STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 Medicare - Medicaid Recertification and Emergency Preparedness survey for Long-Term Care Facilities was conducted 12/4/17 through 12/8/17 and 12/11/17. An extended survey was conducted 12/4/17 through 12/8/17 and 12/11/17. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Two Immediate Jeopardy's were identified in the area of Quality of Care at a Scope and Severity Level 4, isolated, and which constituted Substandard Quality of Care. No complaint(s) were investigated during the survey. No complaint(s) were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 23 current residents, and 3 closed record reviews.	E 000		
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(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:] *[For Hospices at §418.113(b), PRFTs at	E 025		1/15/18

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

Electronically Signed | 12/29/2017

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

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E 025	Continued From page 1 §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's Emergency Preparedness Program the facility failed to ensure prearranged transfer agreements were obtained. The findings included: A review of the facility's Emergency Preparedness Program was conducted on 12/11/17 at 9:50 a.m., with the Administrator and the Director of Regulatory & Accreditation. A request to review the written arrangements, such	E 025	1. A Transfer Agreement has been initiated and approved on 12/11/17 for transfer of residents from Sentara Rehabilitation and Care Residence to other Sentara network facilities in the event of a disaster. 2. All residents are at risk if evacuation strategies are not confirmed. 3. 100% of the facility staff will be educated on the facility Emergency Operations Plan to include transfer arrangements for residents in the event of	

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E 025	Continued From page 2 as a Memorandum of Understanding and Transfer Agreements was made. The Administrator stated they did not have one. No additional information to support compliance with the requirement was provided prior to exit.	E 025	a disaster 1/2/18-1/12/18. 4. The Director of Maintenance will audit all new employee records x 90 days to assure staff have received education regarding the facility Emergency Operations Plan. The audits will be summarized by the Director of Maintenance and presented to the QAPI committee for recommendations and additional oversight.	
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(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:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced	E 026		1/15/18

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E 026	Continued From page 3 by: Based on staff interview and review of the facility's Emergency Preparedness Program the facility failed to develop a policy and procedure (P&P) in the emergency plan describing the facilities role in providing care and treatment at alternate care sites under an 1135 waiver. The findings included: A review of the facility's Emergency Preparedness Program was conducted on 12/11/17 at 9:50 a.m., with the Administrator and the Director of Regulatory & Accreditation. A request to review the P&P in the emergency plan that described the facilities role in providing care and treatment at alternate care sites under an 1135 waiver. The Administrator stated they did not have one. No additional information to support compliance with the requirement was provided prior to exit.	E 026	1. Sentara Life Care policy entitled Section 1135 Waiver was revised July 2017. The policy could not be located during survey. 2. All residents are at risk if staff are unaware of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. 3. 100% of the facility staff will be educated on the facility Emergency Operations Plan to include the facility's role in providing care and treatment at alternate sites under an 1135 waiver on 1/2/18-1/12/18. 4. The Director of Maintenance will audit all new employee records x 90 days to assure new staff have received education regarding the Emergency Operations Plan. The audits will be summarized by the Director of Maintenance and presented to the QAPI committee for recommendations and additional oversight.	
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.	E 035		1/15/18

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E 035	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's Emergency Preparedness Program (EPP) the facility failed to ensure the communication plan included a method of sharing information from the emergency plan with residents, clients and their families or representatives by reviewing the plan. The findings included: A review of the facility's Emergency Preparedness Program was conducted on 12/11/17 at 9:50 a.m., with the Administrator and the Director of Regulatory & Accreditation. A request to review documentation that the communication plan included a method of sharing information from the emergency plan that the facility determined appropriate with residents, clients, families and or representatives. The Administrator stated the facility EPP did not include this. No additional information to support compliance with the requirement was provided prior to exit.	E 035	1. A summary of the facility Emergency Operations Plan was mailed to 100% of family contacts for current residents, and posted in each household on 12/29/17. The Emergency Operations Communication plan, developed October 2017, addresses maintaining family contact information on the resident demographic page of their medical record. 2. All residents are at risk if the emergency plan is not communicated to them or their emergency contacts. 3. 100% of the facility staff will be educated on the facility Emergency Operations and Communication plan 1/2/18-1/12/18. A summary of the Emergency Operations Plan will be included in the Admission packet for each resident. A copy of the summary page will be posted in each household for family members and visitors. 4. The Director of Admisisons will review 10% of all new admissions monthly x 90 days to assure new residents acknowledged receipt of the EOP summary page. The audits will be summarized by the Director of Admissions and presented to the QAPI committee for recommendations and additional oversight.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency	E 036		1/15/18

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E 036	Continued From page 5 preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's Emergency Preparedness Program	E 036	1. A community based full scale exercise was not conducted in 2017. No	

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E 036	Continued From page 6 (EPP) the facility failed to provide documentation that the facility had a written training and testing program that met the requirement of this regulation. The findings included: A review of the facility's Emergency Preparedness Program was conducted on 12/11/17 at 9:50 a.m., with the Administrator and the Director of Regulatory & Accreditation. A request to review documentation of the facility's written training and testing program of the EPP was made. The Administrator stated she was not sure if the facility had one and would follow up with the staff training coordinator. No additional information to support compliance with the requirement was provided prior to exit.	E 036	immediate correction is possible. 2. All residents are at risk if staff are not adequately prepared to respond during the event of an emergency. 3. 100% of the facility staff will be educated on the facility Emergency Operations plan to include evacuation preparedness 1/2/18-1/12/18. The Administrator contacted the Long Term Care Preparedness Coordinator for the Eastern Virginia Healthcare Coalition on 12/27/17 to begin plans for a community based full scale exercise in 2018. 4. The Director of Maintenance will audit all new employee records x 90 days to assure staff have received education regarding the facility's Emergency Operations Plan. The audits will be summarized by the Director of Maintenance and presented to the QAPI committee for recommendations and additional oversight.	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		1/15/18

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E 037	Continued From page 7	E 037		

procedures.
*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under

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E 037	Continued From page 8	E 037		

arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of

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E 037	Continued From page 9 their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's Emergency Preparedness Program	E 037	1. Initial staff training for the Emergency Operations Plan could not be located	

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E 037	Continued From page 10 (EPP) the facility failed to provide documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings that met the requirement of this regulation. The findings included: A review of the facility's Emergency Preparedness Program was conducted on 12/11/17 at 9:50 a.m., with the Administrator and the Director of Regulatory & Accreditation. A request to review documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings. The Administrator stated she was not sure if the facility had one and would follow up with the staff training coordinator. No additional information to support compliance with the requirement was provided prior to exit.	E 037	during survey. No immediate correction is possible. 2. All residents are at risk if staff are inadequately prepared to respond during an emergency. 3. 100% of the facility staff will be educated on the facility's Emergency Operations Plan to include staff responsibilities during a disaster 1/2/18-1/12/18. 4. The Director of Maintenance will audit all new employee records x 90 days to assure staff have received education regarding the facility's Emergency Operations Plan. The audits will be summarized by the Director of Maintenance and presented to the QAPI committee for recommendations and additional oversight.	
F 000	INITIAL COMMENTS An unannounced Medicare - Medicaid Recertification and Emergency Preparedness survey for Long-Term Care Facilities was conducted 12/4/17 through 12/8/17 and 12/11/17. An extended survey was conducted 12/4/17 through 12/8/17 and 12/11/17. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Two Immediate Jeopardy's were identified in the area of Quality of Care at a Scope and Severity Level 4, isolated, and which constituted Substandard Quality of Care. No complaint(s) were investigated during the survey. No complaint(s) were investigated during the survey.	F 000		

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F 000	Continued From page 11 The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 23 current residents, and 3 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		1/15/18

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SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 550	Continued From page 12 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, staff interviews and facility policy reviews, the facility staff failed to ensure they maintained the dignity of 5 out of 26 residents (Resident #50, #353, #55, #83 and #46) in the survey sample. 1. Resident #50 was assessed to require complete assistance to eat during his meals. The facility staff failed to sit while assisting Resident #50 to eat his lunch meal. 2. The facility staff failed to maintain Resident #353's dignity by allowing the resident to be seen on the commode from the Unit's main hall way. 3. The facility staff failed to provide dignity during dining services by wearing gloves while assisting/feeding Resident #55. 4. The facility staff failed to provide dignity during dining services by wearing gloves while feeding/assisting Resident #83. 5. 4. The facility staff failed to maintain Resident #46's dignity by speaking to the resident in an argumentative/ negative manner.	F 550	1. Facility staff were observed during survey to be standing while feeding resident #50. No immediate correction is possible. Facility staff were observed during survey to be wearing gloves while feeding resident #55, and resident #83. No immediate correction is possible. Resident #353 was left sitting on the toilet with her bathroom door opened on 12/4/17. No immediate correction is possible. Resident #46 voiced concerns during the group meeting on 12/6/17 about being spoken to in an argumentative manner on 11/30/17. The staff member involved has been terminated from employment with Sentara after an investigation was completed on 12/14/17. 2. All residents are at risk if they are not treated with respect and dignity. 3. 100% of the facility staff will be educated on Sentara Life Care policy entitled Resident Rights and Responsibilities specifically regarding the resident's right to be treated with respect and dignity on 1/2/18-1/12/18.	

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F 550	Continued From page 13 The findings include: 1. Resident #50 was admitted to the nursing facility on 10/3/14 with diagnoses that included depression, glaucoma, blindness and Alzheimer's dementia. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 10/5/17 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 3 out of a possible 15, which indicated the resident was severely impaired in the skills needed for daily decision making. Resident #50 was assessed totally dependent on one staff for assistance with eating. The care plan dated 10/16/17 identified the resident had glaucoma with blindness and required assistance with all Activities of Living (ADL). The resident was identified as not able to initiate eating and the goal set by the nursing staff for the resident was to provide him with assistance with all meals. Some of the interventions to accomplish this goal included to feed the resident if he is unable to feed himself. On 12/4/17 at 12:15 p.m. certified nursing assistant (CNA) #1 was observed feeding Resident #50 while standing. The CNA was observed leaving the resident and coming back consistently throughout the lunch meal. He sat down for a couple of minutes and stated, "I am trying to catch my breath", after which he stood and continued to feed Resident #50 forkfuls of food and sips of tea. The CNA handed a sandwich to the resident and proceeded down one of the unit's hallways. The resident dropped	F 550	4. The Household Coordinators (or designee) will round in each household twice weekly x 45 days to assure staff are feeding residents without gloves, that staff are seated during meals with residents, and that residents are provided privacy when toileting. The Patient Advocate (or designee) will visit 5 residents weekly x 45 days to assess for feelings of being treated with respect and dignity. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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the sandwich and the CNA retrieved another one for him. Once the CNA obtained the sandwich, he stood over the resident, placed the sandwich to his mouth and said, "Bite it (Resident #50's name), bite it". This process of standing to assist the resident to eat continued throughout the entire lunch meal. A licensed practical nurse (LPN#2) was observed sitting at a table next to Resident #50 assisting another resident with her lunch meal. This LPN did not alert CNA #1 to sit down to assist Resident #50 with his meal. Additionally, the unit's clinical manager, Registered Nurse (RN) #1 walked through the unit while CNA #1 was standing to assist Resident #50 with his meal and did not instruct the CNA to sit while feeding the resident.

On 12/11/17 at 1:00 p.m., an interview was conducted with CNA #1. He stated he stood to feed the resident because he had so much to do causing him to go back and forth to give the resident forkfuls of food, sips of liquid and bites of his sandwich. He stated I should have stopped and sat to feed the resident throughout the completion of his meal.

On 12/11/17 at 1:30 p.m., an interview was conducted with the unit's clinical manager RN #1. She stated she expected all staff on the unit to remain seated while assisting resident's to eat. RN #1 stated she did not understand why CNA #1 moved about during the lunch meal on 12/4/17.

On 12/11/17 at 5:50 p.m., during the pre-exit meeting, the aforementioned issue was brought to the attention of the Administrator and the Director of Nursing (DON). No further information was provided prior to survey exit.

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The facility's policy and procedure titled "Resident Rights and Responsibilities" dated as revised on 1/17/17 indicated "...The patient or resident has the right to respect, dignity, a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility and to be supported by the facility in exercising those rights."

2. The facility staff failed to maintain Resident #353's dignity by allowing the resident to be seen on the commode from the Unit's main hall way.

Resident #353 was admitted to the facility on 11/27/17. Diagnoses for Resident #353 included but are not limited to Abnormality of gait* (1) and mobility.

Resident #353's Admission Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 12/4/17 coded Resident #353 with a BIMS (Brief Interview for Mental Status) score of 15 of 15 indicating no cognitive impairment. In addition the Admission MDS coded Resident #353 as requiring limited assistance with 2 staff person assistance for transfer. Resident #353 was coded as requiring limited assistance with one staff person assistance for toilet use. Resident #353 was coded as always continent of urinary and bowel functions.

An observation on 12/04/17 at approximately 1:30 p.m. during initial tour, housekeeper #5 was observed standing at Resident #352's doorway with the door half opened. Resident #353 was observed sitting on the commode. The surveyor stated, "Oh, she's in the bathroom." waiting to

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see if housekeeper #5 would close the door. The housekeeper did not close the door, and Resident #353 remained visible to those walking down Household Great Bridge's hallway.

On 12/6/17 at approximately 2:20 p.m., an interview was conducted with housekeeper #5. Housekeeper #5 was asked what she felt about Resident
#353 being on the commode with the door open. Housekeeper #5 stated, "I should have closed the door. I knew when I heard you say, "oh she is on the toilet." The housekeeper stated, "I was so focused on the wet floor waiting for it to dry. And then a family member came in." When asked how she would feel if someone allowed anyone walking down the hall to see her on the commode, the Housekeeper replied, "I'd feel bad." Asked if she felt it was a privacy and dignity issue and the housekeeper stated, "Yes."

On 12/05/17 at approximately 2:16 PM, Resident #353 was asked how she felt being exposed to anyone walking down the hall way while she was on the commode. Resident #353 stated, "Well, I've gotten used to it, but I should be allowed my privacy. I feel bad when others see me in my private moments." Resident #353 continued to state, " Some of the staff will close the door allowing for privacy and others will not."

On 12/06/17 at approximately 03:58 PM Resident #353's daughter was visiting with her Mother. The daughter was updated on an observation of housekeeper not allowing for privacy for her mother made on 12/4/17. The daughter stated, "I'm glad you'll are checking residents."

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On 12/07/17 at approximately 5:52 PM, the Director of Environmental Services was asked if it was her expectation for Housekeeping staff to stand at a resident's door with it half way open allowing passers in the hall to see a resident sitting on the commode. The Director of Environmental services stated that it was her expectation for staff to provide privacy for the residents to enhance their dignity. The Director of Environmental Services stated that the Housekeeper had stated to her that she was concerned about the floor drying so no one would fall and there had been several people coming in and out of the room. The Director of Environmental Services was asked if the Housekeeper could have closed the door to the bathroom. The Director of Environmental Services stated that she could have closed the door to provide privacy for the resident.

On 12/08/17 at approximately 3:00 PM, the Director of Nursing (DON) was asked, "Is it your expectation for staff to provide privacy for residents while sitting on the commode?" and the DON stated, "Yes."

The Facility Policy and Procedure titled, "Resident Rights and Responsibilities" with a revision date of 1/17/17 documented the following:

Policy Statement: ... The patient or resident has the right to respect, dignity, a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility and to be supported by the facility in exercising those rights.

The facility administration was informed of the findings during a briefing on 12/11/17 at

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approximately 6:10 p.m. The facility did not present any further information about the findings.

Definitions:

1. Gait: Medline Plus documented Gait is walking patterns.

#3. The facility staff failed to provide dignity during dining services by wearing gloves while assisting/feeding Resident #55.

Resident #55 was originally admitted to the nursing facility on 5/5/17. The diagnosis for Resident #55 included but are not limited to *Dementia. Resident's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/19/2017 coded Resident #55 a 00 out of a possible 15 indicating severe cognitive impairment for making decisions. In addition, the MDS coded Resident #55 requiring extensive assistance of one with eating.

During dining observation on the Coastal Cottage on 12/4/17 at approximately 11:45 a.m., RN # 1 was feeding Resident #55 while wearing gloves throughout the entire lunch meal. On the same day at approximately 2:00 p.m., an interview was conducted RN #1 who stated, "I guess I was nervous and was trying to do the right thing. I was passing out trays and I guess I just forgot to take my gloves off; I felt like I was doing the right thing by wearing gloves but obviously not.

On 12/06/17 at approximately 2:38 p.m., an interview was conducted with the Director of Nursing (DON) who stated, "The staff should not be wearing gloves while feeding but to use hand sanitizer as well as washing your hands; this can

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be a dignity issue for that resident to wear gloves while feeding.

*Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm).

#4. The facility staff failed to provide dignity during dining services by wearing gloves while feeding/assisting Resident #83.

Resident #83 was originally admitted to the nursing facility on 10/31/17. The diagnosis for Resident #83 included but are not limited to *Alzheimer's. Resident's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/07/2017 coded Resident #83 a 00 out of a possible 15 indicating severe cognitive impairment for making decisions. In addition, the MDS coded Resident #83 requiring extensive assistance of one with eating.

During dining observation on the Coastal Cottage on 12/4/17 at approximately 11:45 a.m., Licensed Practical Nurse (LPN) #1 was feeding Resident 83 while wearing gloves throughout the entire lunch meal. On the same day at approximately 12:21 p.m., an interview was conducted with LPN #3 who stated, "I was wearing gloves because I was just getting over pneumonia and I was protecting myself."

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On 12/06/17 at approximately 2:38 p.m., an interview was conducted with the Director of Nursing (DON) who stated, "The staff should not be wearing gloves while feeding but to use hand sanitizer as well as washing your hands; this can be a dignity issue for that resident to wear gloves while feeding.

The facility administration was informed of the findings during a briefing on 12/11/17 at 5:50 p.m. The facility did not present any further information about the findings.

The facility's policy: Life Care-Resident Rights and Responsibilities (Revision - 01/17/17). Policy statement: Prior to, or upon admission to the facility, the patient or resident will be informed of their rights, grievances, procedures, and the rules and regulations governing their conduct and responsibilities while residing in the facility. The patient or resident has the right to respect, dignity, a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility and to be supported by the facility in exercising those rights.

*Alzheimer's is the common form of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment (Source: http://www.cdc.gov/aging/aginginfo/alzheimers.htm).

4. The facility staff failed to maintain Resident #46's dignity by speaking to the resident in an argumentative/ negative manner.

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Resident #46 was admitted to the facility on 7/2/15 with current active diagnosis of Multiple Sclerosis (MS-a chronic, slowly progressive disease of the central nervous system-Taber's Cyclopedic Medical Dictionary).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 10/11/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident required extensive assistance of one staff for toileting and was always incontinent of both bladder and bowel. The resident was wheelchair bound and had range of motion limitations to both lower legs.

On 12/05/17 at 11:42 AM, the resident was observed sitting up in a wheelchair in the hallway. A request to conduct an interview was granted by the resident. The resident then propelled herself into her room, During the resident interview Resident # 46 stated she had experienced a CNA (Certified Nurse Aide) being "argumentative" and making negative remarks. When she asked the CNA to wipe an area on her buttocks due to it feeling wet the CNA stated it was not wet and "swiped" the area. The resident stated she had reported her concern to staff and named the person she had reported this to. This person was later identified as the unit manager.

Just prior to the above resident interview the resident had attended the Resident Council meeting facilitated by another inspector. The following notes were obtained from this meeting and read in part:
12/05/17 at 10:13 AM: Resident council

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meeting... Night shift staff talk down to Resident #46- she has reported and it continue to happens. She has documentation and bring it up during care plan meetings....".

Review of the clinical notes evidenced the following to support the resident's allegations. A care plan meeting note dated 10/19/17 authored by Social Worker #2 (SW) read, in part:"Care plan held with resident and her son...She did say that their is 1 person who talk(s) so negative and she didn't want to say who it was and her son did say they would let the clinical manager know...".

On 12/7/17 at 11:20 p.m., an interview was conducted with the unit manager. The above allegation was shared. The unit manager was asked if she was aware of the resident's allegation of the staff talking negatively and argumentative. She stated she was not aware of these allegations prior to the Resident Council meeting conducted on 12/5/17. The unit manager then read the aforementioned care plan note dated 10/19/17. When asked if there should have been a follow up by either the Social Worker who had knowledge of the allegation or herself, she stated, "Yes, I would have spoken to her in private and followed up on this".

On 12/08/17 at 12:11 PM, an interview was conducted with SW#2. The above care plan meeting note was shared. The SW stated she did not follow up with the unit manager to ensure the allegation of the staff speaking negatively to the resident was addressed. She stated she assumed the resident or son had spoken with the unit manager.

The Facility Policy and Procedure titled, "Resident

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F 550	Continued From page 23 Rights and Responsibilities" with a revision date of 1/17/17 documented the following: Policy Statement: ...The patient or resident has the right to respect, dignity, a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility and to be supported by the facility in exercising those rights. On 12/11/17 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). She stated the allegation of the staff speaking negatively to a resident is considered a dignity issue and should also be reported as potential for abuse. She stated the allegation should have been reported to the State Survey Agency with in 2 hours of the allegation being made. No additional information was provided to the survey team prior to exit to support compliance.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553		1/15/18

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F 553	Continued From page 24 (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, facility document review, and staff interviews the facility staff failed to ensure that 1 of 26 residents were invited to participate in their person-centered plan of care, Resident #10. The facility staff failed to ensure that Resident #10 with a BIMS (Brief Interview for Mental Status) of an 11 and her own Responsible Party was invited to participate in her person-centered plan of care. The findings included: Resident #10 was a 74 year admitted to the facility on 11/1/13 with diagnoses to include, 1.) Anxiety Disorder, 2.) Major Depression, and 3.) Diabetes Mellitus. A review of Resident #10's current facility Face Sheet indicated that the	F 553	1. A care plan meeting was held for resident #10 on 11/22/17. Resident #10 was in attendance for this meeting. 2. All residents are at risk if no invitation to participate in their person centered care plan meeting is extended. 3. The Social workers are responsible to assure residents are notified of their care plan meetings. The Social workers will be educated on Sentara Life Care policy entitled Comprehensive Care Plan, revised on 12/13/17 specifically regarding care plan meeting invitations being extended to the resident and/or resident representative in a timely manner and documented in the medical record 1/2/18-1/12/18. 4. The Medical records clerk will audit 100% of all care scheduled care plan	

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F 553	Continued From page 25 resident was her own Responsible Party. The most recent comprehensive Minimum Data Set (MDS) assessment was a Annual with an Assessment Reference Date (ARD) of 6/6/17. The Brief Interview for Mental Status (BIMS) was an 11 out of a possible 15 which indicated that Resident #10 was cognitively intact and capable of daily decision making. During the initial tour on 12/4/17 an interview was conducted with Resident #10 and is documented in part, as follows: Resident #10 12/04/17 11:00 AM Resident stated she is only made aware of her care plan meeting on the day of her care plan or right before the meeting is about to start, states her son gets a notice way in advance and he attends. However, the resident stated she would like to attend. Son in to visit resident during interview and stated that he does attend and gets a notice in advance. The resident's son was made aware by this surveyor that his mother expresses she would like to attend her care plan as well. Resident #10's current Comprehensive Care Plan dated 11/24/17 to present was reviewed and documented in part, as follows: Problem: Resident will remain LTC (long term care) related to ADL (activities of daily living) care needs and supervision. Goals: Resident will maintain highest level or psychosocial well being over the next 90 days. Interventions: Invite resident/family to care plans	F 553	meetings weekly x 45 days to assure documentation is present indicating meeting invitations were provided. The audits will be summarized by the Director of Social Services and reported to the QAPI committee for additional oversight and recommendations.	

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as scheduled, Continuous Starting 11/24/17.

Resident #10's Social Service's Note dated 3/28/17 was reviewed and documented in part, as follows:

Care plan held family invited but, didn't attend. Resident is able to make her needs known and gets out of her room a little more. Staff to continue to monitor for changes in condition.

On 12/8/17 an interview was conducted with the facility Social Worker and is documented in part, as follows:

12/08/17 09:59 AM Interview conducted with the facility Social Worker. The Social Worker was asked who was invited to Resident #10's care plan meetings. SW stated, "A copy of the care plan letter invite goes to her son 2 to 3 weeks before the care plan. Surveyor asked if a copy of the invite is also given to the resident at that time as well. The Social Worker stated, "No, the son is the only person that gets the invite. The Social Worker was made aware of the residents right and desire to attend her own person-centered care plan meeting and that the resident has a BIMS of 11. The Social Worker stated, "From now on I will make sure she also gets one too."

The facility policy titled, "Life Care-Comprehensive Care Plan" revised on 1/17/2017 is documented in part, as follows:

Procedure:
2. The facility shall inform the resident of the right to participate in their treatment and shall support the resident in this right, A. Facilitate the inclusion of the resident and/or resident

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representative.
3. The patient or resident and/or resident representative has the right to participate in the development, implementation, and request changes of their plan of care. This includes but not limited to: A. Right to participate in the planning process, B. Right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care.
14. Social Services will be responsible for notifying the resident and/or resident representative of Care Plan dates in a reasonable timeframe.

Care Plan Meeting Schedule Process:
1. Social Services will be responsible for notifying the resident and/or resident representative of Care Plan dates in a reasonable timeframe.

On 12/11/17 at 5:50 P.M. a pre-exit conference was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

1.) Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal.

2.) Major Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are

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F 553	Continued From page 28 inappropriate and out of proportion to reality. 3.) Diabetes Mellitus: a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 553		
F 580 SS=D	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	F 580		1/15/18

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F 580	Continued From page 29 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, 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 record review, staff interview and facility policy, the facility staff failed to notify One resident (Resident #147) physician of significant medication omissions in the survey sample of 26 residents. The findings included: Resident # 147 was admitted to the facility on 11/20/17 with diagnoses of multiple closed fractures of pelvis, closed fracture of shaft of right tibia and fibula, rib fractures, coronary artery bypass draft, chronic anticoagulation, asbestosis,	F 580	1. The physician for resident #147 was notified on 12/13/17 that the resident missed several doses of scheduled Lovenox. No new orders were given. 2. All residents who miss medication doses as ordered by the physician are at risk if the physician is not notified. 3. 100% of the licensed nursing staff will be educated on Sentara Life Care policy entitled Medication Administration revised 12/27/17 to include physician notification of any omissions on 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit 10% of all Medication	

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F 580	Continued From page 30 COPD, osteoarthritis of knees, cardiovascular disease, sleep apnea, stroke, internal carotid aneurysm, history of renal mass, hypertension, severe obesity, type 2 diabetes mellitus, major depression, hyperlipidemia, and hypertrophy of prostate. Resident #147 was not provided six doses of enoxaparin (Lovenox) 30 mg./0.3 ml subcutaneous via syringe. The Nursing Drug Guide Handbook dated 2016 indicates: Lovenox-Therapeutic class: Anticoagulants ; Pharmacological class: Low-molecular-weight heparin's. Used to prevent PE (pulmonary embolus) and DVT (deep vain thrombosis) after hip or knee replacement surgery. To prevent PE and DVT in patients with acute illness who are at increased risk because of decreased mobility. An Initial Minimum Data Set (MDS) dated 12/1/17 assessed Resident #147 in the area of Cognitive Patterns - Brief Interview of Mental Status (BIMS) as a (15). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (3/3) in the area of bed mobility, a (7/2) in the area of transfer, a (7/3) in the area of walk in room, (2/2) in the area of dressing, a (0/1) in the area of eating, a (3/3) in the area of toilet use, and a (3/3) in the area of personal hygiene. In the area of Medications this resident was assessed as receiving injections for (7) days. In the area of Insulin this resident was assessed as receiving insulin for (4) days. In the area of Orders for Insulin changes- this	F 580	Administration records 3 x weekly x 45 days to assure documentation is present that indicates physician notification if medications were not given. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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resident was assessed for (0) days.

In the area of Medications Received - this resident was assessed as receiving Anticoagulant for (7) days.

There was no Care Plan for the use of Anticoagulant medications.

A Care Plan dated 12/6/17 indicated : "Problem- Potential for hypo/hyperglygycemia r/t: DX of DM (resident diagnoses of diabetes mellitus) Goals _ resident will have no s/s (signs or symptoms) of diabetic reaction with blood sugars within normal range of 60/120 mg/dl x (time) 90 d (days).
Interventions- Administer medication per MD order, Disciplines -Nursing, Frequency - PRN (as needed).
Intervention- monitor for effectiveness of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- monitor for side effects of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- observe for s/s of low blood sugar (sweating, headache, light headed, confusion, slurred speech, drowsiness,
Intervention -Observe for s/s pf high blood sugar (polyuria, blurred vision, weakness, headache, anorexia, N & V, abdominal pain, acetone breath, mental changes, hypotension),
intervention - Monitor accuchecks per MD order
Intervention- serve diet per MD order, Disciplines - Dietary- Licensed Practical Nurse- Registered Nurse, Frequency -PRN.
Intervention - Notify MD as needed, Disciplines - Skilled Nursing, Frequency - PRN.

A physician's order dated 11/20/17 indicated:

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"enoxaparin (Lovenox) 30 mg/0.3 ml sc syrg - inject 0.3 ml beneath the skin every 12 hours. Lovenox for 3 weeks."

A Medication Administration History document with a date range of 11/20/17 to 12/07/17 indicated: "enoxaparin 30 mg/0.3 ml, 12/03/17 (06:01) - 12/03/17 (07:05) Not Administered; 12/03/17 (19:01) -12/03/17 (20:33) Not Administered; 12/04/17 (06:01) - 12/04/17 (06:28) Not Administered; 12/04/17 (19:01) - 12/04/17 (20:09); 12/05/17 (06:01) - 12/05/17 (10:07) Not Administered; Not Administered; 12/05/17 (06:01) - 12/05/17 (19:01) - 12/05/17 (18:04) Not Administered."

During an interview on 12/4/17 at 1:05 P.M. with Resident #147's wife, she stated, "Resident #147 had not received his heparin due to non-availability for several days."

During an interview on 12/6/17 at 12:45 P.M. with the 300 Nurse Manager, she stated she was not aware of Resident #147 medications not being available, but would look into it." The 300 Nurse Manager stated, "it looks like there was a mix-up in his order." When asked had the doctor been informed of the missed doses, she stated, "No".

A review of a Facility Policy for Notification of Changes In Condition revised 6/2/17 indicated: " The resident, legal representative or family member will be immediately informed and the resident's physician will be consulted when changes defined below occur.

1. The nurse on duty will notify the the Practitioner and resident/legal representative/family member when there is an

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F 580	Continued From page 33 occurrence of an accident involving the resident which results in injury and has the potential for requiring physician intervention. 3. The nurse on duty will the Practitioner and resident legal representative/family member when there is a need to alter treatments significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatments." A Medication Administration policy revised 2/21/17 indicated: "The physician must be promptly notified of omission, or refusal, of any medication which causes the resident discomfort, or jeopardizes health and safety. All other omissions or refusals will be reported to the physician after missing three (3) consecutive doses."	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		1/15/18

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F 582	Continued From page 34 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility Medicare Beneficiary Notices, it was determined the facility failed to provide services in	F 582	1. Resident # 62 was discharged from her Medicare Part A stay on 8/12/17. An Advanced Beneficiary Notice was not	

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F 582	Continued From page 35 accordance with applicable Federal regulations for 2 of 3 discharged resident closed records reviewed, (Residents #62 and #396) . The findings included: On review of the Beneficiary Notification Checklists provided by the facility to surveyors it was noted that no residents were listed for having been issued the SNF ABN(Skilled Nursing Facility-Advanced Beneficiary Notice, form CMS-10055). Each resident had received a NOMNC ((Notice of Medicare Provider Non-Coverage- form CMS-10123), however no copies of the SNF ABN(CMS-10055) were provided. On 12/6/17 at 2:20 PM, the facility Administrator stated during interview that the facility does not issue a SNF ABN when Medicare Part A is discontinued by the provider. She provided a copy of the facility Policy titled Generic Notice of Medicare Provider Non-Coverage, revised 2/21/17. The policy did not reference the SNF ABN. The facility Policy states only that the NOMNC is issued. On 12/6/17 at 3:00 PM, the facility Social Worker was interviewed; she confirmed that only the NOMNC is issued to residents. Resident # 62 started a Medicare Part A stay on 7/31/17, and the last covered day of this stay was 8/14/17. Resident #62 remained in the facility with days remaining in the benefit period, and should have been issued a SNF ABN(CMS-10055) and an NOMNC(CMS-10123). Only an NOMNC was issued, with verbal notification to the family on 8/10/17.	F 582	issued. No immediate correction is possible. Resident #396 was discharged form her Medicare Part A stay on 11/17/17. An Advanced Beneficiary Notice was not issued. No immediate correction is possible. 2. All residents are at risk if an Advanced Beneficiary Notice is not issued when Medicare covered services are ending. 3. The Social workers were inserviced on Sentara Life Care policy entitled Notice of Medicare Non Coverage and Advanced Beneficiary Notice developed on 12/12/17 specifically regarding when to issue an Advanced Beneficiary Notice. 4. The Director of Social Services will audit all Notices of Medicare Non Coverage weekly x 45 days to assure an Advanced Beneficiary Notice was issued when indicated. The audits will be summarized by the Director of Social Services and presented to the QAPI committee for recommendations and additional oversight.	

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F 582	Continued From page 36 Resident #396 started a Medicare Part A stay on 11/10/17, and the last covered day of the stay was 11/19/17. Resident #396 remained in the facility with days remaining in the Medicare benefit period. She should have been issued a SNF-ABN and an NOMNC; only an NOMNC was issued. This NOMNC was signed by the resident representative on 11/15/17. No additional information was provided prior to exit.	F 582		
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 resident interview, facility staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 26 residents in the survey sample were free from neglect, Resident #46.	F 600	1. Resident #46 shared with surveyors during the group meeting on 12/5/17 she waited 2 hours for incontinence care on 11/30/17. No immediate correction is possible. The Certified Nursing Assistant assigned to resident #46 on 11/30/17 was	1/15/18

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	495215	A. BUILDING _____ B. WING _____	12/11/2017

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F 600	Continued From page 37 On 11/30/17 the facility staff failed to respond to the call bell for Resident #46 in a timely manner. The resident stated she had rang the call bell due to being incontinent of bladder and needed staff to render incontinence care. The call bell was activated at 4:09 AM and was not responded to for two hours. The resident had been left wet for two hours. The findings included: Resident #46 was admitted to the facility on 7/2/15 with current active diagnosis of Multiple Sclerosis (MS-a chronic, slowly progressive disease of the central nervous system-Taber's Cyclopedic Medical Dictionary). The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 10/11/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident required extensive assistance of one staff for toileting and was always incontinent of both bladder and bowel. The resident was wheelchair bound and had range of motion limitations to both lower legs. On 12/05/17 at 11:42 AM, the resident was observed sitting up in a wheelchair in the hallway. A request to conduct an interview was granted by the resident. The resident then propelled herself into her room, During the resident interview Resident #46 stated she had experienced a CNA (Certified Nurse Aide) being "argumentative" with her during care. When asking the CNA to wipe an area on her buttocks due to it feeling wet the CNA stated it was not wet and "swiped" the area.	F 600	suspended on 12/5/17 pending investigation. She was subsequently terminated on 12/14/17. 2. All residents needing assistance with incontinence care are at risk of being neglected if not assisted promptly. 3. 100% of the facility staff will be educated on Sentara Life Care policy entitled Abuse, Freedom From, revised 1/17/17 to include provision of services to meet the needs of residents on 1/2/18-1/12/18. 4. The Patient Advocate (or designee) will visit 5 residents weekly x 45 days to assess for perceived timeliness of call bell response times. The audits will be summarized by the Director of Nursing and reported to the QAPI committee for recommendations and additional oversight.	

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The resident stated she had reported her concern to staff and named the person she had reported this to (later identified as the unit manager). The resident continued to state that on 10/30/17 it took the staff two hours to respond to a call bell. She stated she put the call bell on because she was wet and needed incontinence care to be provided. The resident stated she had documented this on a note pad at the bedside. The note pad was reviewed and there was an entry authored by the resident that on 11/30/17 it took two hours for the staff to answer the call bell.

Prior to this resident interview the resident had attended the Resident Council meeting facilitated by another inspector. The following notes were obtained from this meeting and read in part: 12/05/17 at 10:13 AM: Resident council meeting. short of staff - concern expressed. two staff on each unit at times. Call bells not answered timely. Resident #46 soaking wet. How do you feel about that. She does not like it. Resident #46 (informs) address the nurse on the floor of her concerns. Residents feel they are under stress if they make a complaint. Night shift staff talk down to-Resident #46- she has reported and it continues to happen. She has documentation and bring {sic} it up during care plan meetings. The Resident Council meeting was attended by 6 residents and one activity staff.

Following the Resident council meeting the activity staff immediately reported Resident #46's allegation.

On 12/6/17 at 4:36 PM, a request to review of any and all grievances for Resident #46 was made to the Director of Nursing (DON). This same day at

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5:52 PM. a grievance form was handed to this inspector. The form titled Incident Abstract Report, report date 12/5/17 read, in part: Event description-Resident stated staff took 2 hours to answer the call bell. When she rendered care, the resident stated the staff member was argumentative. The DON also provided a Facility Reported Incident (FRI) form dated 12/5/17 notifying the State Survey Agency, Adult Protective Agency, the Representative Party and physician of an allegation of abuse/mistreatment. The incident was described as: Resident stated during a Resident Council Meeting that "night shift" staff argue with her," Clinical Manager followed up immediately and meet with patient. Patient stated that on 11/20/17 at 0500 C.N.A (Certified Nurse Aide#5) was "argumentative" with her when she needed assistance being cleaned. The staff was identified and immediately suspended pending investigation.

On 12/7/17 at 11:20 a.m., an interview was conducted with the unit manager. She stated the resident had expressed that her preference was to be woken up every night at 2:00 a.m., to be changed due to incontinence and history of a rash. The care plan was reviewed and was not revised to include the residence preference for staff to wake her up and check her for incontinence. When asked if this should have been care planned the unit manager stated, "I didn't think about it going on the care plan, but it makes sense." The unit manager also stated she was not made aware of the staff taking two hours to answer the call bell. The unit manager was asked if residents had expressed concerns about insufficient staffing and call bells not answered in a timely manner she stated, "Yes".

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The unit manager provided to this inspector a typed note that read: 12/7/17- I spoke with (CNA#5)on Tuesday December 5, 2017 in regard to a complaint from resident in 240. Resident stated she rang the call bell approximately 0310 and no on answered it till about 0513. When (CNA#5) went in the room, she was argumentative per the resident. The resident wanted the top sheet changed because she felt it was wet and (CNA#5) stated it is only water. (CNA#5) said in our conversation on the phone that she does not use wipes on the resident, she uses a washcloth. The sheets could have gotten wet from the washcloth and wet gloves. She did remove the sheet and left the blanket only. She stated she got to her as soon as possible. 12/8/17- I followed up with the resident in 240 on Friday, December 8,2017. The resident was asked if she felt the staff member was being verbally abusive. She stated no she was having trouble with her gown and felt she was not assisting her as she should have.

On 12/8/17 and 12/11/18 an attempt to interview the night shift CNA#5 who was assigned to care for Resident #46 on 11/30/17 was made during the survey. The phone number provided when called was answered by a message that stated the phone was not able to receive messages.

On 12/8/17 at 11:40 AM, certified nurse aide (CNA) #3 was interviewed. She was asked to give examples of neglect. Two examples she gave were "not being changed and being left wet, and not answering call bells in a timely manner". When asked what was timely, she stated, "A couple of minutes". When asked if ten minutes was too long to respond to a call bell, she stated, "Yes, especially if the patient needs your help".

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On 12/8/17 at 11:55 AM, CNA #4 was interviewed. She was asked to give examples of neglect. One example she stated was "Not answering the call bells". When asked what is the time frame to respond to a call bell she stated, "Ideally, immediately...within a few minutes". She was asked if ten to fifteen minutes response time was okay, she stated, "That is way too long".

A review of the call be system Detailed Patient Activity Report" from 11/1/17 through 12/7/17 evidenced on 11/30/17 that at 04:09 am the call bell was placed/activated and the call bell was canceled 2:00:35 hours later. This findings supports the residents allegation that it took two hours for staff to respond to her call bell on 11/30/17. Further investigation of the Detailed Patient Activity Report evidenced frequent long response times to call bells for Resident #46 as follows:
1. On 15 occasions the call bell response time was between 18-20 minutes.
2. On 10 occasions the call bell response time was between 23-30 minutes.
3. On 2 occasions the call bell response time was between 45-50 minutes.

On 12/08/17 at 12:53 PM, and interview was conducted with the Director of Nursing (DON). The above response time findings was shared. The DON was asked, What is the expected response time to call bells? She stated, " I would expect the call bells to be answered within ten to fifteen minutes". When asked, "Is failure to answer a call bell in a timely manner neglect?" She stated, "Yes, I agree". When asked ,"Would you consider waiting two hours for the call bell to

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F 600	Continued From page 42 be answered to be neglect?" She responded "That is unacceptable." Review of the facility's Policy and Procedure title Abuse-Freedom From, revised 11/23/16 read, in part: Purpose- Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The above findings was shared during the pre-exit meeting conducted with the Administrator, the DON and Director of Clinical Services on 12/11/17. No additional information was provided prior to exit.	F 600		
F 623 SS=D	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. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		1/15/18

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F 623	Continued From page 43 (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; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 44 (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: Based on staff interview and record review the facility staff failed to send a copy of the notice of transfer or discharge to the representative of the	F 623	1. A notice of discharge for resident #96 was sent to the Office of the State Long Term Care Ombudsman on 12/27/17.	

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F 623	Continued From page 45 Office of the State Long-Term Care (LTC) Ombudsman for 1 of 3 discharged resident closed records reviewed, Resident #97. The findings included: Resident #97 was admitted to the facility on 8/8/17 for skilled services following a hospitalization. The resident's diagnoses included but not limited to, brain stem cancer and diabetes. The admission MDS (Minimum Data Set) with an assessment reference date of 8/15/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. On 12/07/17 at 05:16 PM, the resident's record was reviewed. The nurses notes documented that on 9/6/17 the resident had a change of condition with complaints of abdominal pain. The MD was notified and an order for a KUB (abdominal X-ray) was obtained. The X-ray was positive for an ileus (intestinal obstruction), the resident was transferred to the hospital for further evaluation and admitted. On 12/7/17 at approximately 6:30 PM, a request was made to the Administrator for evidence to support that the ombudsman office was provided a notice of discharge. 12/08/17 10:05 AM, the Administrator provided a copy of the Policy and Procedure titled Transfer, Discharge & Room Change dated 12/31/16. The Administrator stated the facility did not provide a notice of discharge to the Office of the State Long-Term Care (LTC) Ombudsman for Resident	F 623	2. All residents who are the subject of a facility initiated discharge are at risk if notification to the State Long Term Care Ombudsman is not made. 3. The Social workers will be educated on the requirements to notify the State long Term Care Ombudsman Office and to document this notification in the resident's medical record for all facility initiated discharges on 1/2/18-1/12/18. 4. The Director of Social Services will audit all facility initiated discharges x 45 days to assure a notice was provided the Office of the State Long Term Care Ombudsman office. The Director of Social Services will summarize these audits and present to the QAPI committee for recommendations and additional oversight.	

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F 623	Continued From page 46 #97's discharge to the hospital. The aforementioned policy read, in part: Purpose: To provide patients, residents or resident representative notice of transfer or discharge. Documentation concerning transfer or discharge of a resident must be documented in the clinical record. 5. The facility will send a list of transfers discharges monthly at a minimum to the State Long-Term Care Ombudsman. No additional information was provided prior to exit to support compliance.	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.	F 625		1/15/18

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F 625	Continued From page 47 §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 by: Based on staff interview and record review the facility staff failed to send a copy of the Notice of Bed-Hold Policy and return for 1 of 3 discharged resident closed records reviewed, Resident #97. The findings included: Resident #97 was admitted to the facility on 8/8/17 for skilled services following a hospitalization. The resident's diagnoses included but not limited to,brain stem cancer and diabetes. The admission MDS (Minimum Data Set) with an assessment reference date of 8/15/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. On 12/07/17 at 05:16 PM, the resident's record was reviewed. The clinical notes documented that on 9/6/17 the resident had a change of condition with complaints of abdominal pain. The MD was notified and an order for a KUB (abdominal X-ray) was obtained. The X-ray was positive for an ileus (intestinal obstruction), the resident was transferred to the hospital for further evaluation and admitted. On 12/7/17 at approximately 6:30 PM, a request was made to the Administrator for evidence to	F 625	1. Resident #97 was discharged from the facility to an acute care hospital on 9/6/17 and subsequently expired. No immediate correction is possible. 2. All residents requiring emergent transfer to the hospital are at risk of not receiving the notice of the facility's bed-hold policy in writing. 3. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Bed Hold, revised 1/17/17 to include notification of the bed hold policy at the time of transfer on 1/2/18-1/12/18. 4. The Clinical Manager (or designee) will audit all emergent transfers to the hospital weekly x 45 days to assure notices were issued at the time of transfer. The audits will be summarized by the Director of Nursing and presented to the QAPI committee for recommendations and additional oversight.	

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F 625	Continued From page 48 support that the facility provided written information of the Notice of Bed-Hold Policy to the resident or resident representative prior to transfer to the hospital. 12/08/17 10:05 AM, the Administrator provided a copy of the Policy and Procedure titled Life Care-Bed Hold dated revised on 1/17/17. The Administrator stated the facility did not provide the notice of bed-hold policy to Resident #97 prior to discharge to the hospital. She stated this requirement is part of the new process now, and stated "prior to this I'm not sure it was being done". She further stated the Notice of Bed-Hold Policy would have been scanned to the electronic record. The aforementioned policy read, in part: Policy statement: It is the facility policy to inform the resident or resident representative of the durations of the bed-hold policy, If any, during which the resident is permitted to return and resume residence when admitted to an acute care facility or goes on therapeutic leave. 1. Resident or Resident Representative will be provided a "Notice of Bed Hold Policy" letter at time of transfer; if not immediately possible, notification will be at first available opportunity 2. Notice of bed hold policy will be provided with transfer documents. No additional information was provided prior to exit to support compliance.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		1/15/18

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F 655	Continued From page 49 §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.	F 655		

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F 655	Continued From page 50 (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review and clinical record review the facility staff failed to ensure a summary of the base line care plan was received by 1 resident (Resident #351) of 26 residents in the survey sample. The findings included: Resident #351 was admitted to the facility on 12/2/17. Diagnoses for Resident #351 included but are not limited to Emphysema* (1) and Diabetes Mellitus* (2). Resident #351's Interim Care Plan documented the following: Resident Need: Oxygenation related to COPD (Chronic Obstructive Pulmonary Disease), Emphysema Start Date: 12/3/17 Approaches included but were not limited to: Evaluate respiratory status every shift and as needed Oxygen per Medical Doctor order Resident #351 current Physician orders included no orders for Resident #351 to have, use and provide care for his personally owned CPAP unit. The Interim Care Plan did not document that Resident #351 was admitted with his own personal owned CPAP (Continuous Positive Airway Pressure) unit and that Resident #351	F 655	1. Resident #351 was discharged on 12/15/17. No immediate correction is possible. 2. All newly admitted residents are at risk if a baseline care plan is not initiated within 48 hours. 3. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Baseline Care Plan, revised 1/17/17 to include initiation of the baseline care plan within 48 hours of admission on 1/2/18-1/12/17. 4. The Clinical Manager (or designee) will audit all new admissions weekly x 45 days to assure a baseline care plan was initiated and reviewed with the resident or resident representative. The audits will be summarized by the Director of Nursing and presented to the QAPI committee for recommendations and additional oversight.	

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F 655	Continued From page 51	F 655		

was performing his own care to his unit. In addition, the Interim Care Plan did not document any specifics related to what type of care the CPAP unit required.

On 12/8/17 at approximately 11:50 AM, Social Worker #8 was asked if Residents or Responsible Parties were provided a summary of the Baseline Care plan. She stated, "We haven't started that policy. I just heard about the new regulation last week. Currently we will give if asked for it."

On 12/8/17 at approximately 12:15 PM, the Director of Admissions Social Services was asked if residents were provided a summary of their care plan. She stated, "We have not been giving summaries of the care plan."

On 12/8/17 at approximately 4:00 PM, Resident #351 stated, "No." when asked if he had received a summary of his baseline carnelian since admission.

The Facility Policy and Procedure titled, "Baseline Care Plan" with a revision date of 1/17/17 documented the following:

The facility will provide the resident and/or representative a summary of the baseline care plan to include but not limited to:
A. The initial goals of the resident
B. Summary of residents medications and dietary instructions
C. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility

The facility administration was informed of the

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F 655	Continued From page 52 findings during a briefing on 12/11/17 at approximately 6:10 p.m. The facility did not present any further information about the findings. Definitions: 1. Emphysema: Medline Plus documented: Emphysema is a type of COPD involving damage to the air sacs (alveoli) in the lungs. As a result, your body does not get the oxygen it needs. Emphysema makes it hard to catch your breath. You may also have a chronic cough and have trouble breathing during exercise. 2. Diabetes Mellitus: Medline Plus documented: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high.	F 655		
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 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	F 656		1/15/18

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F 656	Continued From page 53 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 staff interview, clinical record review and facility document review the facility staff failed to develop a care plan for 1 of 26 residents in the survey sample, Resident #23. The facility staff failed to develop a care plan for Resident #23 who was receiving an anticoagulation medication (Eliquis). The findings included: Resident #23 was originally admitted to the nursing facility on 01/12/16. Diagnosis for included but not limited to *Atrial Fibrillation. The current Minimum Data Set (MDS) a quarterly	F 656	1. Resident #23's care plan was developed for the use of an anticoagulation medication on 12/7/17. 2. All residents on anticoagulation medications are at risk if the care plan is not developed. 3. 100% of licensed nursing staff will be educated on Life Care policy entitled Comprehensive Care Plan revised 12/12/17 to include staff participation in the care planning process 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit new physician orders weekly x 45 days for identification of any new anticoagulation orders requiring a	

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F 656	Continued From page 54 assessment with an Assessment Reference Date (ARD) of 09/20/17 coded the resident with a 06 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The residents MDS was coded for the usage of anticoagulant. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an anticoagulant for 7 days. The resident had a Physician order dated 8/15/17: *Eliquis 2.5 mg tablet twice daily upon rising and at bedtime. The review of Resident 23's comprehensive care plan did not include a care plan for the use of an anticoagulation medication. An anticoagulation care plan was given to the surveyor that was created on 12/07/17 at 4:40 p.m., but only created after it was requested by the surveyor from the Administrator on 12/07/17 at 11:35 a.m. The review of the anticoagulation care plan included but not limited to following information: Resident is at risk for adverse bleeding related to anticoagulant secondary to diagnosis of A-Fib. Goal: to prevent and promptly detect and report bleeding. Interventions: Give medication as ordered, report bruising or bleeding to charge nurse, monitor for signs and symptoms (s/s) of bleeding such as: blood in urine, dark/tarry stools and report to nurse, report bruising or bleeding to charge nurse and monitor for nausea/vomiting (n/v), diarrhea, elevated liver function test, rash, fever and headaches.	F 656	comprehensive care plan to address its use. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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F 656	Continued From page 55	F 656		

An interview was conducted with RN #3 (MDS Coordinator) on 12/8/17 at approximately 10:55 a.m., who stated she was asked if there was an anticoagulation care plan, but after the review of the care plan she realize there wasn't one, so one was created. The surveyor asked if there should have been an anticoagulation care plan because the resident was taking the medication Eliquis, she replied, "Yes, there should have been an anticoagulation care plan."

The facility administration was informed of the findings during a briefing on 12/11/17 at 5:50 p.m. The facility did not present any further information about the findings.

The facility's policy: Life Care - Comprehensive Care Plan (Revision Date: 01/17/17).
Purpose: Establishment periodic review of current patient-centered plan of care for each resident to assure a systematic, comprehensive approach to assessing, planning, and periodic review in meeting the resident's needs.

Comprehensive Care Plan have included but not limited to:
-Identify problem areas and address associated risk factors.

*Atrial Fibrillation is the most common type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm. (Source: www.Nhlbl.nih.gov)

*Eliquis is used help prevent strokes or blood clots in people who have Atrial fibrillation (a condition in which the heart beats irregularly,

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F 656	Continued From page 56 increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease (https://medlineplus.gov/ency/article/007365.htm).	F 656		
F 657 SS=E	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. (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 observations, clinical record reviews, staff interviews and facility policy review, the	F 657	1. Resident #63's care plan was revised on 12/19/17 to reflect use of a	1/15/18

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F 657	Continued From page 57 facility staff failed to revise care plans in accordance to their needs for 6 out of 26 residents (Resident #63, #351, #358, #41, #13, #46 and #147) in the survey sample. 1. Resident #63's care plan was not revised to include the current use of a Geri-lounger, use of the gait belt to prevent potential injuries to staff and resident during transfers and her inabilities to alert staff for assistance due to severe Alzheimer's disease. 2. The facility staff failed to revise Resident #351's care plan to include his independence for performing care for his privately owned CPAP unit and failed to specify the specifics of the care of the device. 3. The facility staff failed to revise Resident #358's care plan to include her independence in performing the treatment to her orthopedic surgical PINS and surgical incisions, as well as the specifics of the treatment. 4. The facility staff failed to revise Resident #41's care plan after the Foley catheter was discontinued on 11/22/17. 5. The facility staff failed to revise Resident #13's current person-centered, comprehensive care plan to include activity preferences based on the comprehensive assessment. 6. The facility staff failed to revise Resident #46's care plan to include her preference for being awakened at 2:00 am every day to ensure incontinence care is provided in a timely manner. 7. The facility staff failed to revise the care plan	F 657	geri-lounger and a gait belt. Resident #351's care plan was revise don 12/11/17 to reflect self-cleaning of his CPAP mask. Resident #358 discharged on 12/16/17. No immediate correction is possible. Resident #41's care plan was updated on 12/6/17 to reflect discontinuation of her foley catheter. Resident #13's care plan was updated on 12/6/17 to reflect her preferred activities. Resident #46's care plan was updated on 12/27/17 to reflect her desire to be awakened at 0200 for incontinence care. The order for administration of insulin and blood glucose monitoring for resident #147 was clarified on 12/13/17 for staff to perform. No care plan update was necessary. The care plan for resident #147 was updated on 12/7/17 to reflect use of an anticoagulant medication. 2. All residents are at risk if comprehensive care plans are not revised when changes occur. 3. 100% of all licensed nursing staff, and members of the interdisciplinary team will be educated on Sentara Life Care policy entitled Comprehensive Care Plan revised 12/12/17 to include staff participation in the care planning process and required revisions on 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will interview 5 staff members weekly x 45 days to inquire about necessary updates to care plans. The MDS staff will audit 10% of new physician orders weekly x 45 days to assure care plan updates have been added to the care plans. The audits will be summarized by the DON and presented to the QAPI committee for	

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F 657	Continued From page 58 for the use of insulin, monitoring of blood glucose and the administration of anticoagulant medications for Resident #147 The findings included: 1. Resident #63's care plan was not revised to include the current use of a Geri-lounger, use of the gait belt to prevent potential injuries to staff and resident during transfers and her inabilities to alert staff for assistance due to severe Alzheimer's disease. Resident #63's care plan was not revised to include the current use of a Geri-lounger, use of the gait belt to prevent potential injuries to resident during transfers, or address her inabilities to alert staff for assistance, understand instructions and make everyday choices due to severe Alzheimer's disease. Resident #63 was admitted to the nursing facility on 1/19/16 with diagnoses that included severe Alzheimer's dementia, seizure activity and osteoporosis. The resident was re-admitted to hospice care on 7/25/17 due to failure to thrive. The most recent Minimum Data Set Assessment (MDS) was a quarterly dated 10/26/17 coded the resident impaired with short and long term memory and severely impaired with the skills for decision making. The resident was coded to require total assistance from one staff for transfers. The assessment indicated the resident was not steady to move from a seated to standing position without assistance. This assessment coded the resident to be at risk for falls and to have fallen two or more times without injury. The MDS coded the resident with inabilities to	F 657	recommendations and additional oversight.	

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communicate to understand staff or be understood. Resident #63 was also assessed to have vision problems.

The Significant Change in Status Assessment MDS dated 8/2/17 coded the resident to be walking in the room and in the corridors with assistance of one staff. The resident was assessed to have fallen two or more times without injury and one time with injury.

The Significant Change in Status Assessment MDS dated 7/7/17 coded the resident to have fallen within the last month, within 2-6 months and sustained a fracture related to a fall in the last 6 months.

The current care plan dated as revised on 11/22/17 identified the resident was in a high back wheel chair and to continue rest periods. The care plan also indicated the staff should assess her ability to see and identify surroundings, instruct her on safety measures, keep call light within reach and instruct her to use it to call out for assistance, instruct her on safety measures to reduce the risk of falls (posture, changing positions, use of handrails), remind her to call for assistance before moving from bed to chair and from chair to bed, respond promptly to call bells, assist resident to discuss her feelings, honor resident's right to choose and educate the resident on appropriate foods. The care plan identified the resident was at risk for falls, had repeated falls with injuries and major injury. The care plan did not plan for the use of a Geri-lounger while out of bed, nor did the care plan plan for the use of a gait belt for resident safety during transfers. The resident no longer had a high back wheel chair.

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The hospice care plan dated 9/12/17 also identified the resident was at risk for falls and had falls in the facility with major injuries to include significant skull fracture, wrist and femur fracture. This care plan identified the resident was unsteady and remained at risk for falls especially if she were ambulating or attempting to ambulate without assistance. The hospice care plan identified the resident required assistance but would never ask for it.

Resident #63 was observed in the dining area of the locked unit, reclined in a Geri-lounger while out of bed, during the survey days of 12/4/17, 12/5/17, 12/6/17, 12/7/17, 12/8/17 and 12/11/17. She was not communicative in any way and was confused to person, place and time.

On 12/11/17 at 10:10 a.m., two surveyors observed Certified Nursing Assistant (CNA) #1 to transfer Resident #63 from bed to Geri-Lounger. The resident was able to weight bear on both legs turn and pivot, but unsteady, to transfer to the lounger. The CNA stated this transfer technique was the way he always transferred the resident, although all the ADL sheets recorded 4/2 (total assist with one staff). The CNA stated the resident was unable to communicate any of her needs, use the call bell to alert staff for assistance of any kind or make choices for anything due to the affects of Alzheimer's disease. He stated the resident had no other chair for several months than the Geri-lounger when out of bed and they had to lean her back at all times because she would try to get up and would fall. He said when he gets her up in the morning she is placed only in the Geri-lounger for the entire day.

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An interview was conducted with the unit's clinical manager Registered Nurse (RN) #1 on 12/11/17 at 1:30 p.m. She stated the resident was able to bear weight, turn and pivot to transfer from bed to chair and from chair to bed, and she had performed this transfer with the resident on many times, although she is currently very unsteady. When asked why the MDS assessed the resident as a 4/2, indicating she did not participate in any way during transfers, she stated they were going by what the CNA's recorded which was incorrect and should be recorded as 3/2 (extensive assist of one staff). In addition, RN #1 stated a mechanical lift was never used to transfer the resident. The RN stated the resident has been in a Geri-lounger for months, leaned back to keep her from attempting to get up.

A later interview with RN #1 on 12/11/17 at 3:09 p.m., she stated she spoke with CNA #1 and was informed by him, he mostly took the resident under her arms and transferred her to and from the chair and bed which was not an appropriate way to transfer the resident. She stated she expected the staff to use a gait belt as an assistance device, per the facility's policy, to ensure the resident's safety during all transfers in that she could bear weight, stand a pivot. RN#1 stated Resident #63 was unable to use a call bell, make choices or be able to independently implement any safety measures because of her severe Alzheimer's disease.

On 12/7/17 at 5:15 p.m., an interview was conducted with the Director of Nursing (DON) and two MDS coordinators, along with the presence of three surveyors and a federal contracted surveyor. The MDS coordinators last assessed

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Resident #63 to be able to stand and bear weight, but had coded her as totally dependent on staff for transfers. They were unaware of how the Geri-lounger was currently being used. The DON stated the Geri-Lounger was only to be used for rest breaks, but could not say where or what the resident was resting from because she did not ambulate and was only observed in the Geri-lounger throughout the day when out of bed.

On 12/8/17, at 11:19 a.m., a telephone interview was conducted with Resident #63's assigned hospice nurse. She stated in July 2017, the resident was in a high back wheel chair and was leaning too far forward resulting in a fall out of that type of chair. She said, the Geri-lounger was used for rest from ambulating up until around October 2017 where the Geri-lounger became the safest choice when out of bed. She stated the resident would probably still try to get out of bed and attempt to walk which would result in falling due to her unsteadiness. She said at this point, hospice services was not actively searching for any other chair.

On 12/11/17 at 5:50 p.m., the aforementioned issue was re addressed with the DON and brought to the attention of the Administrator. No further information was provided prior to survey exit.

The policy and procedures titled "Comprehensive Care Plan" dated 1/17/17 indicated "...Care plans will be reviewed and updated as needed to reflect changes...For quarterly reviews, each trigger will be addressed by the Interdisciplinary Team and goals and approaches will either be revised or issued a date resolved..."

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2. The facility staff failed to revise Resident #351's care plan to include his independence for performing care for his privately owned CPAP unit and failed to specify the specifics of the care of the device.

Resident #351 was admitted to the facility on 12/2/17. Diagnoses for Resident #351 included but are not limited to Emphysema* (1) and Diabetes Mellitus* (2).

Resident #351's Interim Care Plan documented the following:

Resident Need: Oxygenation related to COPD (Chronic Obstructive Pulmonary Disease), Emphysema Start Date: 12/3/17

Approaches included but were not limited to:

Evaluate respiratory status every shift and as needed
Oxygen per Medical Doctor order

Resident #351 current Physician orders included no orders for Resident #351 to have, use and provide care for his personally owned CPAP unit.

The Interim Care Plan did not document that Resident #351 was admitted with his own personal owned CPAP (Continuous Positive Airway Pressure) unit and that Resident #351 was performing his own care to his unit. In addition, the Interim Care Plan did not document any specifics related to what type of care the CPAP unit required.

On 12/4/17 at approximately 1:15 PM, Resident #351's CPAP mask was observed lying on top of

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his bedside table. The tubing for it was lying in his opened bedside table drawer without a date as to when it was last cleaned or changed.

On 12/4/17 at approximately 5:45 PM, Resident #351's CPAP mask was observed lying on top of his bedside table. The tubing for it was lying in his opened bedside table drawer without a date as to when it was last cleaned or changed.

12/06/17 at approximately 03:35 PM, Resident #351 was observed in his Room, oxygen at 2 liters via nasal cannula. Resident stated, "Therapy went well." Non dated 1 liter opened bottle of Sterile water observed at bedside.

12/07/17 at approximately 10:02 AM, Resident #351 was observed in his room with the Unit Manager #4 in attendance. 1 Liter opened Sterile Water undated bottle was observed at bedside. The Unit Manager #4 removed the undated bottle of Sterile Water. The Unit Manager #4 and Surveyor looked at CPAP tubing it was dated 12/5/17. The CPAP mask was not with the CPAP tubing. Asked what the practice was for storage of sterile water. The Unit Manager #4 stated that she's only been here a short time, and it is practice to date bottles when open. The Unit Manager #4 stated it should be stored in his locked cabinet in his room which it was not. The Unit Manager #4 stated that she was not sure where the mask is, she stated that she has been teaching staff that night shift usually changes tubing or if someone is in there and sees it needs to be changed at any time. The Unit Manager #4 stated tubing is getting changed Midnight shift on Tuesday nights. When asked what the facility practice is when a resident is admitted with undated tubing, the Unit Manager #4 stated, "I

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guess the admission nurse should change tubing and date so that we know when it was last done and then it would be done on midnight shift every Tuesday after that."

Resident #351 was observed on 12/07/17 at approximately 05:27 PM eating in dining room and sitting in a wheel chair. Resident #351 stated "I clean my own mask (CPAP). I put the water in the CPAP and sometimes the girls do it. I doubt they even know I clean the mask. I clean it with soap and water every day."

On 12/08/17 at approximately 3:00 PM, the Director of Nursing (DON) was asked if it is the expectation that Resident #351's Care Plan be updated/revised to include information that he is independently performing his care for the CPAP unit, and to include the specifics of the care. The DON stated, "Yes, it would be the expectation."

The Facility's Policy and Procedure titled, "Positive Airway Pressure (PAP) Devices: Equipment Cleaning" with a revision date of 6/23/16 documented the following:

PAP Equipment will be maintained in clean condition.
Clean headgear and tubing once a week and as needed.
Wash/wipe clean nasal pillows or mask daily as needed.
Clean the flow generator once a week and as needed.
Clean devise filters once a week and as needed.
Empty daily, refill with distilled or sterile water nightly.
Clean humidifier reservoir weekly.

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The Facility's Policy and Procedure titled, "Baseline Care Plan" with a revision date of 1/17/17 documented the following:

Purpose: To establish the minimum health information necessary to properly care for the resident.
Action Steps: Within 48 hours the facility to establish baseline care plan necessary to properly care for patient and/or resident.
A. Initial goals based on admission orders
B. Physician orders
C. Dietary order
D. Therapy services
E. Social Services
The facility will provide the resident and/or representative a summary of the baseline care plan to include but not limited to:
A. The initial goals of the resident
B. Summary of residents medications and dietary instructions
C. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

The facility administration was informed of the findings during a briefing on 12/11/17 at approximately 6:10 p.m. The facility did not present any further information about the findings.

Definitions:
1. Emphysema: Medline Plus documented: Emphysema is a type of COPD involving damage to the air sacs (alveoli) in the lungs. As a result, your body does not get the oxygen it needs. Emphysema makes it hard to catch your breath. You may also have a chronic cough and have trouble breathing during exercise.
2. Diabetes Mellitus: Medline Plus documented:

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Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high.

3. The facility staff failed to revise Resident #358's care plan to include her independence in performing the treatment to her orthopedic surgical PINS and surgical incisions, as well as the specifics of the treatment.

Resident #358 was admitted to the facility on 11/28/17. Diagnoses for Resident #358 included but are not limited to Fracture of lower end of Left Radius* (1), Fracture of Right Tibia* (2), Chronic Pain Syndrome* (3), Anxiety Disorder* (4), Depression* (5), and Manic Depression* (6).

Resident #358's Admission Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 12/5/17 coded Resident #358 with a BIMS (Brief Interview for Mental Status) with a 15 of 15 indicating no cognitive impairment. In addition, Resident #358 was coded as requiring limited assistance with one staff person assistance for transfer, toilet use and dressing. Resident #358 was coded as always continent of urinary and bowel functions.

Resident #358's Hospital Discharge Instructions included the following:

Discharge: Pin Care Instructions: page 5 of 6
Once a day wash around the pin sites with warm soapy water and anti bacterial soap and a wash cloth.
If pin sites become more red and painful or have increased drainage then wash pin sites twice per day. If the redness/drainage/pain continue please call us.

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You may take a shower and wash your Ex-fix and/or K-wire sites in the shower with warm soapy water and antibacterial soap.

Do not soak your extremity that has an Ex-fix and/or K-wires. No baths or hot tubs.

Discharge: Wound Care: Daily dry dressing changes to medial and lateral incision/sutures on left lower leg and left arm.

From the document December 2017 Physician Order sheet the following were documented:

Left leg: dry dressing:

Left arm: dry dressing

Pin Care to left arm fixator daily: Notes: Pin care to left arm fixator Pin sites daily

Pin Care to left arm fixator daily: Notes: Pin care to left arm fixator pin sites daily

cover left tibia surgical site with xeroform gauze cover with dry dressing cover with Kerlix daily

A 11/29/17 12:22 PM Physician Order documented the following: Pin Care to Left Arm fixator daily Notes: Pin Care to Left arm fixator pin sites daily.

A 12/7/17 19:31 (7:31 PM) Clarification Physician Order documented the following: pin care with soap and water daily to left tibia fixator

A 12/8/17 5:32 AM Clarification Physician Order documented the following: pin care with soap

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F 657	Continued From page 69 and water to left arm fixator daily Resident #358's Treatment Administration Record (TAR) for November 2017 documented the following: Left leg One time daily starting 11/28/17 dry dressing and was discontinued on 12/8/17 Left arm one time daily starting 11/28/17 dry dressing and discontinued on 12/8/17 Pin Care to Left arm fixator daily one time daily starting 11/29/17 and discontinued 12/7/17 Notes: Pin Care to left arm fixator Pin sites daily Cover left tibia surgical site with xeroform gauze cover with dry dressing cover with Kerlix daily one time daily starting 11/29/17 and discontinued on 12/7/17 Pin care to left tibia fixator daily one time daily starting 11/29/17 and discontinued 12/7/17 Left leg one time daily starting 11/28/17 dry dressing and discontinued 12/8/17 Left arm one time daily starting 11/28/17 dry dressing and discontinued 12/8/17 Resident #358's 11/28/17 to Present Care Plan documented the following: Problem: Impaired skin integrity related to left leg status post surgical site. External fixator pins Interventions included but were not limited to: Monitor nutrition parameters Assist resident to eat/drink adequate amount of nutrition	F 657		

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Follow prescribed treatment regimen.

Problem: Impaired skin integrity to left arm status post surgical site with external fixator pins

Interventions included but were not limited to:

Follow prescribed treatment regimen.

On 12/04/17 0 Resident #358 was observed at approximately 1:16 PM. She stated that she had Fracture to Left arm and left leg with pins and rod. The Resident stated the bones were crushed in a car accident a month ago. Resident #358 stated that the Nurses are supposed to do pin care in morning and night. Nurses aren't doing morning pin care always." The resident stated she is in a Bariatric bed. The Resident stated she talked to the Unit Manager #4 about 3 days, and reported that she stated she would talk to somebody. Resident #358 stated that she waits a long time for anyone to come in after I ring bell. Resident #358 stated, "I've waited up to 2 hours." Resident stated she can get to potty by herself but she shouldn't. Resident #358 stated that if she waited I would wet her self.

On 12/7/17 at approximately 10:30 AM, the Unit Manager #4 and surveyor entered Resident #358's room so that the surveyor could show the Unit Manager #4 Hydrogen Peroxide on the bedside table and Dermal Wound Cleanser in the drawer at the foot of Resident #358's bed. Surveyor informed the Unit Manager #4 that the Resident is performing her own wound care using hydrogen peroxide to pin sites and dermal wound cleanser to incision lines of lower left leg with steri strips. The Unit Manager #4 stated that the Educator Registered Nurse #5 had spoken to the

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resident about her wound care and attempted to removed the peroxide and the Resident would not allow it to be removed. The Unit Manager #4 was asked as the PIN care orders did not specify what to do, how would she perform pin care and she stated that she would clean with soap and water.

On 12/08/17 at approximately 3:00 PM, the Director of Nursing (DON) was asked if it is the expectation that Resident #358's specific PIN care orders should be clarified and issues with the Care Plan be updated on the Resident's care plan. The DON stated, "Yes."

On 12/8/17 at approximately 4:30 PM, Unit Manager #4 stated that the Doctor had talked with Resident #358 about hydrogen peroxide and the Resident #358 agreed for it to be removed from her room. The Unit Manager was asked if she felt all the issues with Pin Care should be updated on the care plan, and asked if PIN care instructions should be clarified and Unit Manager #4 stated, "Yes, and the orders have been clarified. The Unit Manager #4 was asked if the Care Plan was updated to address fact that the Resident had been insistent to perform her own PIN Care and the Unit Manager #4 stated, "No."

The Facility was asked to provide a Policy and Procedure for PIN Care and the DON on 12/8/17 at approximately 3:00 PM stated,
"We have no specific PIN Care Policy."

The Facility Policy and Procedure titled, "Comprehensive Care Plan" with a revision date of 1/17/17 documented the following:

Comprehensive Care Plan will:
1. Identify problem areas and address

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associated risk factors.
3. Sound and established goals, timetables, and objectives monitored through measurable objectives and outcomes.

The facility administration was informed of the findings during a briefing on 12/11/17 at approximately 6:00 p.m. The facility did not present any further information about the findings.

Definitions:

1. Fracture Radius: Fracture or break of the wrist bone
2. Fracture Tibia: Fracture or break of the leg shin bone
3. Chronic Pain Syndrome: Medline Plus documented the following: Pain is a signal in your nervous system that something may be wrong. It is an unpleasant feeling, such as a prick, tingle, sting, burn, or ache. Pain may be sharp or dull. You may feel pain in one area of your body, or all over. There are two types: acute pain and chronic pain. Acute pain lets you know that you may be injured or a have problem you need to take care of. Chronic pain is different. The pain may last for weeks, months, or even years. The original cause may have been an injury or infection. There may be an ongoing cause of pain, such as arthritis or cancer. In some cases there is no clear cause. Environmental and psychological factors can make chronic pain worse.
Many older adults have chronic pain. Women also report having more chronic pain than men, and they are at a greater risk for many pain conditions. Some people have two or more chronic pain conditions.

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4. Anxiety Disorder: Medline Plus documented: Fear and anxiety are part of life. You may feel anxious before you take a test or walk down a dark street. This kind of anxiety is useful - it can make you more alert or careful. It usually ends soon after you are out of the situation that caused it. But for millions of people in the United States, the anxiety does not go away, and gets worse over time. They may have chest pains or nightmares. They may even be afraid to leave home. These people have anxiety disorders.

5. Depression: Medline Plus documented: Depression is a serious medical illness. It's more than just a feeling of being sad or "blue" for a few days. If you are one of the more than 19 million teens and adults in the United States who have depression, the feelings do not go away. They persist and interfere with your everyday life.

6. Manic Depression: Medline Plus documented: Bipolar disorder is a mental condition in which a person has wide or extreme swings in their mood. Periods of feeling sad and depressed may alternate with periods of being very happy and active or being cross or irritable.

4. The facility staff failed to revise Resident #41's current person-centered, comprehensive care plan to include the discontinuation of a Foley catheter on 11/22/17.

Resident #41 was admitted to the facility on 7/18/17 with diagnoses to include, 1.) Chronic Kidney Disease and 2.) Diabetes Mellitus.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Quarterly with an

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Assessment Reference Date (ARD) of 10/5/17. The Brief Interview for Mental Status (BIMS) indicated that Resident #41 had long and short-term memory deficits and was severely impaired in cognitive skills for daily decision making. Under Section H Bladder and Bowel, Urinary Incontinence the resident was coded as a 9 indicating (resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days.

Resident #41's Comprehensive person-centered care plan dated 10/12/17 -Present was reviewed and is documented in part as follows:

Problem: Alteration in bladder elimination R/T (related to) Foley catheter STATUS: Active (current)

Goals: Elimination will be safely maintained through indwelling Foley catheter without signs/symptoms of UTI (urinary tract infection) through out the next 90 days.

Interventions:
1. Check tubing for kinks several times each shift.
2. Assess resident for pain, discomfort due to catheter.
3. Change indwelling catheter every month or per MD (medical doctor) order.

Observations made by surveyor while in facility:
12/04/17 11:14 AM Resident #41 lying in bed on back, no Foley catheter present.

12/06/17 2:00 PM Resident #41 up in chair watching TV no Foley catheter present.

12/07/17 11:46 AM Resident #41 up and dressed

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in wheelchair in common area listening to seasonal music activity, no Foley catheter observed. Surveyor asked Unit Manager #2 if resident #41 still has a Foley cath. Unit Manager #2 stated, "No, her catheter was discontinued.

On 12/07/17 01:50 PM Resident #41's Treatment Administration Record was reviewed for November 2017, which indicated that the Foley cath was discontinued on 11/22/17. The Physician's order was reviewed and is documented in part, as follows:

Order Date: 11/22/17 COMPLETED,
Instructions:
1. Discontinue Foley catheter.
2. Check bladder scan or straight cath after gets back to bed today.
3. Replace catheter if bladder scan/straight cath results greater than 300 milliliters.

Resident #41's Nurse's Notes were reviewed and are documented in part, as follows:

11/22/17 at 4:21 P.M.: Per Pace, resident to have Foley d/c'd (discontinued) which was done at 13:30 (1:30 P.M.) today. In and out cath to be administered prior to end of shift to determine the need for reinsertion of catheter.

11/23/17 at 8:25 A.M. Resident continue on voiding trial. CNA (certified Nursing assistant) changed resident wet brief x 2 during shift. No signs/symptoms of pain or discomfort at this time.

An interview was conducted with Unit Manager #2 on 12/07/17 at
4:25 PM. The Unit Manager made aware that Foley cath was still on Resident #41's care plan

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and asked who was responsible for updating this change for the resident on the care plan and when should have it been completed. The Unit Manager stated, "The care plan should have been updated by nursing or MDS department depending on the day the change occurred and done with in 24 hours.

On 12/08/17 10:18 AM, Resident #41's care plan was reviewed and noted to have been revised on 12/6/17 to show the Foley catheter was discontinued which is documented in part,as follows:

Problems: Name (Resident #41) is incontinent of bladder functions (Current)

Goals: Skin will remain intact during the next 90 days.

Interventions:
1. Check for incontinence; change if wet/soiled. Clean skin with mild soap and water. Apply moisture barrier.
2. Use pads/briefs to manage incontinence.

The facility policy titled, "Life Care-Comprehensive Care Plan" revised on 1/17/2017 is documented in part, as follows:

Purpose: Establishment, periodic review of current patient-centered plan of care for each resident to assure a systematic comprehensive approach to assessing, planning, and periodic review in meeting the resident's needs.

Interdisciplinary Responsibilities:
2. Care plans will be reviewed and updated as needed to reflect changes. Care plans to be

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updated within 24 hours.

On 12/11/17 at 5:50 P.M. a pre-exit conference was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

1.) Chronic Kidney Disease: any one of a large group of conditions, including infectious, inflammatory, obstructive, vascular, and neoplastic disorders of there kidney.

2.) Diabetes Mellitus: a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.

The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

5. The facility staff failed to revise Resident #13's current person-centered, comprehensive care plan to include activity preferences based on the comprehensive assessment.

Resident #13 was admitted to the facility on 12/2/2013 with diagnoses to include, 1.) Dementia, 2.) Depression, and 3.) Anxiety Disorder.

The most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 6/8/17. The Brief Interview for Mental Status (BIMS) indicated that Resident #13 had long and

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short-term memory deficits and was severely impaired in cognitive skills for daily decision making. Under Section D Mood (G.) Trouble concentrating on things, such as reading the newspaper or watching television, Resident #13 was coded Yes for symptoms present and 2-6 days for symptom frequency. In Section F Preferences for Customary Routine and Activities Staff Assessment Resident #13 was coded for all of the following to apply: E. Receiving bed bath, F. Receiving sponge bath, I. Family or significant other involvement in care discussions, K. Place to lock personal belongings, M. Listening to music, O. Keeping up with the news, P. Doing things with groups of people, Q. Participating in favorite activities, and T. Participating in religious activities or practices.

Resident #13's Comprehensive Care Plan dated 6/21/17 -9/11/17 was reviewed and is documented in part, as follows:

Problems: Name (Resident #13) participation in activities is impaired due to multiple medical problems and confusion.

Goals: Name will stimulation and socialization daily in room and verbally reply to visitors.

Interventions: Offer Name (Resident #13) distractions including family visits, television, music in room via radio and staff visit during care. Post Activity calendar in room.

Resident #13's current Comprehensive Care Plan dated 11/29/17 - Present was reviewed and is documented in part, as follows:

Problems: Name (Resident #13) participation in

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activities is impaired due to multiple medical problems and confusion.

Goals: Name will stimulation and socialization daily in room and verbally reply to visitors.

Interventions: Offer Name (Resident #13) distractions including family visits, television, music in room via radio and staff visit during care. Post Activity calendar in room.

Resident #13 observations while on survey by this surveyor:
12/04/17 12:18 PM Resident lying in bed on right side TV on non religious show. No radio noted in room.
12/05/17 10:24 AM Resident lying in bed on back TV on non-religious show.
No radio noted in room.
12/6/17 10:45 AM Resident lying in bed on back TV on show not a music station. No radio noted in room.
12/06/17 02:52 PM Resident lying on right side TV on no radio present in room. TV on a show, non religious not a music station.

On 12/06/17 02:11 PM an interview was conducted with RN Unit Manager #2 and was asked by this surveyor if there had bee changes in Name (Resident #13)? RN #2 stated, " She was on hospice and came off and they did a significant change assessment on her." Surveyor asked, "Does she have family that visit regularly and does she ever get up?" RN #2 stated, "Yes, her son visits daily usually around 6 in the morning and again in the afternoon. She doesn't get up she stays in her room in the bed."

Resident #13's Activity Participation Logs were

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reviewed from May 2017 through December 2017 and are documented in part, as follows:

May 2017 through November 2017 checked for Resident #13:
Observed Leisure: 1.) Watching TV, 2.) Family/Friend visit/Visitors.

December 2017: 1.) Listening to music (only checked for 1 day December 2nd., 2.) Watching TV, 3.) Family/Friend visit/Visitors.

On 12/6/17 03: 00 PM an interview was conducted with the Therapeutic Activities Coordinator after reviewing the Resident #13's most recent comprehensive MDS under activities and preferences and the current comprehensive care plan. This surveyor asked what activities were in place for the resident. The Therapeutic Activities Coordinator stated, "her TV and her son visits daily. This surveyor showed the Therapeutic Activities Coordinator Resident #13's Comprehensive MDS and current comprehensive care plan and asked what should have been included in her daily activities based on these documents. The Therapeutic Activities Coordinator stated, "we should have included her religious/spiritual preferences, reading of the bible, going out of the room for activities, and having her radio with gospel music playing. We should have been more specific and followed her preferences."

On 12/07/17 10:47 AM surveyor observed a radio now present in Resident #13's room on a stand in front of her bed but it is turned off. However, the TV is on and currently on a station with religious preaching heard.

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Resident #13's current Comprehensive Care Plan dated 11/29/17 - Present was revised on 12/6/17 by the Therapeutic Activities Coordinator and is documented in part, as follows:

Problem: Name (Resident #13) is dependent on staff and needs assistance to initiate leisure pursuits. She has strong family support and her son visits daily. She also finds strength in faith.

Goals: Name (Resident #13) will have meaningful stimulation daily; demonstrating signs of engagement, comfort, or enjoyment in leisure pursuits at least 75 % of the time by next review date.

Interventions:
1. Offer/provide brief social visits as needed for rapport.
2. Offer/provide comforting activities such as playing gospel music for her; reading the Bible to her; devotional stories; musical entertainment; using touch and holding her hand for comfort; sensory stimulation.
3. Assist her so she can enjoy the following TV channels: She enjoys the Christian channels on TV, the gospel music TV channel.
4. Provide 1:1 needs programming for meaningful stimulation.
5. Allow family to spend quality time with Name (Resident #13).
6. Refer to chaplain for spiritual support visits.
7. Provide flowers in her room to promote comfort and relaxing environment when available.

The facility policy titled, "Life Care-Comprehensive Care Plan" revised on 1/17/2017 is documented in part, as follows:

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Purpose: Establishment, periodic review of current patient-centered plan of care for each resident to assure a systematic comprehensive approach to assessing, planning, and periodic review in meeting the resident's needs.

Interdisciplinary Responsibilities:
2. Care plans will be reviewed and updated as needed to reflect changes. Care plans to be updated within 24 hours.

On 12/11/17 at 5:50 P.M. a pre-exit conference was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

1.) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses.

2.) Major Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.

3.) Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal.

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6. The facility staff failed to revise Resident #46's care plan to include her preference for being awakened at 2:00 am every day to ensure incontinence care is rendered in a timely manner to prevent complications.

Resident #46 was admitted to the facility on 7/2/15 with current active diagnosis of Multiple Sclerosis (MS-a chronic, slowly progressive disease of the central nervous system-Taber's Cyclopedic Medical Dictionary).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 10/11/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident required extensive assistance of one staff for toileting and was always incontinent of both bladder and bowel. The resident was wheelchair bound.

Resident #46's Comprehensive Person Centered Care Plan dated 10/18/17 to present was reviewed. The care plan identified the resident was incontinent of both bladder and bowel. The goal was listed as the resident would not have complications associated with incontinence over the next 90 days. The two interventions listed were to apply protective garments/pads as needed and provide peri-care after each incontinent episode as needed.

On 12/05/17 at 11:42 AM, the resident was observed sitting up in a wheelchair in the hallway. A request to conduct an interview was granted by the resident. The resident then propelled herself into her room, During the resident interview Resident #46 stated that on 11/30/17 it took the

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staff two hours to respond to a call bell. The resident stated she had put the call bell on because she was wet and needed incontinent care to be rendered.

Prior to this resident interview the resident had attended the Resident Council meeting facilitated by another inspector. The following notes were obtained from this meeting and read in part: 12/05/17 at 10:13 AM: Resident council meeting. short of staff - concern expressed. two staff on each unit at times. Call bells not answered timely. Resident #46 soaking wet. How do you feel about that. She does not like it. She has documentation and bring {sic} it up during care plan meetings.

Further investigation and evidence supported the resident's allegation that on 11/30/17 it took the staff two hours to respond to the call bell.

On 12/6/17 at 4:36 PM, a request to review of any and all grievances for Resident #46 was made to the Director of Nursing (DON). This same day at 5:52 PM a grievance form was handed to this inspector. The form titled Incident Abstract Report, report date 12/5/17 read, in part: Event description-Resident stated staff took 2 hours to answer the call bell. When she rendered care, the resident stated the staff member was argumentative. The DON also provided a Facility Reported Incident (FRI) form dated 12/5/17 notifying the State Survey Agency, Adult Protective Agency, the Representative Party and physician of an allegation of abuse/mistreatment. The staff was identified and immediately suspended pending investigation.

The clinical record evidenced a care plan meeting

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note dated 7/27/17 authored by the Social Worker. The note read that the resident "stated that she would like to be changed around 2 am."

On 12/7/17 at 11:20 a.m., an interview was conducted with the unit manager. She stated the resident had expressed that her preference was to be woken up every night at 2:00 a.m., to be changed due to incontinence and history of a rash. The care plan was reviewed and was not revised to include the residence preference for staff to wake her up and check her for incontinence. When asked if this should have been care planned the unit manager stated, "I didn't think about it going on the care plan, but it makes sense." The unit manager was asked if the staff are aware of the resident's preference to be woken up at two o'clock each morning to be checked for incontinence and rendered incontinent care, she stated, "When she has a routine person (staff) it seems to be done...not sure if that could be put on the CNA care plan..."

The above findings was shared during the pre-exit meeting conducted with the Administrator, the DON and Director of Clinical Services on 12/11/17.

No additional information was provided prior to exit.

7. The facility staff failed to revise the care plan for the use of insulin, monitoring of blood glucose and the administration of anticoagulant medications for Resident #147.

Resident # 147 was admitted to the facility on 11/20/17 with diagnoses of multiple closed fractures of pelvis, closed fracture of shaft of right

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tibia and fibula, rib fractures, coronary artery bypass draft, chronic anticoagulation, asbestosis, COPD, osteoarthritis of knees, cardiovascular disease, sleep apnea, stroke, internal carotid aneurysm, history of renal mass, hypertension, severe obesity, type 2 diabetes mellitus, major depression, hyperlipidemia, and hypertrophy of prostate.

The facility staff failed to have parameter for the use of insulin and the monitoring of glucose levels. The facility staff were not aware of the dosage of insulin administered or the blood sugar levels form 11/20/17 through 12/8/17. Resident #147 wife stated she had been administering insulin twice a day and obtaining blood sugars levels since admission. She also stated that the facility did not inquire about the dosages administered or the blood sugars levels since admission.

An Initial Minimum Data Set (MDS) dated 12/1/17 assessed Resident #147 in the area of Cognitive Patterns - Brief Interview of Mental Status (BIMS) as a (15). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (3/30 in the area of bed mobility, a (7/2) in the area of transfer, a (7/3) in the area of walk in room, (2/2) in the area of dressing, a (0/1) in the area of eating, a (3/3) in the area of toilet use, and a (3/3) in the area of personal hygiene.

In the area of Medications this resident was assessed as receiving injections for (7) days.

In the area of Insulin this resident was assessed

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as receiving insulin for (4) days.

In the area of Orders for Insulin Changes- this resident was assessed for (0) days.

In the area of Medications Received - this resident was assessed as receiving Anticoagulant for (7) days.

A Care Plan dated 12/6/17 indicated : "Problem- Potential for hypo/hyperglygycemia r/t: DX of DM (resident diagnoses of diabetes mellitus) Goals _ resident will have no s/s (signs or symptoms) of diabetic reaction with blood sugars within normal range of 60/120 mg/dl x (time) 90 d (days).
Interventions- Administer medication per MD order, Disciplines -Nursing, Frequency - PRN (as needed).
Intervention- monitor for effectiveness of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- monitor for side effects of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- observe for s/s of low blood sugar (sweating, headache, light headed, confusion, slurred speech, drowsiness,
Intervention -Observe for s/s pf high blood sugar (polyuria, blurred vision, weakness, headache, anorexia, N & V, abdominal pain, acetone breath, mental changes, hypotension,
intervention - Monitor accuchecks per MD order
Intervention- serve diet per MD order, Disciplines - Dietary- Licensed Practical Nurse- Registered Nurse, Frequency -PRN.
Intervention - Notify MD as needed, Disciplines - Skilled Nursing, Frequency - PRN.

There were no care plans for the use of an

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F 657	Continued From page 88 anticoagulant. There were no care plans for Resident #147 wife to administer insulin, monitor blood glucose levels, and administer Pro Air Inhaler treatments. During an interview on 12/8/17 at 2:47 P.M. with the 300 Unit Nurse Manager she stated, there were no care plans to address the aforementioned areas.	F 657		
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 observations, staff interviews, medical record review, and facility document review the facility staff failed to ensure that 1 of 26 residents were provided activities based on the resident's comprehensive assessment, care plan, and preferences, Resident #13. The facility staff to ensure that Resident #13 was provided activities based on the comprehensive assessment, care plan, and preferences. The findings included:	F 679	1. The therapeutic recreational care plan for resident #13 was revised on 12/6/17 to include her preferred activities. 2. All residents are at risk if preferred activities are not provided or documented accordingly. 3. All therapeutic recreation staff, and staff conducting and/or recording participation in all household activities will be educated on Sentara Life Care policy entitled Activity Program revised 3/23/17 to include staff responsibilities and department expectations for therapeutic	1/15/18

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F 679	Continued From page 89 Resident #13 was admitted to the facility on 12/2/2013 with diagnoses to include, 1.) Dementia, 2.) Depression, and 3.) Anxiety Disorder. The most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 6/8/17. The Brief Interview for Mental Status (BIMS) indicated that Resident #13 had long and short-term memory deficits and was severely impaired in cognitive skills for daily decision making. Under Section D Mood (G.) Trouble concentrating on things, such as reading the newspaper or watching television, Resident #13 was coded Yes for symptoms present and 2-6 days for symptom frequency. In Section F Preferences for Customary Routine and Activities Staff Assessment Resident #13 was coded for all of the following to apply: E. Receiving bed bath, F. Receiving sponge bath, I. Family or significant other involvement in care discussions, K. Place to lock personal belongings, M. Listening to music, O. Keeping up with the news, P. Doing things with groups of people, Q. Participating in favorite activities, and T. Participating in religious activities or practices. Resident #13's Comprehensive Care Plan dated 6/21/17 -9/11/17 was reviewed and is documented in part, as follows: Problems: Name (Resident #13) participation in activities is impaired due to multiple medical problems and confusion. Goals: Name will stimulation and socialization daily in room and verbally reply to visitors.	F 679	recreational activities 1/2/18-1/12/18. 4. The Therapeutic Activities Team Coordinator will audit 5 charts weekly x 45 days to assure each assessment and care plan identify preferred activities for each resident, and that each resident is assured opportunities to participate in the identified activities of choice. The audits will be summarized by the Manager, Rehabilitative Services and presented to the QAPI committee for recommendations and additional oversight.	

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Interventions: Offer Name (Resident #13) distractions including family visits, television, music in room via radio and staff visit during care. Post Activity calendar in room.

Resident #13's current Comprehensive Care Plan dated 11/29/17 - Present was reviewed and is documented in part, as follows:

Problems: Name (Resident #13) participation in activities is impaired due to multiple medical problems and confusion.

Goals: Name will stimulation and socialization daily in room and verbally reply to visitors.

Interventions: Offer Name (Resident #13) distractions including family visits, television, music in room via radio and staff visit during care. Post Activity calendar in room.

Resident #13 observations while on survey by this surveyor:
12/04/17 12:18 PM Resident lying in bed on right side TV on non religious show. No radio noted in room.
12/05/17 10:24 AM Resident lying in bed on back TV on non-religious show.
No radio noted in room.
12/6/17 10:45 AM Resident lying in bed on back TV on show not a music station. No radio noted in room.
12/06/17 02:52 PM Resident lying on right side TV on no radio present in room. TV on a show, non religious not a music station.

On 12/06/17 02:11 PM an interview was conducted with RN Unit Manager #2 and was asked by this surveyor if there had bee changes

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in Name (Resident #13)? RN #2 stated, " She was on hospice and came off and they did a significant change assessment on her." Surveyor asked, "Does she have family that visit regularly and does she ever get up?" RN #2 stated, "Yes, her son visits daily usually around 6 in the morning and again in the afternoon. She doesn't get up she stays in her room in the bed."

Resident #13's Activity Participation Logs were reviewed from May 2017 through December 2017 and are documented in part, as follows:

May 2017 through November 2017 checked for Resident #13:
Observed Leisure: 1.) Watching TV, 2.) Family/Friend visit/Visitors.

December 2017: 1.) Listening to music (only checked for 1 day December 2nd., 2.) Watching TV, 3.) Family/Friend visit/Visitors.

On 12/6/17 03: 00 PM an interview was conducted with the Therapeutic Activities Coordinator after reviewing the Resident #13's most recent comprehensive MDS under activities and preferences and the current comprehensive care plan. This surveyor asked what activities were in place for the resident. The Therapeutic Activities Coordinator stated, "her TV and her son visits daily. This surveyor showed the Therapeutic Activities Coordinator Resident #13's Comprehensive MDS and current comprehensive care plan and asked what should have been included in her daily activities based on these documents. The Therapeutic Activities Coordinator stated, "we should have included her religious/spiritual preferences, reading of the bible, going out of the room for activities, and

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having her radio with gospel music playing. We should have been more specific and followed her preferences."

On 12/07/17 10:47 AM surveyor observed a radio now present in Resident #13's room on a stand in front of her bed but it is turned off. However, the TV is on and currently on a station with religious preaching heard.

Resident #13's current Comprehensive Care Plan dated 11/29/17 - Present was revised on 12/6/17 by the Therapeutic Activities Coordinator and is documented in part, as follows:

Problem: Name (Resident #13) is dependent on staff and needs assistance to initiate leisure pursuits. She has strong family support and her son visits daily. She also finds strength in faith.

Goals: Name (Resident #13) will have meaningful stimulation daily; demonstrating signs of engagement, comfort, or enjoyment in leisure pursuits at least 75 % of the time by next review date.

Interventions:
1. Offer/provide brief social visits as needed for rapport.
2. Offer/provide comforting activities such as playing gospel music for her; reading the Bible to her; devotional stories; musical entertainment; using touch and holding her hand for comfort; sensory stimulation.
3. Assist her so she can enjoy the following TV channels: She enjoys the Christian channels on TV, the gospel music TV channel.
4. Provide 1:1 needs programming for meaningful stimulation.

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5. Allow family to spend quality time with Name (Resident #13).
6. Refer to chaplain for spiritual support visits.
7. Provide flowers in her room to promote comfort and relaxing environment when available.

The facility policy titled, "Life Care-Activity Program revised 3/23/17 was reviewed and is documented in part, as follows:

Purpose: The facility will provide for an ongoing program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well being of each resident/participant.

On 12/11/17 at 5:50 P.M. a pre-exit conference was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

1.) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses.

2.) Major Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.

3.) Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and

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F 679	Continued From page 94 indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal.	F 679		
F 684 SS=J	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 observations, record review, family, staff interview and facility policy the facility staff failed to provide treatment and care in accordance with professional standards of practice for 2 of 26 residents in the survey sample, Residents #147 and #358. 1. For Resident #147 the facility staff failed to: (1) obtain physician orders for the administration of insulin, (2) for glucose monitoring, (3) for a family member (Wife) to administer insulin and obtain blood sugars under the supervision of a licensed staff. 2. The facility staff failed to ensure Resident #358 received pin care in accordance with professional standards of practice. The findings included:	F 684	1. The physician order for administration of insulin and blood glucose monitoring for resident #147 were clarified on 12/8/17 to indicate staff will perform these tasks. Resident #358 was discharged home on 12/16/17. No immediate correction is possible. 2. All residents are at risk if a family member requests to administer medications or treatments for them. The facility policy does not allow for accommodation of such requests at this time and no other family members have requested to do this. All residents who request to perform their own pin care or wound treatments are at risk if they have not been properly assessed, educated and monitored to perform these tasks. 3. An inservice was immediately provided to clinical staff on 12/8/17 regarding	1/15/18

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F 684	Continued From page 95 1. Resident # 147 was admitted to the facility on 11/20/17 with diagnoses of multiple closed fractures of pelvis, closed fracture of shaft of right tibia and fibula, rib fractures, coronary artery bypass draft, chronic anticoagulation, asbestosis, COPD, osteoarthritis of knees, cardiovascular disease, sleep apnea, stroke, internal carotid aneurysm, history of renal mass, hypertension, severe obesity, type 2 diabetes mellitus, major depression, hyperlipidemia, and hypertrophy of prostate. The facility staff failed to have parameter for the use of insulin and the monitoring of glucose levels. The facility staff were not aware of the dosage of insulin administered or the blood sugar levels form 11/20/17 through 12/8/17. Resident #147 wife stated she had been administering insulin twice a day and obtaining blood sugars levels since admission. She also stated that the facility did not inquire about the dosages administered or the blood sugars levels since admission. A determination of Immediate Jeopardy (IJ) was confirmed at 1643 P.M. (4:43 PM) on 12/8/17. This citation was originally found at a level four isolated and upon acceptance of the plan of correction, it was lowered to a level two isolated. An Initial Minimum Data Set (MDS) dated 12/1/17 assessed Resident #147 in the area of Cognitive Patterns - Brief Interview of Mental Status (BIMS) as a (15). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (3/30 in the area of bed mobility, a (7/2) in the area of transfer, a (7/3) in the area of walk in room, (2/2) in the area of dressing, a (0/1) in the area of eating, a (3/3) in the area of toilet use, and a (3/3)	F 684	Sentara Life Care policy entitled Self-Administration of Medications revised 6/20/17. 100% of all licensed nursing staff will be re-educated on Sentara Life Care policy entitled Self-Administration of Medications revised 6/20/17 to include assessment, education, and monitoring before being allowed to self-administer medications or self-perform any treatments on 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit all new physician orders daily x 90 days for identification of any orders for a resident to self-administer medications. Any new orders identified will be evaluated by the interdisciplinary team for completion of resident education and monitoring to assure appropriateness of the order. The audits will be summarized weekly by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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in the area of personal hygiene.

In the area of Medications this resident was assessed as receiving injections for (7) days.

In the area of Insulin this resident was assessed as receiving insulin for (4) days.

In the area of Orders for Insulin changes- this resident was assessed for (0) days.

In the area of Medications Received - this resident was assessed as receiving Anticoagulant for (7) days.

A Care Plan dated 12/6/17 indicated : "Problem- Potential for hypo/hyperglygycemia r/t: DX of DM (resident diagnoses of diabetes mellitus) Goals _ resident will have no s/s (signs or symptoms) of diabetic reaction with blood sugars within normal range of 60/120 mg/dl x (time) 90 d (days).
Interventions- Administer medication per MD order, Disciplines -Nursing, Frequency - PRN (as needed).
Intervention- monitor for effectiveness of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- monitor for side effects of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- observe for s/s of low blood sugar (sweating, headache, light headed, confusion, slurred speech, drowsiness,
Intervention -Observe for s/s pf high blood sugar (polyuria, blurred vision, weakness, headache, anorexia, N & V, abdominal pain, acetone breath, mental changes, hypotension,
intervention - Monitor accuchecks per MD order
Intervention- serve diet per MD order, Disciplines

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- Dietary- Licensed Practical Nurse- Registered Nurse, Frequency -PRN.
Intervention - Notify MD as needed, Disciplines - Skilled Nursing, Frequency - PRN.

A review of the Care Plan did not indicate a Care Plan for the care and treatment and use of Anticoagulant medications.
A review of the Care Plan did not indicate the care and treatment for Resident #147's wife to administer Insulin, obtain blood glucose levels or provide Pro Air Albuterol treatments.

A Clinical Note dated 11/22/17 at 02:48 AM indicated: " Lantus and Novolog changed to Novolin 70/30 per resident and wife request. Administration changed to PM on several meds. approved and ordered by physician."

A Clinical Note dated 11/23/17 at 9:22 AM indicated: " Patient stated wants wife to administer all insulin and obtain blood sugars for him. Wife and husband educated on risks, Wife signed paperwork to self administer insulin and pro air inhaler. Wife able to answer correctly all questions regarding insulin and pro air inhaler."

A Medication Administration History print-out with a 11:46 A.M. 12/07 17 run date indicated: " Novolin 70/30 100 unit/ml subcutaneous suspension two times daily starting 11/22/17. An Administration History form with a date administered column indicated: 11/22/17 (7:30) date documented (11:22/17 (08:23) Not administered, Notes: resident wife taking BS (blood sugar) and injecting insulin."

An Administration History form indicated: "date

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administered column 11/22/17 (7:30) - 11/22/17 (8:23) Blood Sugar Site - Value (Blank). 11/22/17 (16:30) -11/22/17 - 11/22/17 (17:34) Blood Sugar value 129, Insulin not administered wife administered."

An Administration History form dated 11/23/17 (7:30) - 11/23/17 (8:51) blood sugar site Value (blank) Notes - Resident wife stated she does BS and administer insulin.

There is no further documentation of Novolin or Blood Sugar levels being shared or documented by the facility staff.

A facility form for Resident Self Administration of Medication Review dated 11/22/17 was presented: The form indicated: " Resident Name: and date - 11/22/17. List of medications for self-administration: Insulin, blood sugars.

1. Can the resident name all of his/her medications? (Circle Yes or No)- Yes.
2. Does the Resident know what the medications are used for? Yes
3. Does the Resident follow writer and oral instructions? Yes
4. Is the Resident aware of adverse reactions? Yes
5. Does the Resident know to report all adverse reactions immediately to the nurse? Yes
6. Does the Resident give his/her medications to anyone else? No
7. Is the resident familiar with the rules of the self-medication program? Yes
8. Are medications stored according to the label? Yes
9. Are over the counter medications in the

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resident's room, not prescribed by the physician? No
10. Has the resident returned all unused, old, expired and extra medication(s) to the nurse? Yes
11. Are medications stored, and secured, to prevent access by other residents? Yes
12. Does the resident return the medication container for refills? Yes
13. Has the resident's status changed, so that he/she should have the nurse medicate him/her? No

The resident was observed self-administering medication appropriately. The resident has been interviewed and appears to be adhering to the rules for the self-administration program and should be allowed to continue the program.

Comments: Wife to Self Administer Insulin and and return demonstration completed - do patients blood sugars and pro air albuterol.
This form was signed by Resident #147's wife and Unit 300 Nurse Manager."

During an interview with Resident #147's wife on 12/08/17 at 3;10 P.M. when asked about the "Self-Administration form" she stated, "I did not receive any training or over site for taking his blood sugars, giving him his insulin or giving him his breathing treatments.
I signed the form, but there was no return demonstration or education. I signed the form because I wanted to be the one making sure his insulin and blood sugars were not going all over the place as they were when he was in the hospital. I told them (Facility staff and doctor) that I was going to give him his insulin."

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Resident #147 wife was asked, if staff asked had her about his blood sugar parameter and insulin dosage? She stated, "staff never inquired about his blood sugar levels or insulin dosage." Resident #147 was observed to have Resident #147 blood sugar levels in a note book that she kept in a night stand drawer.

During an interview with Resident #147's wife with a second surveyor at 3:17 P.M. on 12/8/17 she stated, "I give 70/30", showed the insulin in a vial in the resident's top bedside drawer, not dated when opened. When it is finished I get another vial. The blood sugar in the hospital were up and down (240/ 68), so I wanted to have control when I came here, I wanted to do his insulin like I was at home.
I signed a form so I could get control of doing blood sugar checks and administer the insulin. I was not educated by any nurse - I did not do a return demonstration. When asked how would she know how much insulin to give she stated, (i.e.), if blood sugar is 95, she stated 32 units. If 164 - I would give 35 units. I give between 32/35 units on a sliding scale. I take his blood sugars before he eats in the morning and before he eats his dinner."

Resident #147 wife showed her book with blood sugar levels and stated, "staff are not concerned. They don't inquire or ask. I don't share information with unit nurses. They don't act concerned.
The wife was asked, if she did not come in to the facility one day, how would staff know how Resident #147 blood sugars were running? She stated, "they would not know."

During an interview on 12/8/17 with Resident

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#147 doctor he stated, " Resident #147's wife had talked with him and the facilities admission team while Resident #147 was in the hospital during discharge planning. Resident #147 wife had express that she would be doing his blood sugars levels and insulin administration at the nursing home due to the up and down levels Resident #147 experienced during his hospital stay. He stated, I was ok with her giving him the insulin and taking his blood sugars. She stated, she did it at home for Resident #147. The doctor was asked, "Did he write an order indicating it was ok for Resident #147's wife to give insulin and take his blood sugars while a resident at the facility? The doctor stated, "No". The doctor stated, "he was new to long term care and had been working at the facility for a few weeks."

The doctor was asked if Resident #147's wife would have been allowed to give insulin and take blood glucose levels in the hospital ? The doctor stated, "No" The doctor was asked, was he aware that nursing staff were not given Blood Sugar readings by Resident #147 wife? Also, nursing staff were not aware of how much insulin Resident #147's was receiving? The doctor answered, "he was not aware that nursing staff did not know blood sugar readings." The doctor also, answered, "he was not aware that nursing staff did not know how much insulin Resident #147's wife was giving him."

The doctor was asked, was he aware of Resident #147's blood sugar levels and insulin dosage. The doctor stated, "He was not aware."

During a meeting on 12/8/17 at 2:47 P.M. with the 300 Unit Nurse Manager, The Director of Nursing and the Administrator, the Nurse Manager was

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asked if there was a physician's order and a Care Plan for Resident #147's wife to administer insulin and obtain blood sugars. The Nurse Manager stated, "No" and preceded to hand over an revised Care Plan dated 12/8/17 at 1:53 PM.

During this interview the Director of Nursing (DON) stated she was not aware of Resident #147's blood sugars were not being monitored by nursing staff. The DON was asked if Resident #147's wife have a physician's order to administer insulin and take his blood sugars? The DON stated, "No".

During this interview the Administrator stated, "we were trying to be home like and allow the wife to care for her husband as she would at home." When asked was the doctor aware of Resident #147 wife administering insulin and taking his blood sugars, she stated, "Yes", he knew we had talked about the wife providing his care prior to his discharge from the hospital. "The doctor was ok with it." "It is apparent that there is a disconnect."

During an interview on 12/8/17 at 6:23 PM with the 300 Unit Nurse Manager, The DON, the Administrator and Regional Nurse Manager, the Regional Nurse Manager stated, "We agree this is not good."

The facility stated, there were no policy's and procedures for Resident family's to administer medications, provide treatments or take blood sugar levels.

An acceptable Plan of Corrections was provide to the survey team at 6:48 P.M. on 12/8/17. The Immediate Jeopardy was abated at that time.

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Immediate Jeopardy Plan of Corrections:

Self-Administration of Medication

1. The physician orders for Humulin 70/30 insulin, Pro Air HFA inhaler, and , blood glucose monitoring for Resident #147 in room 308 have been clarified for staff to complete blood glucose's and administer medications on 12/8/17. (see attached) A new label has been secured to a new vial of Humulin 70/30 insulin at 5:45 PM. The Director of Nursing and Clinical Manger spoke directly with the patient's wife regarding the facilities concerns with the current practice of her administering medications (see attached). The Clinical Manager, spoke with the physician who was not in agreement that the wife should manage his medications (see attached).

2. Any family who request to self-administer medications and or manage inhalers or blood glucose monitoring are at risk. At this time, no other families have requested to self -administer their own medications. At this time the facility does not have a policy to accommodate family administration of medications to residents. No medications will be administered or procedures will be completed without a physician's order.

3. An inservice was initiated 12/8/17 at 5:50 PM regarding the policy and procedure titled Self-Administration of Medications revised on 6/20/17 (see attached), for all licensed nursing staff currently in the building. The remainder of the licensed nursing staff will be inserviced on this policy before returning to work in person and via campus wide email.

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4. The Clinical Managers or designee will audit new physician orders for identification of any orders to self-administer medications daily x 90 days. Any new orders identified will be evaluated by the Interdisciplinary Team for completion of resident education and monitoring to assure appropriateness of the order. Audits will be reviewed by the DON and summarized weekly and presented to the QAPI committee for additional oversight or recommendations.

5. Date Certain: 12/8/17 4:30 PM: Clinical Manager spoke with MD and clarified his desire for staff to monitor blood glucose's and administer medications.

12/8/17 4:56 PM: DON and Clinical Manager spoke to patients's wife, to address concerns with family administration of medications. Wife in agreement that facility may manage.

12/8/17 5:30 PM: Insulin, blood glucose monitoring and inhaler administrator orders were clarified. A new vial of insulin was labeled and the inhaler was ordered and will be delivered by the pharmacy on the next delivery.

12/8/17 5:30 PM staff inservices initiated

12/8/17 5:45 PM chart audits initiated to evaluate new orders

12/19/17: QAPI committee to review audits Resident #147

2. The facility staff failed to ensure Resident #358 received pin care in accordance with professional standards of practice.

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Resident #358 was admitted to the facility on 11/28/17. Diagnoses for Resident #358 included but are not limited to Fracture of lower end of Left Radius* (1), Fracture of Right Tibia* (2), Chronic Pain Syndrome* (3), Anxiety Disorder* (4), Depression* (5), and Manic Depression* (6).

Resident #358's Admission Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 12/5/17 coded Resident #358 with a BIMS (Brief Interview for Mental Status) with a 15 of 15 indicating no cognitive impairment. In addition, Resident #358 was coded as requiring limited assistance with one staff person assistance for transfer, toilet use and dressing. Resident #358 was coded as always continent of urinary and bowel functions.

Resident #358's Hospital Discharge Instructions included the following:

Discharge: Pin Care Instructions: page 5 of 6
Once a day wash around the pin sites with warm soapy water and anti bacterial soap and a wash cloth.
If pin sites become more red and painful or have increased drainage then wash pin sites twice per day. If the redness/drainage/pain continue please call us.

You may take a shower and wash your Ex-fix and/or K-wire sites in the shower with warm soapy water and antibacterial soap.

Do not soak your extremity that has an Ex-fix and/or K-wires. No baths or hot tubs.

Discharge: Wound Care: Daily dry dressing

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changes to medial and lateral incision/sutures on left lower leg and left arm.

From the document December 2017 Physician Order sheet the following were documented:

Left leg: dry dressing:

Left arm: dry dressing

Pin Care to left arm fixator daily: Notes: Pin care to left arm fixator Pin sites daily

Pin Care to left arm fixator daily: Notes: Pin care to left arm fixator pin sites daily

cover left tibia surgical site with xeroform gauze cover with dry dressing cover with Kerlix daily

A 11/29/17 12:22 PM Physician Order documented the following: Pin Care to Left Arm fixator daily Notes: Pin Care to Left arm fixator pin sites daily.

A 12/7/17 19:31 (7:31 PM) Clarification Physician Order documented the following: pin care with soap and water daily to left tibia fixator

A 12/8/17 5:32 AM Clarification Physician Order documented the following: pin care with soap and water to left arm fixator daily

Resident #358's Treatment Administration Record (TAR) for November 2017 documented the following:

Left leg One time daily starting 11/28/17 dry dressing and was discontinued on 12/8/17

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F 684	Continued From page 107 Left arm one time daily starting 11/28/17 dry dressing and discontinued on 12/8/17 Pin Care to Left arm fixator daily one time daily starting 11/29/17 and discontinued 12/7/17 Notes: Pin Care to left arm fixator Pin sites daily Cover left tibia surgical site with xeroform gauze cover with dry dressing cover with Kerlix daily one time daily starting 11/29/17 and discontinued on 12/7/17 Pin care to left tibia fixator daily one time daily starting 11/29/17 and discontinued 12/7/17 Left leg one time daily starting 11/28/17 dry dressing and discontinued 12/8/17 Left arm one time daily starting 11/28/17 dry dressing and discontinued 12/8/17 Resident #358's 11/28/17 to Present Care Plan documented the following: Problem: Impaired skin integrity related to left leg status post surgical site. External fixator pins Interventions included but were not limited to: Monitor nutrition parameters Assist resident to eat/drink adequate amount of nutrition Follow prescribed treatment regimen. Problem: Impaired skin integrity to left arm status post surgical site with external fixator pins Interventions included but were not limited to: Follow prescribed treatment regimen.	F 684		

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F 684	Continued From page 108 On 12/04/17 0 Resident #358 was observed at approximately 1:16 PM. She stated that she had Fracture to Left arm and left leg with pins and rod. The Resident stated the bones were crushed in a car accident a month ago. Resident #358 stated that the Nurses are supposed to do pin care in morning and night. Nurses aren't doing morning pin care always." The resident stated she is in a Bariatric bed. The Resident stated she talked to the Unit Manager #4 about 3 days, and reported that she stated she would talk to somebody. Resident #358 stated that she waits a long time for anyone to come in after I ring bell. Resident #358 stated, "I've waited up to 2 hours." Resident stated she can get to potty by herself but she shouldn't. Resident #358 stated that if she waited I would wet her self. On 12/7/17 at approximately 10:30 AM, the Unit Manager #4 and surveyor entered Resident #358's room so that the surveyor could show the Unit Manager #4 Hydrogen Peroxide on the bedside table and Dermal Wound Cleanser in the drawer at the foot of Resident #358's bed. Surveyor informed the Unit Manager #4 that the Resident is performing her own wound care using hydrogen peroxide to pin sites and dermal wound cleanser to incision lines of lower left leg with steri strips. The Unit Manager #4 stated that the Educator Registered Nurse #5 had spoken to the resident about her wound care and attempted to removed the peroxide and the Resident would not allow it to be removed. The Unit Manager #4 was asked as the PIN care orders did not specify what to do, how would she perform pin care and she stated that she would clean with soap and water. On 12/08/17 at approximately 3:00 PM, the	F 684		

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Director of Nursing (DON) was asked if it is the expectation that Resident #358's specific PIN care orders should be clarified and issues with the Care Plan be updated on the Resident's care plan. The DON stated, "Yes."

On 12/8/17 at approximately 4:30 PM, Unit Manager #4 stated that the Doctor had talked with Resident #358 about hydrogen peroxide and the Resident #358 agreed for it to be removed from her room. The Unit Manager was asked if she felt all the issues with Pin Care should be updated on the care plan, and asked if PIN care instructions should be clarified and Unit Manager #4 stated, "Yes, and the orders have been clarified.

The Facility was asked to provide a Policy and Procedure for PIN Care and the DON on 12/8/17 at approximately 3:00 PM stated,
"We have no specific PIN Care Policy."

The facility administration was informed of the findings during a briefing on 12/11/17 at approximately 6:00 p.m. The facility did not present any further information about the findings.

Definitions:

1. Fracture Radius: Fracture or break of the wrist bone

2. Fracture Tibia: Fracture or break of the leg shin bone

3. Chronic Pain Syndrome: Medline Plus documented the following: Pain is a signal in your nervous system that something may be wrong. It is an unpleasant feeling, such as a

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prick, tingle, sting, burn, or ache. Pain may be sharp or dull. You may feel pain in one area of your body, or all over. There are two types: acute pain and chronic pain. Acute pain lets you know that you may be injured or a have problem you need to take care of. Chronic pain is different. The pain may last for weeks, months, or even years. The original cause may have been an injury or infection. There may be an ongoing cause of pain, such as arthritis or cancer. In some cases there is no clear cause. Environmental and psychological factors can make chronic pain worse.
Many older adults have chronic pain. Women also report having more chronic pain than men, and they are at a greater risk for many pain conditions. Some people have two or more chronic pain conditions.

4. Anxiety Disorder: Medline Plus documented: Fear and anxiety are part of life. You may feel anxious before you take a test or walk down a dark street. This kind of anxiety is useful - it can make you more alert or careful. It usually ends soon after you are out of the situation that caused it. But for millions of people in the United States, the anxiety does not go away, and gets worse over time. They may have chest pains or nightmares. They may even be afraid to leave home. These people have anxiety disorders.

5. Depression: Medline Plus documented: Depression is a serious medical illness. It's more than just a feeling of being sad or "blue" for a few days. If you are one of the more than 19 million teens and adults in the United States who have depression, the feelings do not go away. They persist and interfere with your everyday life.

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F 684	Continued From page 111 6. Manic Depression: Medline Plus documented: Bipolar disorder is a mental condition in which a person has wide or extreme swings in their mood. Periods of feeling sad and depressed may alternate with periods of being very happy and active or being cross or irritable.	F 684		
F 689 SS=J	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 observations, staff interviews, clinical record reviews and facility document review the facility staff failed to ensure the resident environment was free from hazards which constituted IJ (Immediate Jeopardy) for one resident (Resident #58) and appropriate assistance devices were utilized to prevent subsequent falls for one resident (Resident #63) of 26 sampled residents to prevent accidents over which the facility has control. This citation was originally found at a level four isolated and upon acceptance of the plan of correction, it was lowered to a level two isolated. 1. On 12/4/17 at 3:44 PM, a full portable cylinder oxygen tank was observed leaning freely against a wheelchair inside Resident #58's room. The oxygen tank was not stored in a cylinder stand and had the potential for being knocked over or	F 689	1. The oxygen tank for resident #58 was placed in a tank holder by the DON on 12/4/17 at 4:20 pm. A gait belt was provided to resident #63 on 12/19/17. 2. All residents utilizing oxygen tanks are at risk if the tank is improperly stored. All residents requiring assistive devices are at risk if they are not provided. 3. An inservice was completed on 12/4/17 at 6 pm regarding Sentara Life Care policy entitled Storage of Hazardous Materials, revised on 8/28/17 to include proper storage of oxygen cylinders. 100% of the facility staff will be educated again on the Life Care policy entitled Storage of Hazardous Materials, revised on 8/28/17 to include proper storage of oxygen cylinders 1/2/18-1/12/18. 100% of the facility staff will be educated on Sentara	1/15/18

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F 689	Continued From page 112 damaged. A determination of Immediate Jeopardy (IJ) was confirmed at 4:15 PM on 12/4/17. 2. The facility staff failed to ensure appropriate assistance devices, to include use of gait belt, were used for transfers in order to prevent opportunities for subsequent falls for Resident #63. The findings included: 1. Resident #58 was admitted to the facility on 7/20/17 with active current diagnoses to include, but not limited to chronic obstructive pulmonary disease (COPD), vascular dementia without behavioral disturbances,and muscle weakness with history of falling. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 10/19/17 coded the resident as scoring a 13 out of a possible 15 on the Brief Interview for Mental Status, indicating at the time of the assessment the resident's cognition was intact. The resident was able to ambulate in the room and corridor independently and at times used a wheelchair for mobility. Physician orders dated 8/2/17 instructed the staff to apply oxygen at 2 L (liters) when O2 saturations were less than 90%. On 12/4/17 at 3:44 PM, the resident was observed sitting in a recliner at the bedside. On the opposite side of the room a full portable cylinder oxygen tank was observed leaning against a folded wheelchair. The oxygen tank was not stored in a cylinder stand and had the	F 689	Life Care policy entitled Assistive Devices, revised 1/17/17 to include provision, use, and care planning of devices on 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit all resident rooms, common spaces, rehabilitation gym, and storage areas with oxygen tanks to assure they are maintained in a secure holder daily x 90 days. The Clinical Managers (or designee)will monitor all residents requiring assistive devices weekly x 45 days to assure devices are available to them if indicated. The audits will be summarized by the Director of Nursing and presented to the QAPI committee for recommendations and additional oversight.	

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potential for being knocked over or damaged. There was no other source of oxygen such as an oxygen concentrator in the room.

The identification of the hazard was immediately bought to the attention of the State Survey Agency team at 4:00 PM. After consultation with the State Agency office a determination of Immediate Jeopardy (IJ) was confirmed at 4:15 PM on 12/4/17.

After determination of Immediate Jeopardy a meeting was held with the Administrator and the Director of Nursing (DON) to inform them of the IJ on 12/4/17 at 4:15 PM.

The survey team conducted a 100% sweep of the resident's rooms and common areas to ensure safe storage of portable oxygen cylinder tanks was adhered to. No additional concerns of safe storage were identified.

On 12/4/17 at 4:35 PM, the Administrator presented a corrective action plan to the state survey team. After careful review and discussion the action plan was denied at 4:55 PM. The immediacy was abated at 4:20 PM as the oxygen tank in Resident #58's room was removed by the Director of Nursing and secured appropriately in an oxygen storage room.

On 12/4/17 at 6: 29 PM, the Administrator presented a second corrective action plan to the state survey team. After careful review and discussion the action plan was denied at 6:55 PM. The survey team left the facility at this time.

On 12/5/17 at 9:35 AM, the Administrator presented a third corrective action plan to the

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state survey team. After careful review and discussion the action plan was accepted at 9:53 AM.

The Corrective Action Plan titled QOC (Quality of Care) Environment read, as follows:
1. The oxygen tank noted in room 226 on 12/4/17 for (Resident #58's name) was placed in a tank holder at 4:20 pm by the DON.
2. The following residents are at risk if the oxygen tank is improperly stored: (name of 19 residents).
3. An inservice was completed on 12/4/17 at 6 pm regarding the policy and procedure titled Storage of Hazardous Materials revised on 8/28/17 (see attached), for all facility staff currently in the building. The remainder of the facility staff will be inserviced on this policy before returning to work in person and via campus wide email. !00% of all resident rooms in the facility, common spaces, rehabilitation gym, and storage areas were checked to assure oxygen tanks were stored appropriately at 5:45 pm on 12/4/17.
4. The Clinical Managers or designee will audit all resident rooms, common spaces, rehabilitation gym, and storage areas with oxygen tanks to assure proper storage daily x 90 days. Audits will be reviewed by the DON and summarized weekly and presented to the QAPI committee for additional oversight or recommendations.
5. Date Certain:
12/4/17 at 4:20 pm Oxygen tank was placed in a holder
12/4/17 at 4:30 pm staff inservices initiated
12/4/17 5:45 pm resident rooms, common spaces, rehabilitation gym, and storage areas with oxygen tanks have been checked
12/19/17 QAPI committee to review audits

After accepting the plan for removal of Immediate

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Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of "J", isolated.

Attached to the action plan was a note dated 12/4/17 authored by the DON that read: At 1620 this writer went to room 226 and found 02 tank leaning up against wheelchair on the right-hand side of the room. O2 tank was full and not in a holder. Tank was immediately removed and placed in O2 tank holder. Staff that was present on unit at that time was immediately in-serviced.

An interview was conducted with the Clinical Manager on 12/7/17 at 9:45 AM., to determine time frame that the oxygen cylinder had remained in the resident's room unsecured. She stated she could not determine this but did state that when the resident goes on leave of absents (LOA) from the facility the family members usually request an oxygen tank to be provided. She stated she believes the resident went on LOA over the Thanksgiving holiday. The Clinical Manager was asked how many cylinder tank stands are available on the unit. She stated she is aware of one that was currently in use. She further stated some are stored in the rehab gym. When asked if the staff have access to the gym on off hours, she stated she was not sure.

A review of the clinical notes dated 11/23/17 read, in part:" Resident went LOA with daughter (RP-Representative Party) at 0635...Oxygen tank was also given per family request."

In response to the above findings the Clinical Manager contacted the RP on 12/5/17 and documented the following: " Spoke with RP today

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to educate about having oxygen canisters given to a nurse upon return from LOA for safety purposes. If resident needs to take oxygen with her on outings, the canister will need to be secured and taken in a rolling holder. RP voiced understanding".

The facility policy titled Storage of Hazardous Materials revised 8/28/17 read, in part: Policy Statement- It is the policy of Sentara Life Care Corporation to establish guidelines for the proper storage of all Hazardous Materials.
*Flammable liquids, combustible gases, etc., will not be stored in areas where intense heat or open flame devices could ignite matter. Note: Oxygen cylinders are stored in upright position and are kept in E-tank holder.

According to the National Institute of Health article titled Compressed Gas Cylinder Storage and Handling dated 3/2013 read, in part:
Due to the nature of compressed gas cylinders, special storage and handling precautions are necessary.
Storage: Gas cylinders should be properly secured at all times to prevent tipping, falling or rolling. They can be secured with straps or chains connected to a wall bracket or other fixed surface, or by use of a cylinder stand.
Cylinders should be stored where they will not be knocked over or damaged.
Take precautions so that gas cylinders are not dropped or allowed to strike each other or other objects. Damaging the cylinder valve could turn the cylinder into a dangerous missile with the potential to destroy property and injure personnel.

2. Resident #63 was identified with a history of

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falls and is at risk for falls. The facility staff failed to ensure appropriate assistance devices, to include use of gait belt, were used for transfers in order to prevent opportunities for subsequent falls.

Resident #63 was admitted to the nursing facility on 1/19/16 with diagnoses that included Alzheimer's dementia, seizure activity and osteoporosis. The resident was re-admitted to hospice care on 7/25/17 due to failure to thrive.

The most recent Minimum Data Set Assessment (MDS) was a quarterly dated 10/26/17 coded the resident impaired with short and long term memory and severely impaired with the skills for decision making. The resident was coded to required total assistance from one staff for transfers. The assessment indicated the resident was not steady to move from a seated to standing position without assistance. This assessment coded the resident to be at risk for falls and to have fallen two or more times without injury.

The Significant Change in Status Assessment MDS dated 8/2/17 coded the resident to be walking in the room and in the corridors with assistance of one staff. The resident was assessed to have fallen two or more times without injury and one time with injury.

The Significant Change in Status Assessment MDS dated 7/7/17 coded the resident to have fallen within the last month, within 2-6 months and sustained a fracture related to a fall in the last 6 months.

The care plan dated as revised on 11/22/17 identified the resident to have fallen out of a high

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back wheel chair, was at risk for falls in general with a history of falls with injures to include facility acquired fractures. A fall investigation identified a fall as recent as 12/2/17 to have fallen out of the same chair. This care plan identified the resident was at risk for continuous falls as dated 9/15/17. The care plan also identified the resident had a diagnosis of severely advanced Alzheimer's dementia, visually impaired, on antianxiety medication, seizure like activity, chronic pain issues, never to understand or have the ability to express desires or wants and with impaired physical mobility related to weakness. The care plan identified the resident was receiving hospice care. For transfers the care plan indicated the resident required assistance and supervision as needed. The care plan did not plan for the use of a Geri-lounger while out of bed, nor did the care plan plan for the use of a gait belt for resident safety during transfers. The resident no longer had a high back wheel chair.

The hospice care plan dated 9/12/17 also identified the resident was at risk for falls and had falls in the facility with major injuries to include significant skull fracture, wrist and femur fracture. This care plan identified the resident was unsteady and remained at risk for falls especially if she were ambulating or attempting to ambulate without assistance. The hospice care plan identified the resident required assistance but never asks for it.

Resident #63 was observed in the dining area of the locked unit, reclined in a Geri-lounger while out of bed, during the survey days of 12/4/17, 12/5/17, 12/6/17, 12/7/17, 12/8/17 and 12/11/17. She was not communicative in any way and was confused to person, place and time.

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On 12/11/17 at 10:10 a.m., two surveyors observed Certified Nursing Assistant (CNA) #1 to transfer Resident #63 from bed to Geri-Lounger. The resident was able to weight bear on both legs turn and pivot, but unsteady, to transfer to the lounger. The CNA stated this transfer techniques was the way he always transferred the resident, although all the ADL sheets recorded 4/2 (total assist with one staff).

An interview was conducted with the unit's clinical manager Registered Nurse (RN) #1 on 12/11/17 at 1:30 p.m. She stated the resident was able to bear weight, turn and pivot to transfer from bed to chair and from chair to bed, and she had performed this transfer with the resident on many times. When asked why the MDS assessed the resident as a 4/2, indicating she did not participate in any way during transfers, she stated they were going by what the CNA's recorded which was incorrect and should be recorded as 3/2 (extensive assist of one staff). In addition the RN #1 stated a mechanical lift was never used to transfer the resident.

A later interview with RN #1 on 12/11/17 at 3:09 p.m., she stated she spoke with CNA #1 and was informed by him, he mostly took the resident under her arms and transferred her to and from the chair and bed which was not an appropriate way to transfer the resident. She stated she expected the staff to use a gait belt as an assistance device, per the facility's policy, to ensure the resident's safety during all transfers in that she could bear weight, stand a pivot.

On 12/8/17, at 11:19 a.m., a telephone interview was conducted with Resident #83's assigned

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F 689	Continued From page 120 hospice nurse. She stated in July 2017, the resident was in a high back wheel chair and was leaning too far forward resulting in a fall out of that type of chair. She said, the Geri-lounger was used for rest from ambulating up until around October 2017 where the Geri-lounger became the safest choice when out of bed. She stated the resident would probably still try to get out of bed and attempt to walk which would result in falling due to her unsteadiness. She said at this point, hospice services was not actively searching for any other chair. On 12/11/17 at 5:50 p.m., the aforementioned issue was brought to the attention of the Administrator and the Director of Nursing (DON). No further information was provided prior to survey exit. The facility's policy and procedure titled "Gait Belt (Transfer Belt)" dated 4/27/17 indicated the "Purpose: Gait belt will be available to use as needed, to ensure the safety of staff and residents. Apply gait belt snugly to the resident's waist. To bring resident to standing position, keep your back straight and pull on the gait belt, holding on each side. After the resident is standing, use gait belt to assist, use gait belt to assist in stabilizing and turning resident. If resident begins to fall, draw resident close to your body using gait belt and slowly lower resident to floor..."	F 689		
F 695 SS=D	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	F 695		1/15/18

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F 695	Continued From page 121 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 observations, resident interview, staff interviews, facility documentation review and clinical record reviews the facility staff failed to ensure appropriate respiratory care was provided to 2 residents in the sample of 26, Resident #351 and #64. 1. The facility failed to ensure 1 resident (Resident #351) with respiratory care of a CPAP machine received care consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences. 2. The facility staff failed to ensure the filters on the oxygen concentrator were free of debris for Resident #64. The Findings included: 1. Resident #351 was admitted to the facility on 12/2/17. Diagnoses for Resident #351 included but are not limited to Emphysema* (1) and Diabetes Mellitus* (2). Resident #351's Interim Care Plan documented the following: Resident Need: Oxygenation related to COPD (Chronic Obstructive Pulmonary Disease), Emphysema Start Date: 12/3/17	F 695	1. The oxygen concentrator filter for resident #64 was cleaned on 12/11/17. Resident #351 was discharged home on 12/15/17. No immediate correction is possible. 2. All residents receiving oxygen therapy or utilizing a continuous positive airway pressure (CPAP) respiratory mask are at risk if the devices are not properly cleaned. 3. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Resident Equipment-Disinfecting and Cleaning revised on 12/18/17 to include weekly cleaning of respiratory equipment on 1/2/18-1/12/18. 4. The Clinical Manager (or designee) will round twice weekly x 45 days to assure respiratory equipment cleanliness. The Clinical Managers will maintain a cleaning checklist to confirm cleaning has occurred. All audits will be summarized by the Director of Nursing and presented to the QAPI committee for recommendations and additional oversight.	

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Approaches included but were not limited to:

Evaluate respiratory status every shift and as needed
Oxygen per Medical Doctor order

Resident #351 current Physician orders included no orders for Resident #351 to have, use and provide care for his personally owned CPAP unit.

The Interim Care Plan did not document that Resident #351 was admitted with his own personal owned CPAP (Continuous Positive Airway Pressure) unit and that Resident #351 was performing his own care to his unit. In addition, the Interim Care Plan did not document any specifics related to what type of care the CPAP unit required.

On 12/4/17 at approximately 1:15 PM, Resident #351's CPAP mask was observed lying on top of his bedside table. The tubing for it was lying in his opened bedside table drawer without a date as to when it was last cleaned or changed.

On 12/4/17 at approximately 5:45 PM, Resident #351's CPAP mask was observed lying on top of his bedside table. The tubing for it was lying in his opened bedside table drawer without a date as to when it was last cleaned or changed.

12/06/17 at approximately 03:35 PM, Resident #351 was observed in his Room, oxygen at 2 liters via nasal cannula. Resident stated, "Therapy went well." Non dated 1 liter opened bottle of Sterile water observed at bedside.

12/07/17 at approximately 10:02 AM, Resident

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#351 was observed in his room with the Unit Manager #4 in attendance. 1 Liter opened Sterile Water undated bottle was observed at bedside. The Unit Manager #4 removed the undated bottle of Sterile Water. The Unit Manager #4 and Surveyor looked at CPAP tubing it was dated 12/5/17. The CPAP mask was not with the CPAP tubing. Asked what the practice was for storage of sterile water. The Unit Manager #4 stated that she's only been here a short time, and it is practice to date bottles when open. The Unit Manager #4 stated it should be stored in his locked cabinet in his room which it was not. The Unit Manager #4 stated that she was not sure where the mask is, she stated that she has been teaching staff that night shift usually changes tubing or if someone is in there and sees it needs to be changed at any time. The Unit Manager #4 stated tubing is getting changed Midnight shift on Tuesday nights. When asked what the facility practice is when a resident is admitted with undated tubing, the Unit Manager #4 stated, "I guess the admission nurse should change tubing and date so that we know when it was last done and then it would be done on midnight shift every Tuesday after that."

Resident #351 was observed on 12/07/17 at approximately 05:27 PM eating in dining room and sitting in a wheel chair. Resident #351 stated "I clean my own mask (CPAP). I put the water in the CPAP and sometimes the girls do it. I doubt they even know I clean the mask. I clean it with soap and water every day."

On 12/08/17 at approximately 3:00 PM, the Director of Nursing (DON) was asked if it is the expectation that Resident #351's Care Plan be updated/revised to include information that he is

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independently performing his care for the CPAP unit, and to include the specifics of the care. The DON stated, "Yes, it would be the expectation."

The Facility's Policy and Procedure titled, "Positive Airway Pressure (PAP) Devices: Equipment Cleaning" with a revision date of 6/23/16 documented the following:

PAP Equipment will be maintained in clean condition.
Clean headgear and tubing once a week and as needed.
Wash/wipe clean nasal pillows or mask daily as needed.
Clean the flow generator once a week and as needed.
Clean devise filters once a week and as needed.
Empty daily, refill with distilled or sterile water nightly.
Clean humidifier reservoir weekly.

The Facility Policy and Procedure titled, "Life Care-Medications-Prescriber Medication Orders" with a revision date of 01/17/17 documented the following:

Written Orders - Orders written on the Physician's Order form by the physician must be signed and dated and must be concise regarding the name of the medication, strength, form, method, route, and reason for use.

The facility administration was informed of the findings during a briefing on 12/11/17 at approximately 6:10 p.m. The facility did not present any further information about the findings.

Definitions:

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1. Emphysema: Medline Plus documented: Emphysema is a type of COPD involving damage to the air sacs (alveoli) in the lungs. As a result, your body does not get the oxygen it needs. Emphysema makes it hard to catch your breath. You may also have a chronic cough and have trouble breathing during exercise.

2. Diabetes Mellitus: Medline Plus documented: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high.

2. The facility staff failed to ensure the oxygen concentrator filters were free from debris for Resident #64.

Resident #64 was admitted to the facility on 1/25/16 with diagnoses to include, but not limited to chronic obstructive pulmonary disease (COPD).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 10/26/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact.

The Person Centered Comprehensive Plan of Care dated 11/1/17 evidenced as a problem that the resident was not able to maintain oxygen saturation levels and received oxygen at 2 liters/ minute. The goal was that the resident would maintain an oxygen saturation level with in acceptable limits. Interventions included, but not limited to; changing the tubing as ordered, and check/fill the humidifier.

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The physician order dated 9/11/17 instructed the staff to clean the filter weekly and as needed. The aforementioned plan of care was not revised to include this order.

On 12/04/17 at 12:34 PM, the resident was observed in bed and awake. The resident was receiving oxygen via nasal cannula at 2 liters/minute from the oxygen concentrator. The nasal cannula tubing and oxygen humidifier were dated as changed on 11/29/17. Both external filters on the sides of the concentrator were observed coated with a white lint like substance.

On 12/06/17 at 03:47 PM, the resident was observed in bed and awake. The resident was receiving oxygen via nasal cannula at 2 liters/minute from the oxygen concentrator. One of two filters remained coated with white lint like substance and in need of cleaning (right side). The Humidifier was dated as changed on 12/6/17.

On 12/7/17 at 9:55 AM, the unit manager was interviewed. The observation of the facility staff failure to ensure the oxygen filters were free of debris was shared. She stated it was the responsibility of the staff who orders supplies to change the filters weekly. She states the filters are not rinsed under the water, but instead discarded and replaced with new filters. She stated she had noted approximately a month ago that there was education needed to staff to ensure the filters were being changed. She stated she verbally spoke to the staff person responsible for changing the filters but did not do an inservice. She stated she will make sure that the staff are made aware that some of the concentrators have one filter while others have two.

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F 695	Continued From page 127 The above findings was shared with the Director of Nursing on 12/11/17 at 1:30 AM, she stated the "supply person" was responsible for checking the oxygen filters and changing them as needed. No additional information was provided prior to exit.	F 695		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff interview and facility policy, the physician failed to review the resident's total program of care to include physician orders for medications and treatments for 2 of 26 residents in the survey sample, Residents #147 and #351. 1. The physician failed to (1) write orders for the administration of insulin, (2) for glucose	F 711	1. The physician's order for blood glucose monitoring, administration of insulin and administration of an inhaler for resident #147 was clarified on 12/8/17 to indicate staff would complete these tasks. Resident #351 was discharged on 12/15/17. No immediate correction is possible. 2. All residents are at risk if physician	1/15/18

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F 711	Continued From page 128 monitoring, (3) for a family member (Wife) to administer insulin and obtain blood sugars under the supervision of a licensed staff and orders for the wife to provide Pro Air Inhaler treatments for Resident #147. 2. The physician failed to write orders for Resident #351 CPAP - use and to perform his own treatments and cleaning of the CPAP (Continuous Positive Airway Pressure). The findings included: 1. Resident # 147 was admitted to the facility on 11/20/17 with diagnoses of multiple closed fractures of pelvis, closed fracture of shaft of right tibia and fibula, rib fractures, coronary artery bypass draft, chronic anticoagulation, asbestosis, COPD, osteoarthritis of knees, cardiovascular disease, sleep apnea, stroke, internal carotid aneurysm, history of renal mass, hypertension, severe obesity, type 2 diabetes mellitus, major depression, hyperlipidemia, and hypertrophy of prostate. The facility staff failed to have parameter for the use of insulin and the monitoring of glucose levels. The facility staff were not aware of the dosage of insulin administered or the blood sugar levels form 11/20/17 through 12/8/17. Resident #147 wife stated she had been administering insulin twice a day and obtaining blood sugars levels since admission. She also stated that the facility did not inquire about the dosages administered or the blood sugars levels since admission. An Initial Minimum Data Set (MDS) dated 12/1/17 assessed Resident #147 in the area of Cognitive	F 711	orders are not obtained for medications and treatments. 3. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Prescriber Medication Orders revised on 1/17/17 to include administration of medications and treatments only upon clear and complete physician orders 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit 5 charts weekly x 45 days to evaluate physician orders for clarity and completeness. The audits will be summarized by the Director of Nursing and presented to the QAPI committee for recommendations and additional oversight.	

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Patterns - Brief Interview of Mental Status (BIMS) as a (15). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (3/30 in the area of bed mobility, a (7/2) in the area of transfer, a (7/3) in the area of walk in room, (2/2) in the area of dressing, a (0/1) in the area of eating, a (3/3) in the area of toilet use, and a (3/3) in the area of personal hygiene.

In the area of Medications this resident was assessed as receiving injections for (7) days.

In the area of Insulin this resident was assessed as receiving insulin for (4) days.

In the area of Orders for Insulin changes- this resident was assessed for (0) days.

In the area of Medications Received - this resident was assessed as receiving Anticoagulant for (7) days.

A Care Plan dated 12/6/17 indicated : "Problem- Potential for hypo/hyperglygycemia r/t: DX of DM (resident diagnoses of diabetes mellitus) Goals _ resident will have no s/s (signs or symptoms) of diabetic reaction with blood sugars within normal range of 60/120 mg/dl x (time) 90 d (days).
Interventions- Administer medication per MD order, Disciplines -Nursing, Frequency - PRN (as needed).
Intervention- monitor for effectiveness of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- monitor for side effects of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- observe for s/s of low blood sugar (sweating, headache, light headed, confusion,

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slurred speech, drowsiness,
Intervention -Observe for s/s pf high blood sugar (polyuria, blurred vision, weakness, headache, anorexia, N & V, abdominal pain, acetone breath, mental changes, hypotension,
intervention - Monitor accuchecks per MD order
Intervention- serve diet per MD order, Disciplines - Dietary- Licensed Practical Nurse- Registered Nurse, Frequency -PRN.
Intervention - Notify MD as needed, Disciplines - Skilled Nursing, Frequency - PRN.

A review of the Care Plan did not indicate a Care Plan for the care and treatment and use of Anticoagulant medications.
A review of the Care Plan did not indicate the care and treatment for Resident #147's wife to administer Insulin, obtain blood sugar levels or provide Pro Air Albuterol treatments.

During an interview on 12/8/17 with Resident #147 doctor he stated, " Resident #147 wife had talked with him and the facilities admission team while Resident #147 was in the hospital during discharge planning. Resident #147 wife had express that she would be doing his blood sugars levels and insulin administration at the nursing home due to the up and down levels Resident #147 experienced during his hospital stay. He stated, I was ok with her giving him the insulin and taking his blood sugars. She stated, she did it at home for Resident #147. The doctor was asked, "Did he write an order indicating it was ok for Resident #147's wife to give insulin and take his blood sugars while a resident at the facility? The doctor stated, "No". The doctor stated he was new to long term care and had been working at the facility for a few weeks.

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The doctor was asked if Resident #147's wife would have been allowed to give insulin and take blood sugars in the hospital ? The doctor stated, "No" The doctor was asked, was he aware that nursing staff were not given Blood sugar readings by Resident #147 wife? Also, nursing staff were not aware of how much insulin Resident #147's was receiving? The doctor answered, "he was not aware that nursing staff did not know blood sugar readings." The doctor also, answered, "he was not aware that nursing staff did not know how much insulin Resident #147's wife was giving him."
The doctor was asked, was he aware of Resident #147's blood sugar levels and insulin dosage? The doctor stated, "He was not aware."

During a meeting on 12/8/17 at 2:47 P.M. with the 300 Unit Nurse Manager, The Director of Nursing and the Administrator, the Nurse Manager was asked if there was a physician's order for Resident #147's wife to administer insulin and obtain blood sugars. The Nurse Manager stated, "No".

During this interview the Director of Nursing (DON) stated she was not aware of Resident #147's blood sugars were not being monitored by nursing staff. The DON was asked if Resident #147's wife have a physician's order to administer insulin and take his blood sugars? The DON stated, "No".

During this interview, the Administrator stated, "we were trying to be home like and allow the wife to care for her husband as she would at home." When asked was the doctor aware of Resident #147 wife administering insulin and taking his blood sugars, she stated, "Yes", he knew, we had

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talked about the wife providing his care prior to Resident #147's discharge from the hospital. "The doctor was ok with it." "It is apparent that there is a disconnect."

A Clinical Note dated 11/22/17 at 02:48 AM indicated: " Lantus and Novolog changed to Novolin 70/30 per resident and wife request. Administration changed to PM on several meds. approved and ordered by physician."

A Clinical Note dated 11/23/17 at 9:22 AM indicated: " Patient stated, wants wife to administer all insulin and obtain blood sugars for him. Wife and husband educated on risks, Wife signed paperwork to self administer insulin and pro air. inhaler. Wife able to answer correctly all questions regarding insulin and pro air inhaler."

A physician order dated 11/20/17 indicated: Enoxaparin (Lovenox) 30 mg. 0.3 ml sc Syrg - inject 0.3 ml beneath the skin every 12 hours. Lovenox for 3 weeks.

Insulin glargine (Lantus vial) 100 unit/ml SC soln - inject 25 Units beneath the skin every 24 hours. Indications diabetes mellitus, hyperglycemia.

Insulin glargine (lantus vial) 100 unit/ml SC soln - inject 2-14 Units beneath the skin 4 times a day before meals and at bedtime. "

A physician order dated 12/6/17 indicated: albuterol sulfate 2.5 mg 3 ml (0.083 %) solution for nebulization (3 ml) Vial) order date 11/20/17 - frequency- As needed every four hours starting 11/20/17.

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Enoxaparin 30 mg/0.3 subcutaneous syringe - Unspecified fracture of left acetabulum, initial encounter for closed fracture, multiple fractures of pelvis without disruption of pelvic ring , initial encounter for closed fracture. unspecified fracture of right lower leg. initial encounter for closed fracture - Frequency - every twelve hours for twenty one days. Schedule- Upon rising - bedtime.

A Medication Administration History print-out with a 11:46 A.M. 12/07 17 run date indicated: " Novolin 70/30 100 unit/ml subcutaneous suspension two times daily starting 11/22/17. An Administration History form with a date administered column indicated: 11/22/17 (7:30) date documented (11:22/17 (08:23) Not administered, Notes: resident wife taking BS (blood sugar) and injecting insulin

An Administration History form indicated: date administered column 11/22/17 (7:30) - 11/22/17 (8:23) Blood Sugar Site - Value (Blank). 11/22/17 (16:30) -11/22/17 - 11/22/17 (17:34) Blood Sugar value 129, Insulin not administered wife administered.

An Administration History form dated 11/23/17 (7:30) - 11/23/17 (8:51) blood sugar site Value (blank) Notes - Resident wife stated she does BS and administer insulin.

There is no further documentation of Novolin or Blood Sugar levels being shared or documented by the facility staff.

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A Medication Administration policy revised 2/21/17 indicated: "The physician must be promptly notified of omission, or refusal, of any medication which causes the resident discomfort, or jeopardizes health and safety. All other omissions or refusals will be reported to the physician after missing three (3) consecutive doses."

A Pharmacy Process Prescriber Medication Orders Policy revised on 1/17/17 indicated: "The licensed nurse will read the order. If the order is not clear to the nurse, the physician will be contacted for clarification. The nurse communicates the order to the pharmacy via Vision for fax."

2. The physician failed to write orders for Resident #351's CPAP - use and to perform his own treatments and cleaning of the CPAP (Continuous Positive Airway Pressure).

Resident #351 was admitted to the facility on 12/2/17. Diagnoses for Resident #351 included but are not limited to Emphysema* (1) and Diabetes Mellitus* (2).

Resident #351's Interim Care Plan documented the following:

Resident Need: Oxygenation related to COPD (Chronic Obstructive Pulmonary Disease), Emphysema Start Date: 12/3/17

Approaches included but were not limited to:

Evaluate respiratory status every shift and as needed

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Oxygen per Medical Doctor order

Resident #351 current Physician orders included no orders for Resident #351 to have, use and provide care for his personally owned CPAP unit.

The Interim Care Plan did not document that Resident #351 was admitted with his own personal owned CPAP (Continuous Positive Airway Pressure) unit and that Resident #351 was performing his own care to his unit. In addition, the Interim Care Plan did not document any specifics related to what type of care the CPAP unit required.

On 12/4/17 at approximately 1:15 PM, Resident #351's CPAP mask was observed lying on top of his bedside table. The tubing for it was lying in his opened bedside table drawer without a date as to when it was last cleaned or changed.

On 12/4/17 at approximately 5:45 PM, Resident #351's CPAP mask was observed lying on top of his bedside table. The tubing for it was lying in his opened bedside table drawer without a date as to when it was last cleaned or changed.

12/06/17 at approximately 03:35 PM, Resident #351 was observed in his Room, oxygen at 2 liters via nasal cannula. Resident stated, "Therapy went well." Non dated 1 liter opened bottle of Sterile water observed at bedside.

12/07/17 at approximately 10:02 AM, Resident #351 was observed in his room with the Unit Manager #4 in attendance. 1 Liter opened Sterile Water undated bottle was observed at bedside. The Unit Manager #4 removed the undated bottle of Sterile Water. The Unit Manager #4 and

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Surveyor looked at CPAP tubing it was dated 12/5/17. The CPAP mask was not with the CPAP tubing. Asked what the practice was for storage of sterile water. The Unit Manager #4 stated that she's only been here a short time, and it is practice to date bottles when open. The Unit Manager #4 stated it should be stored in his locked cabinet in his room which it was not. The Unit Manager #4 stated that she was not sure where the mask is, she stated that she has been teaching staff that night shift usually changes tubing or if someone is in there and sees it needs to be changed at any time. The Unit Manager #4 stated tubing is getting changed Midnight shift on Tuesday nights. When asked what the facility practice is when a resident is admitted with undated tubing, the Unit Manager #4 stated, "I guess the admission nurse should change tubing and date so that we know when it was last done and then it would be done on midnight shift every Tuesday after that."

Resident #351 was observed on 12/07/17 at approximately 05:27 PM eating in dining room and sitting in a wheel chair. Resident #351 stated "I clean my own mask (CPAP). I put the water in the CPAP and sometimes the girls do it. I doubt they even know I clean the mask. I clean it with soap and water every day."

On 12/08/17 at approximately 3:00 PM, the Director of Nursing (DON) was asked if it is the expectation that Resident #351's Care Plan be updated/revised to include information that he is independently performing his care for the CPAP unit, and to include the specifics of the care. The DON stated, "Yes, it would be the expectation."

On 12/11/17 at approximately 3:00 PM, the DON,

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Unit Manager #4, were questioned by surveyor asking if it was an expectation to have Physician orders for Treatments. The DON stated, "Yes."

The Facility's Policy and Procedure titled, "Positive Airway Pressure (PAP) Devices: Equipment Cleaning" with a revision date of 6/23/16 documented the following:

PAP Equipment will be maintained in clean condition.
Clean headgear and tubing once a week and as needed.
Wash/wipe clean nasal pillows or mask daily as needed.
Clean the flow generator once a week and as needed.
Clean devise filters once a week and as needed.
Empty daily, refill with distilled or sterile water nightly.
Clean humidifier reservoir weekly.

The facility administration was informed of the findings during a briefing on 12/11/17 at approximately 6:10 p.m. The facility did not present any further information about the findings.

Definitions:

1. CPAP-Continuous positive airway pressure:...Patients with obstructive sleep apnea treated with CPAP wear a face mask during sleep which is connected to a pump (CPAP machine) that forces air into the nasal passages at pressure high enough to overcome obstructions in the airway and stimulate normal breathing. Source-www.Mayoclinic.org

2. Emphysema: Medline Plus documented:

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F 711	Continued From page 138 Emphysema is a type of COPD involving damage to the air sacs (alveoli) in the lungs. As a result, your body does not get the oxygen it needs. Emphysema makes it hard to catch your breath. You may also have a chronic cough and have trouble breathing during exercise. 3. Diabetes Mellitus: Medline Plus documented: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high.	F 711		
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 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	F 725		1/15/18

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F 725	Continued From page 139 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility failed to have sufficient nursing staff to meet the resident's needs in a manner to promote the resident's rights, physical and mental well-being in accordance to the plan of care for 1 of 26 residents in the survey sample, Resident #46. On 11/30/17 the facility staff failed to respond to the call bell for Resident #46 in a timely manner. The resident stated she had rang the call bell due to being incontinent of bladder and needed staff to render incontinence care. The call bell was activated at 4:09 AM and was not responded to for two hours. The resident had been left wet for two hours. The findings included: Resident #46 was admitted to the facility on 7/2/15 with current active diagnosis of Multiple Sclerosis (MS-a chronic, slowly progressive disease of the central nervous system-Taber's Cyclopedic Medical Dictionary). The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 10/11/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident required extensive assistance of one staff for toileting and was always incontinent of both bladder and bowel. The resident was wheelchair bound and had range of motion limitations to both lower legs.	F 725	1. There was a documented delay in response to resident #46's request for assistance. No immediate correction is possible. 2. All residents are at risk if their request for assistance is not responded to in a timely manner. 3. The Certified Nursing assistant assigned to resident #46 on 11/30/17 has been terminated. 100% of the facility staff will be educated regarding facility expectations of timely response to requests for assistance 1/2/18-1/12/18. 4. The Director of Nursing will review staffing needs weekly x 45 days to assure adequate staff are assigned for resident care needs. The Patient Advocate (or designee) will visit 5 residents weekly x 45 days to assess for perceived timeliness of call bell response times. The audits will be summarized by the Director of Nursing and presented to the QAPI committee for recommendations and additional oversight.	

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Resident #46's Comprehensive Person Centered Care Plan dated 10/18/17 to present was reviewed. The care plan identified the resident was incontinent of both bladder and bowel. The goal was listed as the resident would not have complications associated with incontinence over the next 90 days. Three interventions listed were to apply protective garments/pads as needed and provide peri-care after each incontinent episode, and keep skin clean and dry as needed.

On 12/05/17 at 11:42 AM, the resident was observed sitting up in a wheelchair in the hallway. A request to conduct an interview was granted by the resident. The resident then propelled herself into her room, During the resident interview the resident stated that on 11/30/17 it took the staff two hours to respond to a call bell. She stated she put the call bell on because she was wet and needed incontinence care to be provided. While rendering care the staff were "argumentative" with her. The resident stated she had documented this on a note pad at the bedside. The note pad was reviewed and there was an entry authored by the resident that on 11/30/17 it took two hours for the staff to answer the call bell.

Prior to this resident interview the resident had attended the Resident Council meeting facilitated by another inspector. The following notes were obtained from this meeting and read in part: 12/05/17 at 10:13 AM: Resident council meeting. short of staff - concern expressed. two staff on each unit at times. Call bells not answered timely. Resident # 46 soaking wet. How do you feel about that. She does not like it. (Name of another resident) waited two hours for meds. waiting for pain meds. happened once . Facility staff, Stated we are working on it. Not aware Resident #46

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(informs) address the nurse on the floor of her concerns. Residents feel they are under stress if they make a complaint. Night shift staff talk down Resident #46- she has reported and it continue to happens. Six residents were in attendance of this meeting.

A review of the call be system Detailed Patient Activity Report" from 11/1/17 through 12/7/17 evidenced on 11/30/17 that at 04:09 am the call bell was placed/activated and the call bell was canceled 2:00:35 hours later. This findings supports the residents allegation that it took two hours for staff to respond to her call bell on 11/30/17. Further investigation of the Detailed Patient Activity Report evidenced frequent long response times to call bells for Resident #46 as follows:
1. On 15 occasions the call bell response time was between 18-20 minutes.
2. On 10 occasions the call bell response time was between 23-30 minutes.
3. On 2 occasions the call bell response time was between 45-50 minutes.

On 12/7/17 at 11:20 a.m., an interview was conducted with the unit manager. She stated the resident had expressed that her preference was to be woken up every night at 2:00 a.m., to be changed due to incontinence and history of a rash. The unit manager also stated she was not made aware of the staff taking two hours to answer the call bell. The unit manager was asked if residents had expressed concerns about insufficient staffing and call bells not answered in a timely manner she stated, "Yes". When asked was there a particular shift that the residents state are not staffed sufficiently she stated, "All shifts". The unit manager stated that normal staffing

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patterns on the Town and Country unit a 40 bed unit, were 2 licensed practical nurses (LPN's) and 4 Certified Nurse Aides (CNA's) for day shift (7am-3pm), 2 LPN's and 4 CNA's for evening shift (3pm-11pm) an 1 LPN and 2 CNA's for night shift (11pm-7am). The unit manager stated that there was supposed to be 2 LPN's for night shift and as of January 2018 more positions will be opened up. She also stated the CNA workload should be 1-10 residents on days and evenings but half the time they have more than 10 residents. The census on the unit was 37 during initial tour of the combined units (Town/Country).

On the night of 11/30/17 there were 2 CNA's on the night shift to cover both the Town and Country units.

An attempt to interview the night shift CNA who was assigned to care for Resident #46 on 11/30/17 was made during the survey. The phone number provided when called was answered by a message that stated the phone was not able to receive messages.

On 12/4/17 a dining room lunch observation was conducted on the Town/Country unit. One CNA was observed distributing lunch trays to residents who ate in their rooms. The CNA would take one tray at a time as they were plated and served and take them individually to the resident room. After the observation the CNA (Certified Nurse Aide #7 was interviewed. She stated that when the staffing is short (3 CNA's) it takes about 45 minutes to pass trays, which also interferes with assisting residents who need to be fed.

Review of the day shift daily assignment sheet for 12/4/17 evidenced there were 3 CNA's for a

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census of 37 residents.

On 12/8/17 at 11:15 AM, LPN #10 was interviewed. She was asked about staffing. She stated that the unit is short staffed at least once a week. When asked what "short staff" was, she stated three CNA's. She stated this makes it more difficult to complete nursing tasks due to nursing having to assist residents with toileting, answering call bells, feeding and passing out water.

On 12/8/17 at 11:55 AM, CNA#4 was interviewed. She was asked about staffing. She stated, "If there is a call out and we only have three CNA's there is a significant difference". When asked what the significant difference is, she stated "answering call bells, feeding residents and passing trays".

On 12/08/17 at 12:53 PM, and interview was conducted with the Director of Nursing (DON). The above response time findings was shared. The DON was asked, What is the expected response time to call bells? She stated, "I would expect the call bells to be answered within ten to fifteen minutes". When asked, "Is failure to answer a call bell in a timely manner neglect?" She stated, "Yes, I agree". When asked ,"Would you consider waiting two hours for the call bell to be answered to be neglect?" She responded "That is unacceptable." The DON was asked if the failure to answer call bells in a timely manner was due to insufficient staffing. She stated she was not sure and would have to look further into this.

Review of the facility's Policy and Procedure title Abuse-Freedom From, revised 11/23/16 read, in

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F 725	Continued From page 144 part: Purpose- Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The above findings was shared during the pre-exit meeting conducted with the Administrator, the DON and Director of Clinical Services on 12/11/17. The Administrator was asked what is the expected time frame to answer a call bell, she stated, "Ten minutes". No additional information was provided prior to exit.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		1/15/18

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F 732	Continued From page 145 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to ensure that the Daily Nurse Staffing was posted in a prominent place readily accessible to residents and visitors. The facility staff failed to ensure that the Daily Nurse Staffing was posted in a prominent place readily accessible to residents and visitors. The findings included: On 12/08/17 01:37 PM The daily nursing posting was observed past the front door to the right in the facility parlor. However, the posting was in a frame all the way across the room on a shelf which was not accessible for residents and visitors who were in wheelchairs because of chairs/furniture blocking the pathway to the posting. The pathway was not wide enough for a wheelchair to pass. There was no posting of nursing staffing on the 4 facility units to be accessible for residents who do not leave the units. The Administrator was shown the parlor	F 732	1. The nurse staffing information was relocated from the facility parlor to a table at the front entrance of the building on 12/15/17. This location is easily accessible to residents and visitors. A copy of the staffing information was also placed in each facility household on 12/18/17 in a common area for residents who may not leave their households. 2. All residents are at risk if the posted staffing information is not easily accessible. 3. 100% of facility nursing staff will be educated on Sentara Life Care policy entitled Staffing-Nursing, revised on 12/18/17 to include posting requirements and designated locations 1/2/18-1/12/18. 4. The Director of Nursing will monitor nurse staffing data postings twice weekly x 45 days to assure accessibility of the information to residents. The audits will be summarized by the Director of Nursing and reported to the QAPI committee for	

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F 732	Continued From page 146 area and asked if where the staff posting was located was it accessible to her residents who were wheelchair bound. The Administrator stated, "No it isn't because there isn't enough room for a wheelchair to get past the chairs. The Administrator was also made aware that the Nursing Staffing was not posted on the 4 individual units accessible to resident who do not leave the units. On 12/11/17 at 5:50 P.M. a pre-exit conference was held with the Administrator and the Director of Nursing where the above information was shared and the Administrator stated that the facility did not have a policy for the posting of Daily Nursing Staffing. Prior to exit no further information was provided.	F 732	recommendations and additional oversight.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		1/15/18

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F 755	Continued From page 147 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy, the facility staff failed to ensure medications were available for 1 resident (Resident #147) in the survey sample of 26 residents. The findings included: Resident # 147 was admitted to the facility on 11/20/17 with diagnoses of multiple closed fractures of pelvis, closed fracture of shaft of right tibia and fibula, rib fractures, coronary artery bypass draft, chronic anticoagulation, asbestosis, COPD, osteoarthritis of knees, cardiovascular disease, sleep apnea, stroke, internal carotid aneurysm, history of renal mass, hypertension, severe obesity, type 2 diabetes mellitus, major depression, hyperlipidemia, and hypertrophy of prostate. Resident #147 was not provided six doses of enoxaparin (Lovenox) 30 mg./0.3 ml subcutaneous via syringe.	F 755	1. The physician was notified on 12/11/17 that resident #147 missed several doses of Lovenox. No new orders were given. 2. All residents are at risk if prescribed medications are not available for administration when ordered. 3. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Medication Administration revised 12/27/17 to include physician and pharmacy notification for omitted doses or need for doses to be provided for administration on 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit 5 charts weekly x 45 days to determine that all medications are available and have been administered as ordered and that appropriate notifications have been made if indicated. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 755	Continued From page 148	F 755		

The Nursing Drug Guide Handbook dated 2016 indicates: Lovenox-Therapeutic class: Anticoagulants ; Pharmacological class: Low-molecular-weight heparin's. Used to prevent PE (pulmonary embolus) and DVT (deep vain thrombosis) after hip or knee replacement surgery. To prevent PE and DVT in patients with acute illness who are at increased risk because of decreased mobility.

An Initial Minimum Data Set (MDS) dated 12/1/17 assessed Resident #147 in the area of Cognitive Patterns - Brief Interview of Mental Status (BIMS) as a (15). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (3/30 in the area of bed mobility, a (7/2) in the area of transfer, a (7/3) in the area of walk in room, (2/2) in the area of dressing, a (0/1) in the area of eating, a (3/3) in the area of toilet use, and a (3/3) in the area of personal hygiene.

In the area of Medications Received - this resident was assessed as receiving Anticoagulant for (7) days.

A review of the Care Plan did not indicate a Care Plan for the care and treatment and use of Anticoagulant medications.

A physician's order dated 11/20/17 indicated: "enoxaparin (Lovenox) 30 mg/0.3 ml sc syrg - inject 0.3 ml beneath the skin every 12 hours. Lovenox for 3 weeks."

A Medication Administration History document date range 11/20/17 to 12/07/17 indicated: "enoxaparin 30 mg/0.3 ml, 12/03/17 (06:01) -

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12/03/17 (07:05) Not Administered; 12/03/17 (19:01) -12/03/17 (20:33) Not Administered; 12/04/17 (06:01) - 12/04/17 (06:28) Not Administered; 12/04/17 (19:01) - 12/04/17 (20:09); 12/05/17 (06:01) - 12/05/17 (10:07) Not Administered; Not Administered; 12/05/17 (06:01) - 12/05/17 (19:01) - 12/05/17 (18:04) Not Administered."

During an interview on 12/4/17 at 1:05 P.M. with Resident #147's wife, she stated, "Resident #147 had not received his heparin due to non-availability for several days."

During an interview on 12/6/17 at 12:45 P.M. with the 300 Unit Nurse Manager, she stated she was not aware of Resident #147 medications not being available, but would look into it." The 300 Unit Nurse Manager stated, "it looks like there may have been a mix-up in his order."

A Medication Administration policy revised 2/21/17 indicated: "The physician must be promptly notified of omission, or refusal, of any medication which causes the resident discomfort, or jeopardizes health and safety. All other omissions or refusals will be reported to the physician after missing three (3) consecutive doses."

A Pharmacy Process Prescriber Medication Orders Policy revised on 1/17/17 indicated: "The licensed nurse will read the order. If the order is not clear to the nurse, the physician will be contacted for clarification. The nurse communicates the order to the pharmacy via Vision for fax."

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F 755	Continued From page 150 A Medications - Ordering/Receiving medications policy original date 12/8/17 indicated Valid orders for medication and related products are received from the pharmacy on a timely basis. Medication orders must be valid orders for the pharmacy to dispense.	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		1/15/18

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F 758	Continued From page 151 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, staff interviews, family interviews and facility policy review, the facility staff failed to ensure 2 of 26 residents (Resident #60 and #69) were free of unnecessary drugs. 1. The facility staff failed to implement non-pharmacological interventions prior to the administration of antianxiety medication, Ativan to Resident #60. 2. The facility staff failed to implement non-pharmacological interventions prior to the administration of antianxiety medication, Ativan to Resident #69. The findings include: 1. Resident #60 was admitted to the nursing facility on 12/2/14 with diagnoses that included	F 758	1. Resident #60 and #69 both received as needed doses of Ativan. No documentation was present to indicate behavioral interventions were attempted prior to giving the Ativan. No immediate correction is possible. 2. All residents who receive as needed psychotropic medications without the opportunity to receive behavioral interventions first are at risk of receiving unnecessary medications. 3. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Psychoactive Medications revised 1/17/17 to include documentation of behavioral interventions prior to administration of as needed psychoactive medications on 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit 5 charts weekly x 45 days to	

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F 758	Continued From page 152 Alzheimer's disease and anxiety disorder. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 10/26/17 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 3 out of a possible score of 15 which indicated he was severely impaired in the skills for daily decision making. Resident #60 was coded for an Anxiety disorder, and to have received antianxiety medication 7 out of 7 days during the assessment period. The care plan dated as revised on 11/2/17 identified Resident #60 to have an anxiety disorder and received antianxiety medications on a regular basis. The goal set by the staff for the resident was that the resident would not experience adverse side effects due to antianxiety medication use over the next 90 days. Some of the approaches to accomplish this goal included to administer medication as ordered, noting effectiveness and side effects, engage the resident in group/individual activities, provide atmosphere with one-on-one support during periods of increased anxiety, allow the resident to talk about event and causes, if known and record behavior. Resident #60 had physician's orders dated 3/15/17 for *Ativan 0.5 milligrams (mg) every 6 hours as needed (PRN) for agitation. *Ativan is used to treat anxiety disorders. It is also used for short-term relief of the symptoms of anxiety or anxiety caused by depression (https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001078/).	F 758	determine if behavioral interventions have been documented prior to administration of as needed psychoactive medications. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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F 758	Continued From page 153	F 758		

The Medication Administration Record reviewed over the last 6 months, and indicated the following administration of Ativan 0.5 milligram (mg) tablet without documentation in the clinical record that non-pharmacological interventions were implemented prior to administration of the antianxiety medication:
July 2017-8 times
August 2017-17 times
September 2017-11 times
October 2017-10 times
November 2017-8 times
December 2017-4 times

An interview was conducted with Licensed Practical Nurse (LPN) #2 on 12/4/17 at 2:50 p.m. She stated the resident was easily agitated and medicated with Ativan to calm her, but could not show where she tried other interventions prior to the medication.

An interview was conducted with the unit's clinical manager Registered Nurse (RN) #1 on 12/11/17 at 1:30 p.m. She stated she was sure the staff tried approaches to address Resident #60's agitation before medication, but she could not provide evidence through documentation.

On 12/8/17 at 4:30 p.m., the Director of Nursing (DON) said there was no place in the clinical record that showed interventions prior to administration of the Ativan, but the facility was in the process of developing a system to implement policy and training pending review of pharmacy software.

Resident #60 was observed by this surveyor on the locked unit's dining room in her wheelchair 12/4/17, 12/5/17, 12/6/17, 12/7/17, 12/8/17 and

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12/11/17 throughout the day from 10:15 a.m. to 5:30 p.m. She was confused at all times and many times agitated with other residents, as well as attempting to rise from her wheelchair. On 12/11/17 at 1:45 p.m. she appeared agitated stood and fell on the floor.

On 12/11/17 at 5:50 p.m., during the pre-exit meeting, the Administrator and the DON reiterated they did not currently have a process in place to show non-pharmacological measures were tried prior to administration of PRN antianxiety medications.

2. Resident #69 was admitted to the nursing facility on 9/25/13 with diagnoses that included Alzheimer's disease.

The most recent Minimum Data Set (MDS) assessment was a quarterly dated 11/7/17 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 4 out of a possible score of 15 which indicated he was severely impaired in the skills for daily decision making. Resident #69 was not coded for an Anxiety disorder.

The care plan dated as revised on 11/14/17 identified Resident #69 to display anxiety symptoms at times. The goal set by the staff for the resident was that the resident would have decreased episodes of anxiety over the next 90 days. Some of the approaches to accomplish this goal included assessment and documentation of the resident's level of anxiety and administer medication if interventions do not relieve anxiety.

Resident #69 had physician's orders dated

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F 758	Continued From page 155	F 758		

11/17/17 for Ativan 0.5 milligrams (mg) every 6 hours as needed (PRN) for agitation.

The Medication Administration Record reviewed since 11/17/17 indicated the following administration of Ativan 0.5 milligram (mg) tablet without documentation in the clinical record that non-pharmacological interventions were implemented prior to administration of the antianxiety medication:
November 2017-3 times on the 11/7 shift
December 2017-3 times on the 11/7 shift

An interview was conducted with the unit's clinical manager Registered Nurse (RN) #1 on 12/11/17 at 1:30 p.m. She stated Resident #69 was a wanderer with agitation during the night mostly on the 11/7 shift and the Ativan was given to decrease his agitation. She stated she was sure the nursing staff tried other interventions prior to administering the Ativan, but she could not provide evidence through documentation.

On 12/8/17 at 4:30 p.m., the Director of Nursing (DON) said there was no place in the clinical record that could show interventions prior to administration of the Ativan, but the facility was in the process of developing a system to implement policy and training pending review of pharmacy software.

Resident #69 was observed by this surveyor in bed asleep on the locked unit 12/4/17, 12/5/17, 12/6/17, 12/7/17, 12/8/17 and 12/11/17 throughout most of the day from 10:15 a.m. to 5:30 p.m. He was awakened during mealtime, but slept on and off throughout most of the day.

On 12/11/17 at 1:20 p.m., this surveyor and RN

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F 758	Continued From page 156 #1 went to his room to talk to the resident and found him asleep. The RN stated, "He walks the floor most nights and he is tired during the day, so you mostly find him asleep until nighttime." During an interview with Resident #69's Resident Representative on 12/04/17 02:22 PM, she stated she was concerned about the resident walking all night and he had recently fallen with injuries. She stated the resident was use to getting up at 4:00 a.m. because he worked as a farmer. She stated she was told the facility was going to give him medication to decrease his irritability, but hoped it did not increase his fall episodes. On 12/11/17 at 5:50 p.m., during the pre-exit meeting, the Administrator and the DON reiterated they did not currently have a process in place to show non-pharmacological measures were tried prior to administration of PRN antianxiety medications.	F 758		
F 760 SS=E	. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and	F 760	1. The physician was notified on	1/15/18

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F 760	Continued From page 157 facility policy, the facility staff failed to ensure medications were available for 1 resident (Resident #147) in the survey sample of 26 residents. The findings included: Resident # 147 was admitted to the facility on 11/20/17 with diagnoses of multiple closed fractures of pelvis, closed fracture of shaft of right tibia and fibula, rib fractures, coronary artery bypass draft, chronic anticoagulation, asbestosis, COPD, osteoarthritis of knees, cardiovascular disease, sleep apnea, stroke, internal carotid aneurysm, history of renal mass, hypertension, severe obesity, type 2 diabetes mellitus, major depression, hyperlipidemia, and hypertrophy of prostate. Resident #147 was not provided six doses of enoxaparin (Lovenox) 30 mg./0.3 ml subcutaneous via syringe. The Nursing Drug Guide Handbook dated 2016 indicates: Lovenox-Therapeutic class: Anticoagulants ; Pharmacological class: Low-molecular-weight heparin's. Used to prevent PE (pulmonary embolus) and DVT (deep vain thrombosis) after hip or knee replacement surgery. To prevent PE and DVT in patients with acute illness who are at increased risk because of decreased mobility. The facility staff failed to have parameter for the use of insulin and the monitoring of glucose levels. The facility staff were not aware of the dosage of insulin administered or the blood sugar levels form 11/20/17 through 12/8/17. Resident	F 760	12/11/17 that resident #147 did not receive several doses of Lovenox. No new orders were given. 2. All residents are at risk if prescribed medications are not available for administration as ordered. 3. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Medication Administration revised 12/27/17 to include physician and pharmacy notification for omitted dosed or need for doses of medication to be provided for administration on 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit 5 charts weekly x 45 days to determine that all prescribed medications have been administered as ordered or that physician and pharmacy notification has occurred. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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F 760	Continued From page 158	F 760		

#147 wife stated she had been administering insulin twice a day and obtaining blood sugars levels since admission. She also stated that the facility did not inquire about the dosages administered or the blood sugars levels since admission.

An Initial Minimum Data Set (MDS) dated 12/1/17 assessed Resident #147 in the area of Cognitive Patterns - Brief Interview of Mental Status (BIMS) as a (15). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (3/30 in the area of bed mobility, a (7/2) in the area of transfer, a (7/3) in the area of walk in room, (2/2) in the area of dressing, a (0/1) in the area of eating, a (3/3) in the area of toilet use, and a (3/3) in the area of personal hygiene.

In the area of Medications this resident was assessed as receiving injections for (7) days.

In the area of Insulin this resident was assessed as receiving insulin for (4) days.

In the area of Orders for Insulin changes- this resident was assessed for (0) days.

In the area of Medications Received - this resident was assessed as receiving Anticoagulant for (7) days.

A Care Plan dated 12/6/17 indicated : "Problem- Potential for hypo/hyperglygycemia r/t: DX of DM (resident diagnoses of diabetes mellitus) Goals _ resident will have no s/s (signs or symptoms) of diabetic reaction with blood sugars within normal range of 60/120 mg/dl x (time) 90 d (days). Interventions- Administer medication per MD

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F 760	Continued From page 159 order, Disciplines -Nursing, Frequency - PRN (as needed). Intervention- monitor for effectiveness of medication, Disciplines- Skilled Nursing, Frequency - PRN. Intervention- monitor for side effects of medication, Disciplines- Skilled Nursing, Frequency - PRN. Intervention- observe for s/s of low blood sugar (sweating, headache, light headed, confusion, slurred speech, drowsiness, Intervention -Observe for s/s pf high blood sugar (polyuria, blurred vision, weakness, headache, anorexia, N & V, abdominal pain, acetone breath, mental changes, hypotension, intervention - Monitor accuchecks per MD order Intervention- serve diet per MD order, Disciplines - Dietary- Licensed Practical Nurse- Registered Nurse, Frequency -PRN. Intervention - Notify MD as needed, Disciplines - Skilled Nursing, Frequency - PRN. A review of the Care Plan did not indicate a Care Plan for the care and treatment and use of Anticoagulant medications. A physician's order dated 11/20/17 indicated: "enoxaparin (Lovenox) 30 mg/0.3 ml sc syrg - inject 0.3 ml beneath the skin every 12 hours. Lovenox for 3 weeks." A Medication Administration History document date range 11/20/17 to 12/07/17 indicated: "enoxaparin 30 mg/0.3 ml, 12/03/17 (06:01) - 12/03/17 (07:05) Not Administered; 12/03/17 (19:01) -12/03/17 (20:33) Not Administered; 12/04/17 (06:01) - 12/04/17 (06:28) Not Administered; 12/04/17 (19:01) - 12/04/17	F 760		

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F 760	Continued From page 160 (20:09); 12/05/17 (06:01) - 12/05/17 (10:07) Not Administered; Not Administered; 12/05/17 (06:01) - 12/05/17 (19:01) - 12/05/17 (18:04) Not Administered." During an interview on 12/4/17 at 1:05 P.M. with Resident #147's wife, she stated, "Resident #147 had not received his heparin due to non-availability for several days." During an interview on 12/6/17 at 12:45 P.M. with the 300 Unit Nurse Manager, she stated she was not aware of Resident #147 medications not being available, but would look into it." The 300 Unit Nurse Manager came back and stated, "it looks like there may have been a mix-up in his order." A Medication Administration policy revised 2/21/17 indicated: "The physician must be promptly notified of omission, or refusal, of any medication which causes the resident discomfort, or jeopardizes health and safety. All other omissions or refusals will be reported to the physician after missing three (3) consecutive doses." A Pharmacy Process Prescriber Medication Orders Policy revised on 1/17/17 indicated: "The licensed nurse will read the order. If the order is not clear to the nurse, the physician will be contacted for clarification. The nurse communicates the order to the pharmacy via Vision for fax."	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791		1/15/18

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F 791	Continued From page 161 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are	F 791		

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F 791	Continued From page 162 eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and clinical record review the facility staff failed to ensure 1 of 26 residents in the survey sample obtained dental services to meet the residents needs, Resident #64. The facility staff failed to make a follow up oral surgery appointment after a referral was obtained from the dentist for Resident #64. The findings included: Resident #64 was admitted to the facility on 1/25/16 with diagnoses to include, but not limited to chronic obstructive pulmonary disease (COPD). The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 10/26/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The Person Centered Comprehensive Plan of Care dated 11/1/17 identified as a problem that Resident # 64 had a broken front lower tooth. The goal was that the resident would be free of dental pain. One of the intervention listed to achieve the goal was to schedule a dental evaluation and arrange for follow up care as indicated. On 12/04/17 at 12:14 PM, Resident # 64 was	F 791	1. Resident #64 has a routine dental follow up appointment scheduled for 1/4/18. 2. All residents requiring follow up dental services are at risk of not receiving assistance in making appointments. 3. 100% of all licensed nursing staff and Social Services staff will be educated on Sentara Life Care policy entitled Dentistry Services revised 1/17/17 to include provision of assistance in obtaining follow up dental appointments when necessary on 1/2/18-1/12/18. 4. The Director of Social Services (or designee) will audit all dental service recommendations weekly x 45 days to determine if assistance with follow up appointments has been provided. The Director of Social Services will summarize the audits and present to the QAPI committee for recommendations and additional oversight.	

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observed in bed and awake. She was interviewed about dental care. She stated the dentist came to visit a few months ago after losing a "cap". The resident stated the loss of the "cap" interfered with eating and has to use the other side of her mouth to chew. The resident stated a dental follow up for oral surgery was supposed happen but did not know the status at this time. The resident denied any pain at this time.

A review of the clinical record was conducted. The resident's weights indicated no weight loss since the loss of the dental crowns in October 2017. The resident's weight on 10/24/17 was 185 pounds, current weight was 188 pounds.

Clinical notes dated 9/28/17 documented that the "resident's lower tooth fell out. Resident denies pain". The Resident Representative/ Party (RR/RP) and the physician were notified.

Clinical notes dated 9/29/17 documented that the resident's RP was contacted and notified that the dentist who used to come to the facility no longer comes to the facility. A voicemail was left to "find out if the RP wants resident to go for a dental appt. (appointment)."

Clinical notes dated 10/16/17 documented by the unit manager read, "Contacted (name of dental surgery group) for resident to be seen for chipped tooth. Indicated we would have to have a referral prior to being seen. Social work contacting facility dentist".

Clinical notes dated 10/20/17 documented by the unit manager read, "Dentist in to see resident's broken teeth. Contacted (name of dental surgery

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F 791	Continued From page 164	F 791		

group) for referral for extraction...".

The Dental Patient Record dated 10/20/17 note read, " #25 & 26 both crowns are broken at the gingival margin the teeth need to be extracted pt. (patient) has no pain needs referral to oral surgeon".

The clinical record failed to evidence any further action by the staff to ensure the referral to the oral surgeon was complete and an appointment was made.

On 12/7/17 at 9:55 AM, the unit manager was interviewed and asked about the delay and failure to obtain an appointment with the oral surgeon for the resident. She stated, "I'm not sure...I made initial contact with (name of oral surgeon group), I sent them a fax...I believe I called them and left a voice mail...". She further stated, "There probably needs to be a better process between me and the nurses...before we used to have a desk nurse who would make the appointments...I think it got lost in the shuffle...". She stated she refaxed the referral this morning to the oral surgeon's office. She spoke to someone at the office to ensure the refaxed referral was received. She was told someone would review it and get back to the nurses on the unit.

On 12/08/17 at 12:11 PM, an interview about dental services for Resident #64 was conducted with the Social Worker (SW#2). The SW stated she is responsible for scheduling the dentist visits every quarter. A list of residents to be seen is distributed to the units. The contracted dental services provider sends her the resident list. On the day of the dentist visits she assists with coordinating with staff to ensure the residents on

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F 791	Continued From page 165 the list are taken to the designated exam room. She stated the business office handles any additional insurance needs. When asked specifically for the status of the referral to the oral surgeon per the dentist on 10/20/17 she stated she was first made aware of this referral two days ago when the unit manager came to her. She stated she used to get the referrals directly from the dentist after the residents were seen. She would then communicate referrals/follow ups to the nursing staff. At that point nursing would be responsible for the recommended follow ups to include making appointments if the resident required outside dental services. She further stated, "From now on my part will be to call the families to let them know the resident has been seen by the dentist and a referral was needed. In addition, I will follow up with the nursing staff to make sure an appointment was made and follow up on the status of a referral". The SW stated she will ensure documentation will be done with the follow ups. On 12/11/17 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). The above findings of the facility's failure to obtain an appointment to the oral surgeon per the referral dated 10/20/17 and the staffs failure to follow up was shared. The DON response was that it that this was "Not acceptable". No additional information was provided to the survey team prior to exit to support compliance.	F 791		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)	F 825		1/15/18

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F 825	Continued From page 166 §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review the facility staff failed to ensure a speech screen was completed for 1 out of 26 residents (Resident #85) in the survey sample. The facility staff failed to ensure a speech screen was completed for Resident #85 who was having difficulty swallowing. The findings included: Resident #85 was originally admitted to the facility on 8/20/13. Diagnosis for Resident #85 included but not limited to *Dysphagia and *Dementia. The Resident was coded with a Brief Interview for Mental Status (BIMS) score of 12 out of a	F 825	1. A Speech therapy screen was completed for resident #85 on 12/7/17. No services were recommended. 2. All residents referred to rehabilitative services for screening are at risk if the service is not provided. 3. 100% of all facility staff will be educated on Sentara Life Care policy entitled New Patient Referrals/Request for Services revised on 10/9/17 to include completion of a referral request and provision of therapy services if indicated on 1/2/18-1/12/18. 4. The Therapy Team Coordinator will audit all therapy referrals weekly x 45 days to determine if services were provided as indicated. The Therapy Team	

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F 825	Continued From page 167 possible 15, indicating moderate cognitive impairment. In addition, the MDS coded Resident #85 requiring total dependence of two with transfer, extensive assistance of one with bed mobility, dressing, toilet use, personal hygiene and bathing and set-up help only with eating. *Dysphagia is difficulty in swallowing, commonly associated with obstructive or motor disorders of the esophagus (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition). *Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm). The Physician Order Sheet for December 2017 indicated a regular diet. According to clinical documentation written by the social worker (SW) on 11/16/17 at approximately 11:22 a.m., indicated the following: "Had a care plan meeting with Resident #85's daughter in which weight loss was discussed. The daughter stated the following: Mom is not wanting to swallow her food, she can't swallow; therapy has been contacted and the clinical manager to put order in for speech therapy (ST) to screen due to her swallowing issues." An interview was conducted with the social worker (SW) on 12/8/17 at approximately 9:15 a.m., who stated "During the care plan meeting	F 825	Coordinator will summarize the audits and present to the QAPI committee for recommendations and additional oversight.	

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the daughter voiced concerns related to Residents #85 having difficulty swallowing and that she sent the rehab director an email on 11/16/17, requesting a ST screen.

According to clinical documentation, an email was sent from the SW to the Rehab Director on 11/16/17 at approximately 10:47 a.m., the SW requested the following: "Can you have ST screen Resident #85 for swallowing issues, we just had a care plan meeting with the residents' daughter and she states that she believes her mom is having a hard time swallowing."

During the review of Resident's #85 clinical record; the surveyor was unable to locate if a ST screen was completed.

An interview was conducted on 12/8/17 at approximately 10:00 a.m., with the Clinical Manager on Coastal Cottage; the surveyor asked if she had informed ST that Resident #85 needed a speech screen due to swallowing issues that was discussed during her care plan meeting on 11/16/17, she replied, "Usually I will tell the therapist verbally and write an order in Vision but because there is no screen form to complete; I guess I slipped on that one." The surveyor asked when should a screen be completed, she relied "All screens should be followed through within 24 hours."

An interview was conducted with the ST on 12/8/17 at approximately 10:35 a.m., who stated, "The ST screen was verbally told to me about 2 weeks ago when I was treating someone else and I totally forgot; it was my fault." The ST proceeded to say we need to work on our communication progress because when I'm

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treating someone, I shouldn't be verbally told while treating or working with another resident. The ST stated, she was waiting for an order to appear in Vision but one never did, I was informed yesterday, 12/7/17, that a screen was needed on Resident #85 due to swallowing issues; the ST screen was completed on 12/7/17.

According to clinical documentation indicated the following note written on 12/7/17 at approximately 2:18 p.m., "ST screen completed. Resident #85 was seen in the facility's dining room sitting upright in the wheelchair. Resident consumed regular diet textures without sign/symptoms (s/s) of aspiration. No further ST services needed at this time."

On 12/8/17 at approximately 2:40 p.m., an interview was conducted with the Rehab Manager, who stated "She verbally informed the ST the same day she received an email from the SW on 11/16/17 to screen resident due to having difficulty swallowing."

The facility administration was informed of the findings during a briefing on 12/11/17 at 5:50 p.m. The facility did not present any further information about the findings.

The facility's policy: New Patient Referrals/Request for Services (Revision 10/9/17).

Exceptions: Therapy screenings may be done without a physician's order to determine need for therapy services. This includes chart review, and interview of the patient/caregivers, as well as general observation of the patient. Therapists may provide community education and

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F 825	Continued From page 170 wellness/injury prevention training without a physician's orders.	F 825		
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 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,	F 842		1/15/18

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F 842	Continued From page 171 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 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 record review, staff interview and facility policy, the facility staff failed to ensure 1 resident (Resident #147) clinical records were accurate and complete in the survey sample of 26 residents.	F 842	1. The physician order for insulin administration and blood glucose monitoring for resident #147 was clarified on 12/8/17 for staff to perform and record the results. The missed doses of Lovenox for resident #147 was reported to the physician on 12/11/17. No new orders	

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F 842	Continued From page 172 The findings included: Resident # 147 was admitted to the facility on 11/20/17 with diagnoses of multiple closed fractures of pelvis, closed fracture of shaft of right tibia and fibula, rib fractures, coronary artery bypass draft, chronic anticoagulation, asbestosis, COPD, osteoarthritis of knees, cardiovascular disease, sleep apnea, stroke, internal carotid aneurysm, history of renal mass, hypertension, severe obesity, type 2 diabetes mellitus, major depression, hyperlipidemia, and hypertrophy of prostate. Resident #147 was not provided six doses of enoxaparin (Lovenox) 30 mg./0.3 ml subcutaneous via syringe. facility staff failed to ensure Resident #147 clinical records were accurate and complete for the administration and monitoring of insulin and blood glucose levels. The Nursing Drug Guide Handbook dated 2016 indicates: Lovenox-Therapeutic class: Anticoagulants ; Pharmacological class: Low-molecular-weight heparin's. Used to prevent PE (pulmonary embolus) and DVT (deep vain thrombosis) after hip or knee replacement surgery. To prevent PE and DVT in patients with acute illness who are at increased risk because of decreased mobility. An Initial Minimum Data Set (MDS) dated 12/1/17 assessed Resident #147 in the area of Cognitive Patterns - Brief Interview of Mental Status (BIMS) as a (15). In the area of Activities of Daily Living (ADL's) this resident was assessed as a (3/30 in the area of bed mobility, a (7/2) in the area of transfer, a (7/3) in the area of walk in room, (2/2) in the area of dressing, a (0/1) in the area of	F 842	were given. 2. All residents are at risk if the medical record does not accurately reflect the care and services received by the resident. 3. All licensed nursing staff will be educated on Sentara Life Care policy entitled Medication Administration revised 12/27/17 to include accurate documentation in the clinical record 1/2/18-1/12/18. 4. The Clinical Managers (or designee) will audit 5 charts weekly x 45 days to determine that all prescribed medications have been administered as ordered or that physician and pharmacy notification has occurred. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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eating, a (3/3) in the area of toilet use, and a (3/3) in the area of personal hygiene.

In the area of Medications this resident was assessed as receiving injections for (7) days.

In the area of Insulin this resident was assessed as receiving insulin for (4) days.

In the area of Orders for Insulin changes- this resident was assessed for (0) days.

In the area of Medications Received - this resident was assessed as receiving Anticoagulant for (7) days.

There was no Care Plan for the use of Anticoagulant medications.

A Care Plan dated 12/6/17 indicated : "Problem- Potential for hypo/hyperglygycemia r/t: DX of DM (resident diagnoses of diabetes mellitus) Goals _ resident will have no s/s (signs or symptoms) of diabetic reaction with blood sugars within normal range of 60/120 mg/dl x (time) 90 d (days).
Interventions- Administer medication per MD order, Disciplines -Nursing, Frequency - PRN (as needed).
Intervention- monitor for effectiveness of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- monitor for side effects of medication, Disciplines- Skilled Nursing, Frequency - PRN.
Intervention- observe for s/s of low blood sugar (sweating, headache, light headed, confusion, slurred speech, drowsiness,

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Intervention -Observe for s/s pf high blood sugar (polyuria, blurred vision, weakness, headache, anorexia, N & V, abdominal pain, acetone breath, mental changes, hypotension,
intervention - Monitor accuchecks per MD order
Intervention- serve diet per MD order, Disciplines - Dietary- Licensed Practical Nurse- Registered Nurse, Frequency -PRN.
Intervention - Notify MD as needed, Disciplines - Skilled Nursing, Frequency - PRN.

A physician's order dated 11/20/17 indicated: "enoxaparin (Lovenox) 30 mg/0.3 ml sc syrg - inject 0.3 ml beneath the skin every 12 hours. Lovenox for 3 weeks."

A Medication Administration History document date range 11/20/17 to 12/07/17 indicated: "enoxaparin 30 mg/0.3 ml, 12/03/17 (06:01) - 12/03/17 (07:05) Not Administered; 12/03/17 (19:01) -12/03/17 (20:33) Not Administered; 12/04/17 (06:01) - 12/04/17 (06:28) Not Administered; 12/04/17 (19:01) - 12/04/17 (20:09); 12/05/17 (06:01) - 12/05/17 (10:07) Not Administered; Not Administered; 12/05/17 (06:01) - 12/05/17 (19:01) - 12/05/17 (18:04) Not Administered."

During an interview on 12/4/17 at 1:05 P.M. with Resident #147's wife, she stated, "Resident #147 had not received his heparin due to non-availability for several days."

During an interview on 12/6/17 at 12:45 P.M. with the 300 Nurse Manager, she stated she was not aware of Resident #147 medications not being available, but would look into it." The 300 Nurse Manager later stated, "it looks like there was a

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mix-up in his order." When asked had the doctor been informed of the missed doses, she stated, "No".

A Medication Administration History print-out with a 11:46 A.M. 12/07 17 run date indicated: " Novolin 70/30 100 unit/ml subcutaneous suspension two times daily starting 11/22/17. An Administration History form with a date administered column indicated: 11/22/17 (7:30) date documented (11:22/17 (08:23) Not administered, Notes: resident wife taking BS (blood sugar) and injecting insulin

An Administration History form indicated: date administered column 11/22/17 (7:30) - 11/22/17 (8:23) Blood Sugar Site - Value (Blank). 11/22/17 (16:30) -11/22/17 - 11/22/17 (17:34) Blood Sugar value 129, Insulin not administered wife administered.

An Administration History form dated 11/23/17 (7:30) - 11/23/17 (8:51) blood sugar site Value (blank) Notes - Resident wife stated she does BS and administer insulin.

There is no further documentation of Novolin or Blood Sugar levels being shared or documented by the facility staff.

A Medication Administration policy revised 2/21/17 indicated: "The physician must be promptly notified of omission, or refusal, of any medication which causes the resident discomfort, or jeopardizes health and safety. All other omissions or refusals will be reported to the physician after missing three (3) consecutive

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F 842	Continued From page 176 doses."	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 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	F 880		1/15/18

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F 880	Continued From page 177 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 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 observations, record review, staff interview and facility document review the facility staff failed to implement appropriate infection control practices for 2 of 26 residents in the survey sample, Residents #148 and #351. 1. The facility staff failed to ensure isolation	F 880	1. An isolation sign indicating required precautions was posted at the door for resident #148 on 12/15/17. Resident #351 was discharged on 12/15/17. No immediate correction is possible. 2. All residents are at risk of infection if necessary precautions are not communicated properly through required	

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F 880	Continued From page 178 precaution and oxygen signage were posted for Resident #148. 2. The facility staff failed to ensure an opened bottle of sterile water used to care for Resident #351's CPAP unit tubing and mask was clean and dated. The findings included: 1. Resident #148 was admitted to the facility on 11/17/17 with diagnoses of Pneumonia, gastrointestinal hemorrhage. The facility staff failed to post infection and oxygen usage signs. A review of the clinical records indicated: Resident #148 was transferred to room 307 on 12/04/17. During the initial tour of this unit on 12/4/17 at 10:45 A.M. this room was noted to be unoccupied. On 12/4/17 at 2:15 P.M. the room was observed to be occupied with infection gowns, mask, red waste bags hanging from the door. A physician's order dated 12/01/17 indicated: Isolation precautions MRSA -sputum. An isolation precautions sign was not placed on the door until 12/6/17. Staff and family members were observed entering the room. A physician's order dated 11/18/17 indicated: O2 at 2 L/m via nasal cannula with humidification. During the initial tour of this unit on 12/4/17 at 10:45 A.M. this room was noted to be unoccupied. On 12/4/17 at 2:15 P.M. the room was observed to be occupied with infection gowns, mask, red waste bags hanging from the door. There was no signage indicating contact precautions or oxygen in use.	F 880	signage. All residents are at risk if opened bottles of saline used for cleaning respiratory equipment are not properly dated. 3. 100% of the facility staff will be educated on Sentara Life Care policy entitled Isolation Procedure #206 revised 9/1/16 to include posting the appropriate signage indicating which transmission based precautions to follow on 1/2/18-1/12/18. 100% of all licensed nursing staff will be educated on Sentara Life Care policy entitled Medications: Expiration Dates revised 1/17/17 to include dating bottles of saline products when opened on 1/2/18-1/12/18. 4. The Clinical Manager (or designee) will audit isolation rooms weekly x 45 days to assure proper signage is in place as indicated. The Clinical Managers (or designee) will audit 10% of resident rooms weekly to assure any open vials of saline have been properly dated. The audits will be summarized by the DON and presented to the QAPI committee for recommendations and additional oversight.	

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During an interview on 12/7/17 at 10:00 A.M. with the 300 Unit Nurse Manager she stated, it was an over site for the signs not being posted.

2. Resident #351 was admitted to the facility on 12/2/17. Diagnoses for Resident #351 included but are not limited to Emphysema* (1) and Diabetes Mellitus* (2).

Resident #351's Interim Care Plan documented the following:

Resident Need: Oxygenation related to COPD (Chronic Obstructive Pulmonary Disease), Emphysema Start Date: 12/3/17

Approaches included but were not limited to:

Evaluate respiratory status every shift and as needed
Oxygen per Medical Doctor order

Resident #351 current Physician orders included no orders for Resident #351 to have, use and provide care for his personally owned CPAP unit.

The Interim Care Plan did not document that Resident #351 was admitted with his own personal owned CPAP (Continuous Positive Airway Pressure) unit and that Resident #351 was performing his own care to his unit. In addition, the Interim Care Plan did not document any specifics related to what type of care the CPAP unit required.

On 12/4/17 at approximately 1:15 PM, Resident #351's CPAP mask was observed lying on top of his bedside table. The tubing for it was lying in

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his opened bedside table drawer without a date as to when it was last cleaned or changed.

On 12/4/17 at approximately 5:45 PM, Resident #351's CPAP mask was observed lying on top of his bedside table. The tubing for it was lying in his opened bedside table drawer without a date as to when it was last cleaned or changed.

12/06/17 at approximately 03:35 PM, Resident #351 was observed in his Room, oxygen at 2 liters via nasal cannula. Resident stated, "Therapy went well." Non dated 1 liter opened bottle of Sterile water observed at bedside.

12/07/17 at approximately 10:02 AM, Resident #351 was observed in his room with the Unit Manager #4 in attendance. 1 Liter opened Sterile Water undated bottle was observed at bedside. The Unit Manager #4 removed the undated bottle of Sterile Water. The Unit Manager #4 and Surveyor looked at CPAP tubing it was dated 12/5/17. The CPAP mask was not with the CPAP tubing. Asked what the practice was for storage of sterile water. The Unit Manager #4 stated that she's only been here a short time, and it is practice to date bottles when open. The Unit Manager #4 stated it should be stored in his locked cabinet in his room which it was not. The Unit Manager #4 stated that she was not sure where the mask is, she stated that she has been teaching staff that night shift usually changes tubing or if someone is in there and sees it needs to be changed at any time. The Unit Manager #4 stated tubing is getting changed Midnight shift on Tuesday nights. When asked what the facility practice is when a resident is admitted with undated tubing, the Unit Manager #4 stated, "I guess the admission nurse should change tubing

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and date so that we know when it was last done and then it would be done on midnight shift every Tuesday after that."

Resident #351 was observed on 12/07/17 at approximately 05:27 PM eating in dining room and sitting in a wheel chair. Resident #351 stated "I clean my own mask (CPAP). I put the water in the CPAP and sometimes the girls do it. I doubt they even know I clean the mask. I clean it with soap and water every day."

On 12/08/17 at approximately 3:00 PM, the Director of Nursing (DON) was asked if it is the expectation that Resident #351's CPAP unit be clean properly to reduce the potential risks for infection. The DON stated, "Yes, it would be the expectation." The DON was asked if Resident #351 had been assessed to determine if he was cleaning his equipment as recommended by the Standards of Professional Practice. The DON stated, "There is no documentation to show that he was."

The Facility's Policy and Procedure titled, "Positive Airway Pressure (PAP) Devices: Equipment Cleaning" with a revision date of 6/23/16 documented the following:

PAP Equipment will be maintained in clean condition.
Clean headgear and tubing once a week and as needed.
Wash/wipe clean nasal pillows or mask daily as needed.
Clean the flow generator once a week and as needed.
Clean devise filters once a week and as needed.
Empty daily, refill with distilled or sterile water

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nightly.
Clean humidifier reservoir weekly.

The Center of Disease Control (https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf) documented the following:

Medical equipment and instruments/devices must be cleaned and maintained according to the manufacturers ' instructions to prevent patient-to-patient transmission of infectious agents86, 87, 325, 849. Cleaning to remove organic material must always precede high level disinfection and sterilization of critical and semi-critical instruments and devices because residual proteinacous material reduces the effectiveness of the disinfection and sterilization processes 836, 848. Non critical equipment, such as commodes, intravenous pumps, and ventilators, must be thoroughly cleaned and disinfected before use on another patient. All such equipment and devices should be handled in a manner that will prevent HCW (Health Care Worker) and environmental contact with potentially infectious material.

The facility administration was informed of the findings during a briefing on 12/11/17 at approximately 6:10 p.m. The Facility was specifically asked if they any Infection Control Policy relating to CPAP units and tubing that they wanted to present in addition to care of PAP unit Policy. The facility did not present any further information about the findings.

Definitions:

1. CPAP-Continuous positive airway

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F 880	Continued From page 183 pressure:...Patients with obstructive sleep apnea treated with CPAP wear a face mask during sleep which is connected to a pump (CPAP machine) that forces air into the nasal passages at pressure high enough to overcome obstructions in the airway and stimulate normal breathing. Source-www.Mayoclinic.org 2. Emphysema: Medline Plus documented: Emphysema is a type of COPD involving damage to the air sacs (alveoli) in the lungs. As a result, your body does not get the oxygen it needs. Emphysema makes it hard to catch your breath. You may also have a chronic cough and have trouble breathing during exercise. 3. Diabetes Mellitus: Medline Plus documented: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high.	F 880		