, "That happens. Don't ask me what time or day." When asked if the delay in assistance with having her catheter bag changed over impacts her ability to get dressed and go out of the room for daily activities, Resident #41 stated, "Yes. Sure." When asked if she knows why there is a delay in assistance at times, Resident #41 stated, "There is so much for everybody to do. It's nothing against any of them. There just isn't enough of them to go around at that time (in the morning)." When asked to clarify if she meant staff, Resident #41 stated she did. When asked what is the longest time she has had to wait for assistance, Resident #41 stated she has had to wait until

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after lunch once or twice. The resident further stated, "If I keep pushing the button (call light) and keep hollering then they get it done." When asked how this makes her feel, Resident #41 stated, "It makes me wonder if I am just someone that nobody wants to help."

On 4/26/18 at 4:43 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #10 (the day shift supervisor on 3/18/18). LPN #10 was asked if she recalled being understaffed on 3/18/18. LPN #10 stated she could not remember that exact day. LPN #10 stated, "We have had that before but not that often." LPN #10 was asked what she does when staff call out for their shift. LPN #10 stated, "When I get the call outs, depending on the time, I have enough staff there so I can mandate for the next shift. I get the call log and call staff in and I go out on the floor to help." When asked who does this on the night shift, LPN #10 stated the night shift supervisor does. When asked what happens if there is no night shift supervisor, LPN #10 stated, "Then there is no supervisor to be able to mandate or make the calls but there has been a time the nurse on the floor has done that."

On 4/26/18 at 5:32 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. ASM #2 confirmed she was not called and made aware of the staffing issue on 3/18/18 and would have come in to the facility to help if she had been aware. ASM #2 also confirmed no CNAs from the night shift were mandated to stay over and work during the day shift on 3/18/18. ASM #2 stated since 3/18/18, CNAs have to call the assistant director of nursing when they call out

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and nurses have to call her when they call out. ASM #2 stated a memo and an in-service was provided to staff after 3/18/18, and is posted at the time clock, on the staffing coordinator's door and remains on the nursing supervisor clipboard.

The memo referenced above was observed in multiple locations including the units and time clock during the survey. The memo was dated 3/21/18 and documented, "Effective immediatley (sic): All Employees are required to call 2 hours before your shift. All Nurses are required to call out to (name of ASM #2) 1st and the job 2nd. All CNA's are required to call out to (name of assistant director of nursing) 1st and the job 2nd. All Employees that leave 2 hours at the beginning of the shift will be a call out."

On 4/27/18 at 8:14 a.m., ASM #1, the administartor stated the facility did not have a policy regarding staffing.

No concerns regarding staffing were identified after 3/21/18.

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

PAST NON-COMPLIANCE

(1) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. Exposure to chemicals in the environment might play a role." This information was obtained from the website:

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	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

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F 725	Continued From page 173 (2) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm	F 725		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete a performance review for CNAs (certified nursing assistants) at least once every 12 months. The facility staff failed to complete a performance review within 12 months for 48 CNAs employed at the facility since before 4/24/17. The findings include: Review of a list of currently employed CNAs revealed 48 CNAs had been employed at the facility since before 4/24/17. On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were asked to provide annual performance reviews for all currently employed CNAs.	F 730	F730 1. Performance reviews will be completed on CNAs employed at the facility since before 4/24/17. 2. No other concern was identified. 3. Human Resources staff and the Director of Nursing will be re-educated on ensuring performance reviews are conducted on CNAs at least once every 12 months. 4. An audit will be conducted to ensure performance reviews are conducted on CNAs at least once every 12 months weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 730	Continued From page 174 On 4/27/18 at 7:45 a.m., ASM #1 provided the facility policy regarding performance evaluations and stated the policy went into effect on November 28. When asked if the evaluations had been completed for CNAs, ASM #1 stated, "I don't think so." ASM #2 confirmed the evaluations had not been completed. ASM #1 and ASM #2 was made aware this was a concern. The facility document titled, "Performance Evaluations" documented, "The performance evaluation provides a formal vehicle for the supervisor and the employee to discuss the employee's overall work performance and developmental areas as it relates to the employee's job description. Communication between employees and supervisors or managers is very important..." The facility document titled, "COMPETENCIES" documented, "The attachments for Core competencies will be completed upon hire and annually by Licensed Nurses and Certified Aides or Certified Nursing Assistants..." No further information was presented prior to exit.	F 730		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 745	F745 1. Social service followed up on resident #110 request for hearing aids and provided documentation. 2. Each residents has the potential of being affected who has requested assistance with hearing devices.	5/29/18

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F 745	Continued From page 175 facility document review and clinical record review, it was determined the facility staff failed to provide medically-related social services for one of 42 residents in the survey sample, Resident #110. The facility staff failed to provide evidence that social services was following up on Resident #110's request for hearing aides. The findings include: Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most recent MDS (minimum data set assessment) was a quarterly assessment with and ARD (assessment reference date) of 1/24/18. Resident #110 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Section B (Hearing, Speech and Vision) documented Resident #110 as having adequate hearing. On 4/24/18 at 3:03 p.m., an interview was conducted with Resident #110. Resident #110 had some concerns regarding her hearing. While questions were being asked, Resident #110 had to ask "what?" on several occasions because she could not hear this writer. Resident #110 stated that the social worker was aware of her need for hearing aides. Resident #110 stated, "I had a hearing test done and no one followed up on it. ENT (Ear, Nose and Throat) stated that I failed	F 745	3. Social service staff will be re-educated on documenting assisting residents in receiving proper treatment and assistive devices to maintain hearing and vision. 4. Audits will be conducted to ensure documentation is completed when providing residents with assistance in receiving proper treatment and assistive devices to maintain hearing and vision weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 745	Continued From page 176	F 745		

the test." When asked how long ago she had her hearing test, Resident #110 stated, "Six months ago. It may have been longer." Resident #110 stated that the social worker was made aware around the same time of the hearing test.

Review of Resident #110's communication care plan dated 4/28/17, documented in part, the following: " At risk for impaired communication r/t (related to) Impaired hearing. Goal: (Name of Resident #110) will continue to make her needs known daily thru next review. Interventions: Answer questions as needed and repeat as necessary, Maintain eye contact if possible, provide for quiet setting, speak at appropriate volume to facilitate patient hearing, use simple and direct communication to promote understanding."

Review of Resident #110's clinical record revealed no evidence of her hearing test.

Further review of the clinical record failed to evidence notes from the social worker regarding Resident #110's hearing aides.

On 4/26/18 at 11:41 a.m., an interview was conducted with OSM (other staff member) #10, the social worker. When asked if she was aware of Resident #110's request for hearing aides, OSM #10 stated that she was aware. OSM #10 stated, "She (Resident #110) said that she had a hearing test done. I asked her when the test was done." OSM #10 stated that she had no record of when the hearing test was done and stated that she still had to get Resident #110 set-up with another appointment for a hearing test. OSM #10 stated that she was working on it; that she had

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F 745	Continued From page 177 been trying to get in touch with (name of hospital [Virginia Commonwealth University]) audiologist. OSM #10 could not remember when Resident #110 had initially requested hearing aides but that it had been some time. OSM #10 stated that she had no evidence or documentation that she was trying to get Resident #110 and appointment with VCU audiologist. On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Vision and Hearing Guidance," documents in part, the following: "Vision and hearing guidance to ensure that residents receive proper treatment and assistive (sic) devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- in making appointments, and - By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices...The facility's responsibility is to assist residents and their representatives in locating and utilizing any available resources (e.g. Medicare or Medicaid program payment, local health organizations offering items and services which are available free to the community) for the provision of the services the residents needs...Social services will be actively involved with providing these resources and coordinating efforts with the clinical team." No further information was presented prior to exit.	F 745		

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F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a resident was free from unnecessary medication for one of 42 residents in the survey sample, Resident #20. The facility staff failed to hold Resident #20's medication Midodrine (1) per physician's order on multiple dates in April 2018. The findings include: Resident #20 was admitted to the facility on	F 757	F757 1. Resident #20 physician was notified of administering midodrine when it should have been held per physician's orders. 2. A review of residents on Midodrine will be conducted to ensure it is given as ordered by the physician. 3. Licensed staff will be re-educated on administering Midodrine as ordered by the physician. 4. Audits of residents who have Midodrine orders will be conducted weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.	5/29/18

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F 757	Continued From page 179	F 757		

5/20/17. Resident #20's diagnoses included but were not limited to hypotension (low blood pressure), urinary tract infection and bipolar disorder (2). Resident #20's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/24/18, coded the resident as being cognitively intact.

Review of Resident #20's clinical record revealed a physician's order dated 2/6/18 for Midodrine 2.5 milligrams one time a day, and to hold the medication for a systolic blood pressure greater than 100 or a diastolic blood pressure greater than 90. Review of Resident #20's April 2018 MAR (medication administration record) revealed the resident was administered Midodrine on the following dates (as evidenced by a check mark and nurses' initials) although the resident's systolic blood pressure was greater than 100 or diastolic blood pressure was greater than 90:
- 4/1/18- blood pressure 141/93
- 4/2/18- blood pressure 122/55
- 4/10/18- blood pressure 124/74
- 4/14/18- blood pressure 106/68
- 4/22/18- blood pressure 148/78

Resident #20's comprehensive care plan dated 9/12/17 documented, "Impaired Cardiovascular status related to: Hypotension...Medications as ordered by physician and Observe use and effectiveness..."

On 4/26/18 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9 (Resident #20's unit manager). LPN #9 was asked what is meant when by a check mark and nurses' initials on the MAR. LPN #9 stated, "It means it was done." LPN #9 was read Resident #20's physician order for Midodrine and asked

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F 757	Continued From page 180	F 757		

what should be done if the resident's systolic blood pressure is greater than 100 or diastolic blood pressure is greater than 90. LPN #9 stated, "It should be held and you should contact the MD (medical doctor) because you need to find out the next step for orders." LPN #9 was informed Resident #20's Midodrine was initialed as administered on the above dates and also made aware of Resident #20's blood pressures on the above dates. LPN #9 was asked if the medication should have been held on those dates. LPN #9 stated the medication should have been held and the doctor should have been contacted. LPN #9 stated the nurses who administered the Midodrine on those above dates may have contacted the doctor and he said to give the medication but confirmed there was no documentation to evidence this.

The nurses who initialed Midodrine administration to Resident #20 on 4/1/18, 4/10/18, 4/14/18 and 4/22/18 were not available for interview.

On 4/26/18 at 4:43 p.m., a telephone interview was conducted with LPN #10 (the nurse who initialed administration of Resident #20's Midodrine on 4/2/18). LPN #10 was asked what should be documented on the MAR if a medication is held. LPN #10 stated, "I don't know the exact number. There is a number on the legend. I don't know if it's a three or a seven. There is a little box that pops up that says hold and we write a note." Resident #20's physician's order for Midodrine was read to LPN #10 and LPN #10 was asked what should be done if the resident's systolic blood pressure is greater than 100 or diastolic blood pressure is greater than 90. LPN #10 stated, "You will hold it." LPN #10 was asked if she recalled ever holding Resident #20's

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Midodrine. LPN #10 stated she recalled holding the medication on several occasions. When asked if she recalled holding the medication in April 2018, LPN #10 stated, "I don't have her consistently. I don't know the last time I had (name of Resident #20) so I can't say for certain."

On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document regarding medication administration documented, "Verify that the medication hasn't expired and that no contraindications exist."

No further information was provided prior to exit.

(1) "Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616030.html

(2) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

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F 757	Continued From page 182 meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bipolar+disorder&_ga=2.1717494.671965706.1525089773-139120270.1477942321	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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, staff interview and facility document review, it was determined that the facility staff failed to label and store medications in a safe manner in two of three medication	F 761	F761 1. The open vial of PPD solution, bottle of lorazepam intensol and expired diazepam suppositories were discarded. 2. A review of medication rooms will be conducted to ensure medications are labeled appropriately and there are no expired medications. 3. Licensed Nursing staff will be re-educated on ensuring medications are labeled with an open date when opened and discard expired medications. 4. An audit will be conducted to ensure medications are labeled with an open date when opened and expired medications are discarded weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 761	Continued From page 183 storage rooms, Wing C and Wing A. 1. The facility staff failed to label an open date on an open vial of PPD (purified protein derivative (1)) solution and an open bottle of lorazepam intensol, and failed to discard expired diazepam suppositories in the Wing C medication storage room. 2. The facility staff failed to ensure an expired medication, Lorazepam (1) was not available for use. The findings include: 1. The facility staff failed to label an open date on an open vial of PPD solution (1) and an open bottle of lorazepam intensol (2), and failed to discard expired diazepam suppositories (3) in the Wing C medication storage room. On 4/25/18 at 3:29 a.m., observation of the Wing C medication storage room was conducted with LPN (licensed practical nurse) #12. The following was observed in the unit medication refrigerator: -One open vial of PPD solution (half full) with no open date labeled on the vial or the box containing the vial. The manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." -One open bottle of lorazepam intensol (almost full) with no open date labeled on the bottle or the box containing the bottle. The manufacturer's instructions documented, "Discard opened bottle after 90 days." -One bottle of diazepam 10 milligram suppositories with a pharmacy label that	F 761		

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F 761	Continued From page 184	F 761		

documented, "Discard after 12/27/17" and a handwritten expiration date of 12/27/17.

An interview was conducted with LPN #12 immediately after the above medications were found. LPN #12 was asked what should be done when a medication is opened. LPN #12 stated, "Write down the date you open the medication. As soon as you pick it up you should know this medication was opened on this day." When asked where the date should be written, LPN #12 stated the date should be written on the medication lid or pack. When asked why the open date should be labeled, LPN #12 stated, "To make sure it has been administered number one and to make sure after a certain amount of time certain medications have to be discarded." LPN #12 was asked when PPD solution should be discarded in relation to when it is opened. LPN #12 stated he was not sure but he thought 30 days. LPN #12 confirmed the PPD solution was open and not labeled with an open date. LPN #12 was shown the lorazepam intensol and asked if the medication was labeled with an open date. LPN #12 stated, "I'm not seeing an open date on it." When LPN #12 was shown, the diazepam suppositories LPN #12 confirmed the expiration date was 12/27/17.

On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "4.1 STORAGE OF MEDICATION" documented, "Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and

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F 761	Continued From page 185 to support safe effective drug administration..." No further information was presented prior to exit. (1) Aplisol PPD solution is used in the diagnosis of tuberculosis (a lung disease). This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134 (2) Lorazepam intensol is used to relieve anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html (3) Diazepam is used to relieve anxiety, muscle spasms and seizures. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682047.html 2. The facility staff failed to ensure an expired medication, Lorazepam (1) was not available for use in the medication storage room located on A-wing. On 04/25/18 at 3:20 a.m., the facility's medication storage room located on A-wing was inspected with LPN (licensed practical nurse) # 2. An inspection of the refrigerator in the A-wing medication storage room revealed an opened 30-milliliter bottle of Lorazepam available for use. The bottle of Lorazepam documented, "Opened 12/29/17." The "Pharmacy Description" of Lorazepam documented in part, 'Discard opened bottle after 90 days."	F 761		

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F 761	Continued From page 186 The lorazepam stored the refrigerator in the A-wing medication storage room was observed available for use and was 26 days past the discard date. On 04/25/18 at 3:30 a.m., an interview was conducted with LPN # 2. When asked if the lorazepam was expired, LPN # 2 stated, "Yes. It should have been discarded." On 04/26/18 at 10:32 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the process for ensuring expired medications are not available for use ASM # 2 stated, "Random audits of the medication carts and medication rooms are done at least monthly. When expired meds are found they are disposed of properly...sent back to pharmacy or destroyed. This (the expired lorazepam stored the refrigerator in the A-wing medication storage room) was overlooked." On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: (1) Used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html.	F 761		

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility staff failed to serve food in a sanitary manner in one of three dining rooms, Unit B. The facility staff failed touched the residents' bread with their bare hands while serving food in the Unit B dining room. The findings include: On 4/24/18 at 12:30 p.m., observation of the Unit B dining room was conducted. At 12:59 p.m., CNA (certified nursing assistant) #14 was observed putting her bare fingers into a resident's	F 812	F812 1. Staff will not touch bread with their bare hands. 2. Each resident has the potential to be affected. 3. Nursing staff will be re-educated on not touch bread or any food item with their bare hands. 4. An audit will be conducted to ensure staff is not touching bread or food items with their bare hands weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 812	Continued From page 188 bread package. She then pulled out cornbread and served it to a resident. CNA #14 did not sanitize her hands before or after serving the bread to the resident. On 4/24/18 at 1:39 p.m., another CNA (CNA #13), was observed serving bread to a resident with her bare hands. CNA #13 did not sanitize her hands before or after serving the bread to the resident. On 4/25/18 at 2:59 p.m., an interview was conducted with CNA #13, regarding the above observation. CNA #13 stated, "We take the tray off the cart, put the tray on the table, take lids off drinks." When asked how staff should be handling the bread, CNA #13 stated that she would take the bread out of the bag and lay it on top of the bag. When asked how she would take it out of the bag, CNA #13 stated that she would use her hands. When asked if she would use her bare hands, CNA #13 stated, "Yes." CNA #13 stated that she was not supposed to wear gloves while serving. CNA #13 stated, "I could turn the bag open." When asked if serving bread with bare hands was sanitary, CNA #13 stated, "No. It is not sanitary." On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842	F842 1. Resident #319 and Resident #468 no longer reside at the facility. Resident #95 care plan was reviewed for accuracy.	5/29/18

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F 842	Continued From page 189 resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical	F 842	2. Any resident has the potential to be affected. 3. Licensed Nursing and social service staff will be re-educated on ensuring documentation is completed in the medical record to include but not limited to informing residents of the results of an investigation of abuse, monitoring residents for changes in health conditions and maintaining an accurate care plan. 4. An audit will be conducted to ensure documentation is completed in the medical record to include but not limited to informing residents of the results of an investigation of abuse, monitoring residents for changes in health conditions and maintaining an accurate care plan weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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F 842	Continued From page 190 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to maintain a complete and accurate clinical record for three of 42 residents in the survey sample, Residents # 319, # 468 and # 95. 1. The facility staff failed to document Resident # 319 was informed of the results of an investigation of abuse. 2. The facility staff failed to document a concern with Resident #468's health condition on 3/15/18 and that facility staff were going to monitor the	F 842		

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resident for any changes.

3. The facility staff failed to write an accurate care plan for Resident #95.

The findings include:

1. The facility staff failed to complete a facility incident report after a reported allegation of abuse for Resident # 319.

Resident # 319 was admitted to the facility on 09/18/17 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), dementia (2), gastroesophageal reflux disease (3), hypertension (4), atrial fibrillation (5), muscular dystrophy (6), depression, dysphagia (7), and post mastectomy (8).

Resident # 319's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/18/17, coded Resident # 319 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 319 was coded as requiring extensive assistance of one staff member for activities of daily living.

The statement given by Resident # 319 and taken by OSM (other staff member) # 10, the social worker dated 09/19/2017 documented, "Last night patient (Resident # 319) reported to SS (social services) that she was having trouble sleeping so she used her call bell to ask for help. The nurse came in and was pleasant and helped patient straighten the bed. Patient stated she

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called for help again and this time nurse came in and helped again but the third time the nurse came in and made a noise and walked out. Patient stated that the nurse was mad. The nurse came back in the room but about 4 (four) to 5 (five) [one of them was a male] nurse was also with her. Patient stated they grabbed her up and through [sic] her in the wheelchair. According to the patient they were not gentle with her and attack [sic] her. Once she was up at the nurse's station she felt scared because of the nurse looks they were giving her. She asked for a more comfortable chair but nobody would help her so she put herself on the floor to get comfortable. Patient did stated to SS that she has been a victim of abuse in the past (outside of this facility). Patient did state to SS that she told the nurses that she would sue them because of what they did and the nurses just laughed."

Review of the facility's investigative notes for Resident # 319 and Resident # 319's clinical record failed to evidence documentation that she was informed of the results of the investigation.

On 04/26/18 at 3:05 p.m. a telephone interview was conducted with ASM (administrative staff member) # 3, the former administrator. When asked if Resident # 319 was informed of the findings of the investigation of her complaint, ASM # 3 stated, "She was informed of the findings following the investigation. She called in February (2018) and March (2018) within two to three weeks of each other and I spoke with her on the phone about the results." When asked if his conversations with Resident # 319 were documented ASM # 3 could not recall.

On 04/27/18 at 11:20 an interview was conducted

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F 842	Continued From page 193 with ASM # 2, director of nursing. When asked about the documentation of ASM # 3's conversations with Resident # 319 regarding the results of the investigation ASM # 2 stated, "We don't have anything documented." On 04/27/18 at approximately 11:30 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) Disease that makes it difficult to breathe that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html. (5) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.	F 842		

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F 842	Continued From page 194 2. The facility staff failed to document a concern with Resident #468's health condition on 3/15/18 and that facility staff were going to monitor the resident for any changes. Resident #468 was admitted to the facility on 10/5/06 and readmitted on 5/1/12 with diagnoses that included but were not limited to unspecified dementia, muscle weakness, anorexia, high blood pressure, and atrial fibrillation. Resident #468's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/7/18. Resident #468 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam. On 4/24/18 at 2:18 p.m., an interview was conducted with Resident #468's responsible party, the daughter. The daughter had made an allegation that her mother was not acting herself the night before she left for the hospital on 3/15/18. The daughter asked the nurse to come down to her mother's room and they notice food in her mouth. The nurse wiped away the food. The daughter stated that she wanted her mother to go out that night to the hospital, but the nurses stated that she was fine. The daughter stated that her mother died in the hospital on 3/16/18 but can't say with certainty that the facility was responsible for her death. Review of Resident #468's clinical record revealed that she was transferred to the hospital on 3/16/18. The following nursing note was documented, "Resident up for breakfast in jerri chair consumed 25 % (percent) with assistance from CNA (certified nursing assistant) (drank all liquids). Resident consumed medication per	F 842		

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nurse on duty without any difficulties. A (alert) & O (oriented) the (sic) confusion able to answer questions but incoherent with response (per normal baseline). Resident up at nurse station per normal doing normal activities. Resident noted by nurse and aide @145 pm (sic) of not responding to verbal or tactile stimuli (sic) NP (nurse practitioner) on floor and assessed resident and gave verbal to send to ER (emergency room) (Resident has her eyes opened and will follow persons with her eyes but no response, pupil reactive to light, not talking however resident is making a snoring like noise) (sic) 02 (oxygen) started at 2 l (liters)/min (minute) via non rebreather, HOB (Head of bed) in upright position, Resident moving hands and grasping writers fingers when hand was rubbed but would not grasps on command), + (positive) cap (capillary) refill to hands (sic) skin warm and dry to touch, WNL (within normal limits) of baseline skin tone color. EMT (emergency Medical Technician) arrived within 3 mins (minutes) of being called and took over from there."

Review of Resident #468's hospital records revealed that she had expired in the hospital on 3/16/18 due to unspecified aspiration pneumonia.

Review of the clinical record revealed failed to evidence a nursing note describing the events of 3/15/18 when the daughter was worried about her mother's condition. The nursing note right before 3/16/18 was dated 3/8/18.

There was no evidence in the clinical record that Resident #468 had a mouth full of food on 4/15/18 or 4/16/18 when she had been transferred to the hospital.

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F 842	Continued From page 196 On 4/26/18 at 2:13 p.m., an interview was conducted with LPN #4, the unit manager. LPN #4 stated that she was the nurse that had sent the resident out to the hospital on 3/16/18. When asked what had happened, LPN #4 stated that she could not remember what the resident had looked like prior to her being sent out. LPN #4 could recall that the she remembered seeing Resident #468 up at the nurses' station that morning (3/16/18). LPN #4 stated that the resident appeared to look normal and within her baseline. LPN #4 stated that Resident #468 was at the nurses' station right after breakfast. LPN #4 stated that she had also seen Resident #468 in the dining room for breakfast feeding herself with some cueing from a CNA (certified nursing assistant). LPN #4 did not recall the resident coughing or having difficulties eating. LPN #4 stated that when the resident was sent out to the hospital, there was no obvious blockage of her airway. LPN #4 stated that Resident #468's mouth was clear on 4/16/18 when she was sent out to the hospital. LPN #4 stated that the resident did not eat lunch that day because EMT had arrived when lunch trays were being passed out on the unit. LPN #4 did not recall Resident #468 having issues swallowing her medications that morning. When asked if she could recall the daughter's concern about Resident #468's change in condition the night before, LPN #4 stated that she did. LPN #4 stated that she was not sure if it was exactly the night before but did recall what had happened. LPN #4 stated that on 3-11 shift, the daughter had told the nurse (LPN #4) that she was concerned about her mother's condition. LPN #4 went down to the resident's room and noticed that she was holding food in her right cheek. LPN #4 wiped out her mouth and	F 842		

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then stated that the resident appeared to be back to her normal self (alert and oriented x2). LPN #4 stated that at first the daughter had wanted her mom to be sent out to the hospital. LPN #4 stated that once the resident was back to her normal self, the daughter was okay with the facility monitoring her mother. LPN #4 stated that Resident #468's vital signs were normal and that there was no other indication that she needed to be sent out to the hospital. LPN #4 then told the daughter that she would notify her if anything changed. LPN #4 recalled the daughter feeding Resident #468 a twinkie right after LPN #4 cleaned out her mouth. LPN #4 stated that she did not document this incident and should have in the clinical record.

Review of the investigations conducted by administration on 3/19/18 revealed that the daughter had been concerned with the resident's condition on 3/15/18, 3-11 shift; the night before Resident #468 as sent out to the hospital. The following witness statement was documented by LPN #4 on 3/19/18: "On 3/15/18 I was coming out of my office when I noticed (Name of daughter) talking to (Name of nurse) and heard (nurse) state well there's (Name of LPN #4) while pointing in my direction. (Name of daughter) then started walking towards writer...Writer informed (Name of daughter) I as going to get nurse on duty to come with us to the room. Writer got nurse (Name of Resident's nurse) and went to room and noticed that Res. (resident) was in her jerri chair and appeared normal. however (sic) writer was able to note that Res was hoarding food to the right side of her mouth. Writer used a toothette (sic) and was able to clean residents mouth out. CNA (Name of 3-11 CNA) made RP (responsible party) and writer aware that resident does this often,

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writer on this. there after (sic) RP gave resident a twinkie which she started eating. When writer was first approached by (name of daughter), she wanted to send Res to ER however (sic) after food was cleaned out of her mouth, RP stated she looked normal to me and writer asked if she wanted her sent out. (Name of daughter) stated No she appears to be fine, just monitor her and if she has any change please let me know right away. "

On 4/27/18 at approxiamtely 1:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

3. The facility staff failed to write an accurate care plan for Resident #95.

Resident #95 was admitted to the facility on 2/12/18 with diagnoses that included but were not limited to: multiple sclerosis (1), anemia, depression and pressure ulcers.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 3/8/18 coded the resident as having a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as being dependent on staff for all activities of daily living.

Review of the resident's care plan initiated on 4/11/18 documented, "Focus. Elevated temp (temperature) Interventions. Administer Pain medication as ordered. Coordinate with patient/Family/RP (responsible party) to identify

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F 842	Continued From page 199 patient's favorite items/activities that could serve to distract from pain." An interview was conducted on 4/26/18 at 1:05 p.m. with LPN #4 , the unit manager and the nurse who initiated the care plan. When asked why residents had care plans, LPN #4 stated, "Basically they have care plans to make us aware of what they have and put into place." When asked who used the care plans, LPN #4 stated, "The nurses. Basically everyone does actually." When asked if staff were expected to follow the care plan, LPN #4 stated, "Yes." LPN #4 was made aware of the findings at that time. When asked if it was important for the care plan to be complete and accurate LPN #4 stated it was. LPN #4 was asked to review Resident #95's care plan for elevated temperature. LPN #4 stated, "I did that." On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another.	F 842		

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F 842	Continued From page 200 If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 1. Multiple Sclerosis -- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from: https://medlineplus.gov/multiplesclerosis.html	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880	F880 1. Infection control practices are being followed for resident #35 catheter tubing and drainage bag no longer touching the floor, providing clean water cups during medication administration, bare hands not touching the rims of residents' cups, surfaces of residents' dishes and putting fingers inside the residents' fruit cup. 2. Any resident has the potential of being affected. 3. Nursing staff will be re-educated on maintaining infection control techniques for catheter tubing and	5/29/18

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F 880	Continued From page 201 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880	drainage bag not touching the floor, providing clean water cups during medication administration, bare hands not touching the rims of residents' cups, surfaces of residents' dishes and putting fingers inside the residents' fruit cup. 4. An audit will be conducted to ensure infection control techniques are maintained for catheter tubing and drainage bag not touching the floor, clean water cups provided during medication administration, bare hands not touching the rims of residents' cups, surfaces of residents' dishes and putting fingers inside the residents' fruit cup weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

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infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain infection control practices for one of 42 residents in the survey sample (Resident #35), during the medication administration observation, and in two of three dining rooms (unit B and C-wing dining room).

1. Resident #35's catheter tubing and drainage bag was observed touching the floor.

2. The facility staff failed to provide a clean water cup during the medication administration observation on 4/24/18 at 12:49 p.m.

3. The facility staff failed to wash their hands after touching their face during the dining observation on 4/24/18 at 1:10 p.m., and failed to keep their bare hands from touching the rims of residents' cups and putting their fingers inside the residents' fruit cup.

4. The facility staff failed to keep their bare hands from touching the surfaces of the resident's dishes while serving the resident's lunch in the C-wing dining room.

The findings include:

1. Resident #35 was admitted to the facility on 10/1/16. Resident #35's diagnoses included but

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were not limited to difficulty swallowing, muscle weakness and major depressive disorder. Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/2/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded Resident #35 as requiring extensive assistance of one staff with bed mobility and requiring extensive assistance of two or more staff with transfers. Section H coded the resident as having an indwelling catheter.

Review of Resident #35's clinical record revealed a physician's order for a Foley catheter for a diagnosis of urinary retention. Resident #35's comprehensive care plan dated 10/18/16 documented, "Alteration in elimination of bowel and bladder and am (sic) risk for UTI's (urinary tract infections) r/t (related to) History of UTI's Indwelling Urinary Catheter, Urinary Retention...Keep drainage bag of catheter below the level of the bladder at all times and off floor..."

On 4/24/18 at 2:38 p.m., Resident #35 was observed sitting in a wheelchair. The catheter tubing was observed touching the floor.

On 4/25/18 at 7:45 a.m., Resident #35 was observed lying in bed. The bottom of the catheter drainage bag was observed touching the floor.

On 4/26/18 at 9:55 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked where a resident's catheter tubing and drainage bag should be positioned. LPN #5 stated, "Below waste level." When asked if the bag and tubing should touch the floor, LPN #5 stated, "No." When asked why, LPN #5

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stated, "Contamination."

On 4/26/18 at 10:27 a.m., an interview was conducted with LPN #9. LPN #9 was asked where a resident's catheter tubing and drainage bag should be positioned. LPN #9 stated, "It should be in a dignity bag and the bag should be hooked to the bed and lower than the waist." When asked if the tubing or drainage bag should touch the floor, LPN #9 stated, "No."

On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document regarding catheter care failed to reveal documentation regarding the above findings.

No further information was provided prior to exit.

2. The facility staff failed to provide a clean water cup during the medication administration observation on 4/24/18 at 12:49 p.m.

A medication administration observation was made on 4/24/18 at 12:49 p.m. with LPN (licensed practical nurse) #13. LPN #13 took a plastic cup and held the cup with her index finger and thumb. Her bare index finger was inside the cup and as she spoke to a resident, she waved the cup around in the air. LPN #13 then filled the cup with water and took it and medications into a resident's room. The resident took the medication and drank the water out of the cup.

An interview was conducted on 4/25/18 at 3:01 p.m. with LPN #13. When asked if there was

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F 880	Continued From page 205 anything wrong with putting bare fingers inside a resident's water cup, LPN#13 stated, "Yes. That would be cross contamination." An interview was conducted on 4/26/18 at 3:05 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked when staff were to wash their hands, LPN #4 stated, "When they're visibly soiled, in between residents after giving care." When asked if there was, anything wrong with staff putting their fingers inside a resident drinking cup, LPN #4 stated, "That's an infection control issue." On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings. Review of the facility's policy titled, "ORAL DRUG ADMINISTRATION" did not address proper handling of resident's drinking cups. No further information was obtained prior to exit. 3. The facility staff failed to wash their hands after touching their face during the dining observation on 4/24/18 at 1:10 p.m., and failed to keep their bare hands from touching the rims of residents' cups and putting their fingers inside the residents' fruit cup. A dining observation was made on 4/24/18 at 12:59 p.m. in the B Unit dining room. CNA (certified nursing assistant) #20 was holding a resident's cup by rim and set it down on the table by the resident. The resident picked up the cup and drank from it. CNA #22 rubbed her face with	F 880		

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right hand. Then put her hands into her pockets. CNA #22 then picked up a cup by the rim and gave it to a resident. CNA #22 then picked up a fruit cup by holding it by the rim with her index finger inside the cup. CNA #22 then took the paper off a straw and used it to stir sugar into the coffee with her bare hands. CNA #22 then gave the cup with the same straw to a resident who began drinking from the straw.

An interview was conducted on 4/25/18 at 2:59 p.m. with CNA #20 and CNA #22. When asked if holding the resident's drinking cup by the rim was appropriate, CNA #20 stated it was not. When asked why, CNA #20 stated, "It's an infection control issue."

An interview was conducted on 4/26/18 at 3:05 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked when staff were to wash their hands, LPN #4 stated, "When they're visibly soiled, in between residents after giving care." When asked if staff should wash their hands after touching their face or putting their hands in their pockets, LPN #4 stated, "Yes. They should use the wipes." When asked if holding the drinking glass by the rim was acceptable, LPN #4 stated, "No. Now I've put my hand around where they're going to put their mouths." When asked if putting their bare fingers inside a dessert cup was acceptable, LPN #4 stated, "No." When asked how staff were to provide straw to the residents, LPN #4 stated, "They are supposed to leave the top part (with the paper on it) and hold it from there." When asked why staff should not do that, LPN #4 stated, "Cross contamination."

Review of the facility's policy titled, "HAND HYGIENE" documented, "To protect patients from

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health care-associated infections, hand hygiene must be performed routinely and thoroughly. In effect, clean and healthy hands with intact skin, short fingernails, and no rings minimize the risk of contamination....Using an alcohol based hand rub is appropriate for decontaminating the hands before direct patient contact; after removing gloves..."

No further information was provided prior to exit.

4. The facility staff failed to keep their bare hands from touching the surfaces of the resident's dishes while serving the resident's lunch in the C-wing dining room.

On 04/24/18 at 12:18 p.m., the C-wing dining room was observed during the lunch meal.

CNA (certified nursing assistant) # 1 came into the dining room from the hallway with a lunch tray after removing the tray from the lunch cart and closing the door of the food cart with her bare hands. CNA # 1 took the tray to the resident's table, removed a lunch plate from the hot plate with her bare hands, with her thumbs on the rim of the plate and placed it down on the table in front of the resident. CNA #1 then removed a dessert bowl from the serving tray with bare hands and her thumbs on the rim of the bowl and placed it down on the table in front of the resident. CNA # 1 was observed going back into the hallway, opened the door to the food cart with her bare hands, removed a lunch tray, closed the food cart door with her bare hands and entered the dining room. CNA # 1 took the tray to the resident's table, removed a lunch plate from the hot plate with bare hands and her thumbs on the rim of the plate and placed it down on the table in

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front of the resident. CNA #1 then removed a dessert bowl from the serving tray with bare hands and her thumbs on the rim of the bowl and placed it down on the table in front of the resident.

CNA # 2 came into the dining room from the hallway with a lunch tray after removing the tray from the lunch cart and closing the door of the food cart with her bare hands. CNA # 2 took the tray to the resident's table, removed a lunch plate from the hot plate with her bare hands and her thumbs on the rim of the plate and placed it down on the table in front of the resident. CAN#2, then removed a dessert bowl from the serving tray with her bare hands and thumbs on the rim of the bowl and placed it down on the table in front of the resident. CNA # 2 was observed going back into the hallway, opened the door to the food cart with her bare hands, removed a lunch tray, closed the food cart door with her bare hands and entered the dining room. CNA # 2 took the tray to the resident's table, removed a lunch plate from the hot plate with bare hands and her thumbs on the rim of the plate and placed it down on the table in front of the resident. CNA #2 then removed a dessert bowl from the serving tray with her bare hands and thumbs on the rim of the bowl and placed it down on the table in front of the resident.

On 04/24/18 at 1:32 p.m., an interview was conducted with CNA # 1 and CNA # 2. When asked to describe the procedure for handling and serving the resident's food CNA # 1 stated, "Everything needs to come off the tray and off the hot plate and set them in front of the resident. When lifting a dish hands should be on the bottom. Finger should not touch the surface of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

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F 880	Continued From page 209	F 880		

the plates or bowls." When asked about the process using the food carts CNA # 2 stated, "The doors on the food carts are closed after each tray is taken out to make sure they don't get contaminated and it helps keep the food warm." When asked if the lunch trays were handed to them or if they opened and closed the food cart doors and removed the lunch trays themselves CNA # 1 and CNA # 2 stated, "We opened and closed the food carts ourselves." When asked if they washed their hands between serving each resident or after touching the food cart and before serving the residents CNA # 1 and CNA # 2 stated, "No." After being informed of the observations during the meal, CNA # 1 and CNA # 2 stated they don't remember touching the surfaces of the dishes.

On 6/26/18 at 8:20 a.m., an interview was conducted with OSM (other staff member) # 19, district dietary manager. When asked to describe the process for handling resident's plates and bowls when serving the resident's their meal. OSM # 19 stated, "Their fingers should not be placed over the lip of the plate or bowl." When informed of the observations during lunch on the C-wing dining room on 04/2418 at 12:18 p.m. OSM # 19 stated, "They should use hand sanitizer between each resident and after handling the food cart before serving the resident."

On 04/26/18 at 2:00 p.m., OSM # 19 provided the facility's policy "Meal Distribution" to this surveyor. The policy documented, "6. Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining."

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F 880	Continued From page 210 On 04/26/18 at approximately 5:10 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 880		

VDH

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	VA0083	A. BUILDING _____ B. WING _____	04/27/2018

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/24/18 through 4/27/18. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 180 certified bed facility was 165 at the time of the survey. The survey sample consisted of 35 current residents, Resident #118, #142, #267, #119, #86, #150, #318, #90, #95, #157, #88, #97, #2, #6, #110, #116, #46, #41, #38, #417, #53, #369, #16, #20, #33, #144, #8, #60, #87, #81,#105, #35, #111, #94 and #27; and seven closed record reviews #468, #169, #319, #269, #268, #167 and #71.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-110. Management and administration. Cross reference to F625 12VAC5-371-140. Policies and procedures Cross reference to F625 12VAC5-371-150. Resident rights. Cross reference to F625 12 VAC 5 - 371 - 150 H Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to obtain the sex offenders registry prior to the admission of Resident #269. The facility staff failed to obtain the sex offender's registry on Resident #269 prior to admission to the	F 001	F001 1. Facility will obtain sex offender's registry on residents prior to admission to facility. 2. Each residents has the potential of being affected. 3. Admissions staff will be re-educated on obtaining sex offender registry on residents prior to admission to the facility. 4. Audits will be conducted to ensure sex offender registry are obtained on residents prior to admission to the facility weekly for four weeks then monthly for three months. Results of the visits will	5/29/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Crump LNHA — TITLE: Administrator — (X6) DATE: 5/14/18

VDH

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F 001	Continued From Page 1 facility on 9/28/17. The findings include: Resident #269 was admitted to the facility on 9/28/17 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability).(2), traumatic brain injury and mood disorder. The MDS (minimum data set) assessment completed closest to the incident of 12/11/17, with an assessment reference date of 12/22/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making cognitive daily decisions. The resident was coded as requiring limited assistance or supervisions of one staff member for all of his activities of daily living. In Section E - Behavior, the resident was coded as not having any behaviors during the look back period. The nurse's note dated, 12/9/17 at 6:48 p.m. documented, "CNA (certified nursing assistant) observed residents' hand in another resident's pant, writer was summoned to event site. Write asked resident what occurred, resident stated you may tell the administration, all they will do is kick me out. Immediately write separated the two parties involved, supervisor notified immediately. MD (medical doctor) and R/P (responsible party) notified and Administrator made aware. Resident was placed on 1:1 close supervision at this time." Review of the clinical record failed to evidence documentation of a sex offender's registry for	F 001	be reviewed at the monthly QAPI meeting for three months to ensure compliance.	

VDH

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F 001	Continued From Page 2 Resident #269. A copy of the sex offender's registry for Resident #269 was requested. A copy of the sex offenders registry was provided on 4/26/18 at 8:00 a.m. The sex offenders' registry was dated to have been completed on 9/29/17, one day after the resident's admission to the facility. An interview was conducted with other staff member (OSM) #11 on 4/26/18 at 8:13 a.m. When asked the process for admissions in regards to the sex offender's registry, OSM #11 stated, "When I get a referral, I go to the sex offenders' registry. I make sure they are not on the list. I print it out and it goes into each resident's admission file." The copy of the sex offender's registry for Resident #269 was reviewed with OSM #11. When asked if the registry was obtained prior to the resident's admission, OSM #11 stated, "It appears to be that it was done the day after. I was not here then." When stated it was a concern, OSM #11 stated, "Yes it is. We will be following the protocol of doing it prior to admission. An interview was conducted with administrative staff member (ASM) #1, the administrator, on 4/26/18 at 8:22 a.m. When asked to process for admissions in regards to the sex offender's registry, ASM #1 stated, "The are to be done prior to admission. Must be completed before we admit them." ASM #1 was made aware of the above concern at this time. The facility provided a copy of the "Admission File Checklist." The Checklist documented a check off for "Sexual Predator/Offender Verification."	F 001		

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F 001	Continued From Page 3 No further information was provided prior to exit. 12 VAC 5 - 371 - 150 A cross references to F 600 and F 608. 12 VAC 5 - 371 - 250 F cross references to F 657. 12 VAC 5 - 371 - 270 A cross references to F 745. Based on staff interview and facility document review, it was determined that the facility staff failed to ensure a licensure verification was obtained in accordance with the laws of the State of Virginia, for 4 of 25 employee records reviewed and a 30-day criminal background check was not completed timely for 2 of the 25 employee records reviewed. 1. For CNA #8 (Certified Nursing Assistant), the facility staff failed to obtain a license verification at the time of hire. 2. For CNA #9, the facility staff failed to obtain a license verification at the time of hire. 3. For CNA #10, the facility staff failed to obtain a license verification at the time of hire. 4. For CNA #11, the facility staff failed to obtain a license verification at the time of hire, and failed to obtain a 30-day criminal background check in a timely manner. 5. For OSM #5 (Other Staff Member, a dietary staff member), the facility staff failed to obtain the 30-day criminal background check in a timely manner. The findings include: On 4/26/18 a review was conducted of 25 employee records of new hires over the previous 2 year period. The following concerns were identified:	F 001	1. Facility will obtain license verifications at the time of hire and 30-day criminal background checks in a timely manner. 2. No other concerns noted. 3. Human resources, Therapy Manager and HCS Managers will be re-educated on obtaining license verifications at the time of hire and obtaining 30-day criminal background checks in a timely manner. 4. Audits will be conducted to ensure license verifications are obtained at the time of hire and 30-day criminal background checks are obtained in a timely manner weekly for four weeks then monthly for three months. Results of the visits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	5/29/18

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F 001	Continued From Page 4 1. For CNA #8 (Certified Nursing Assistant), the facility staff failed to obtain a license verification at the time of hire. CNA #8 was hired on 7/25/17 and there was no evidence of a license verification in her file. 2. For CNA #9, the facility staff failed to obtain a license verification at the time of hire. CNA #9 was hired on 8/22/17, and the license verification was not obtained until 9/22/17. 3. For CNA #10, the facility staff failed to obtain a license verification at the time of hire. CNA #10 was hired on 12/5/17. The license verification was not obtained until 12/16/17. 4. For CNA #11, the facility staff failed to obtain a license verification at the time of hire, and failed to obtain a 30-day criminal background check in a timely manner. CNA #11 was hired on 9/26/17. The license verification was not obtained until 10/31/17 and the 30-day criminal background check was not obtained until 11/1/17. 5. For OSM #5 (Other Staff Member, dietary staff) the facility failed to obtain a 30-day criminal background check in a timely manner. OSM #5 was hired on 12/16/16. The 30-day criminal background check was not obtained until 2/24/17. On 4/26/18 at approximately 3:00 PM OSM #1 (Other Staff Member, Human Resources) was made aware of the findings. She stated that she was new to the facility but would search for the missing items. On 4/26/18 at approximately 5:50 PM, she stated that the above identified items were not found, and that each above identified staff member did work, without the required pre-screening requirements completed. On 4/26/18 at 5:24 PM at the end of day meeting,	F 001		

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F 001	Continued From Page 5 the Administrator and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. 12VAC5-371-110. Management and administration. B. The nursing facility must comply with: 1. These regulations (12VAC5-371); 2. Other applicable federal, state or local laws and regulations; and 3. Its own policies and procedures. 12VAC5-371-140. Policies and procedures. E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check 12VAC5-371-150. Resident rights. A. The nursing facility shall develop and implement policies and procedures that ensure resident's rights as defined in §§32.1-138 and 32.1-138.1 of the Code of Virginia. Virginia Nursing Home Regulation 12VAC5-371-150 states that a facility must comply with the requirements of §32.1-126.01: Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; suspension or revocation of license. "Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation	F 001		

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F 001	Continued From Page 6 disclosing any criminal convictions or any pending criminal charges...A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange." 12VAC5-371-180. Infection control cross reference to F880. 12VAC5-371-210. Nurse staffing cross reference to F725. 12VAC5-371-220. Nursing services cross reference to F580. 12VAC5-371-220. Nursing services cross reference to F757. 12VAC5-371-250. Resident assessment and care planning cross reference to F641. 12VAC%-371-300. Pharmaceutical services cross reference to F761. 12VAC5-371.371.A. cross references to F584 F656 does not cross reference 12VAC5-371-140. Policies and Procedures cross references to F622, F623, F645, F842 12VAC5-371-250. Resident assessment and Care Planning cross references to F686, F679 12VAC5-371-220. Nursing Services cross references to F685, F686, F695, F558 12VAC5-371-110. Management and	F 001		

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F 001	Continued From Page 7 Administration cross references to F607, F608	F 001		