STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. BUILDING ______ B. WING ______	C 08/31/2017

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F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 8/29/17 through 8/31/17. Five (5) complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 124 certified bed facility was 75 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13) and 8 closed record review (Residents #14 through #21).	F 000	F000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or of any conclusion set forth in the statement of deficiencies. This POC is prepared solely because it is required by the provisions of Federal and State laws.	
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review the facility's staff failed to assure that sufficient and appropriate social services are provided to meet the resident's needs for 1 of 21 residents (Resident #8), in the survey sample. The facility staff failed to assure a Pre-admission Screening and Resident Review (PASRR) Level II evaluation was conducted for Resident #8. The findings included: Resident #8 was originally admitted to the facility	F 250	F250 The facility staff must assure that sufficient and appropriate social services are provided for residents by obtaining a Pre-Admission Screening and Resident Review (PASRR) Level II when necessary. 1. A Level II screening has been requested for resident #8. 2. All residents with a mental health diagnosis may be at risk. 3. A 100% audit was conducted by the Social worker to determine any additional Level II screenings needed. All new admissions will be reviewed by the Admissions Coordinator prior to admission to assure a Level II screen is completed if necessary. 4. The Administrator will audit 2 new admissions weekly x 90 days for compliance. Audits will be presented to the QAPI comittee for additional oversight or recommendations. 5. Date certain: 10/15/17	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Wilhelm RN, LNHA	Administrator	9/21/17

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

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F 250	Continued From page 1 8/23/16, and readmitted from a local hospital on 11/22/16 after an acute illness. The current diagnoses include schizophrenia and intellectual disability. Resident #8 had a quarterly MDS (minimum data set) assessment completed with an ARD (assessment reference date) of 8/14/17. It coded the resident as completing the Brief Interview for Mental Status and scoring 15 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were intact. This MDS assessment also coded the resident in section "G" Functional Status, as requiring supervision of 1 person with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident was also coded as independent after set-up with locomotion and eating. In section "H" Bladder and Bowel, the resident was coded as always continent of bowels and bladder. Review of the clinical record revealed a level I PASRR completed on 8/15/16 but a follow-up Level II assessment was not located in the clinical record. After a Level II evaluation is conducted, a report or summary is generated. This summary is a legal document with identified service needs for placement and treatment. Nursing facilities must keep a copy of this summary in an individual's clinical chart at all times. PASRR identified services must be addressed in the nursing facility's plan of care. Finally, PASRR laws also mandate that nursing facilities notify the PASRR authority when an individual experiences certain changes in status. These follow-up PASRR	F 250		

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evaluations may be called resident reviews or change in status evaluations. Sometimes these are conducted as phone based reviews, and sometimes they are in-person evaluations. PASRR laws ensure that nursing facilities continue to monitor individuals with disabilities for placement and treatment appropriateness. (http://www.dmas.virginia.gov/Content_atchs/ltc/VA%20PASRR%20Training%20Dec%202015.pdf)

An interview was conducted with Social Worker #2 on 8/31/17 at approximately 12:35 p.m. Social Worker #2 stated she delivered the letter to Resident #8 that she was being discharged for non-compliance with the smoking policy and she was identifying facilities which permit smoking for placement. Social Worker #2 also stated the resident was unsafe sitting alongside the driveway to smoke. She further stated if a facility was not identified the intention had been to discharge the resident to her brother's home, until he notified social services that placement in his home was not an option. Social Worker #2 was asked if PASRR authorities (to have a Level II screening) had been notified of Resident #8's pending discharge for evaluation of needed community supports and appropriate treatment. Social Worker #2 stated she had made 2 phone calls to the local community service board but had not spoken with anyone concerning Resident #8's status or pending discharge. Documentation of whom was contacted and why the call was made was not provided to the surveyor

The Level 1 screening dated 8/15/16, completed prior to Resident #8's admission to the nursing facility recommended a referral for a secondary assessment (Level II) for "Mental Retardation" Intellectual Disability which was manifested prior

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to age 18 and a dual diagnosis of an mental illness (schizophrenia).

The Level II screening was not coordinated or completed for Resident #8. The only documentation the facility was able to produce was a phone call on 8/18/17, nothing in 2016.

As a result of not having the Level II screening completed PASRR services were never addressed such as unique disability supports and services the resident needed while a resident in the nursing facility to ensure safety, health and well-being. Also, transition to the community supports have not been explored at a time when the facility staff desires to discharge the resident from the facility.

The above findings were shared with the Administrator and Director of Nursing. No additional information was provided.

The Facility's policy on PASRR process was requested but not provided but the state of Virginia PASRR information is as follows:

PASRR components include a Level I screening. In VA, this is called the DMAS 95. This screening identifies the presence or suspicion of a disability condition. Every person admitting to a Medicaid certified nursing facility, regardless of the individual's pay source, must have a Level I screen conducted. If a disability is present or suspected, the individual is referred for a Level II evaluation. If the Level I screen indicates no disability is present or

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F 250	Continued From page 4 suspected, then no further PASRR activity is required prior to admission to a nursing facility. Persons with sole dementia with no suspicion of an underlying mental illness and with no suspicion of an IDD condition do not need to be referred for PASRR Level II evaluations are individualized. They evaluate the suspected PASRR condition and make level of care, placement, and treatment recommendations. Some Level II decisions are abbreviated, and can be completed using information submitted as part of the online Level I process. Some Level II evaluations require a comprehensive onsite evaluation by an Ascend clinical professional. (http://www.dmas.virginia.gov/Content_atchs/ltc/VA%20PASRR%20Training%20Dec%202015.pdf)	F 250		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, the facility staff failed to ensure a clean and sanitary Posey Bed. The findings included: Resident #3 was admitted to the facility on 11/28/14 with a readmission on 5/29/17. Diagnoses for Resident #3 included but are not limited to Huntington's Disease (1), Non-Alzheimer's Dementia, and Anxiety.	F 253	F253 The facility staff must assure a sanitary, orderly, and comfortable interior environment. 1. The mesh panel on resident #3's bed was replaced on 8/31/17. 2. All residents with assistive devices are at risk. 3. The clinical managers will audit this and other identified devices to assure cleaning needs are met twice weekly x 90 days. 4. The DON will review audits, summarize and present to the QAPI committee for additional oversight or recommendations. 5. Date certain: 10/15/17	

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Resident #3's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 8/3/17 coded Resident #3 with both short and long term memory problem and severely impaired cognitive skills for daily decision making. Resident #3 was coded as activity did not occur for Walking. Resident #3 was coded as requiring Total dependence with one person physical assist for Locomotion. Resident #3 was coded as always incontinent of bowel and bladder functioning. Resident #3 was coded as totally dependent with two staff person assistance for dressing.

Resident #3's Physician order dated 10/14/16 documented: Posey Safe Bed (2), Check resident every 2 hours, and as needed.

Resident #3's 9/29/16 General note was the last documented Activity for Resident #3 that occurred outside of her room. The Posey Safe Bed was ordered and started 10/14/16 per Physician order.

On 8/29/17 at approximately 11:45 a.m., Resident #3 was observed lying on her right side in her Posey bed with eyes closed, facing the window. A sheet was partially covering the upper portion of Resident #3. It was difficult to see Resident #3 through the mesh panels as the mesh clouded the clarity of the Resident's features.

On 8/29/17 at approximately 1:30 p.m., Resident #3 was observed in her Posey Bed, lying on her back and moving from right to left in her bed. Resident #3 had a shirt and only an adult incontinent brief on. The sheet was lying beside Resident #3. The room was dark, no lights were

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F 253	Continued From page 6 on. On 8/29/17 at approximately 4:50 p.m., Resident #3 was observed in her dark room, lying on her back moving from right to left. On 8/29/17 at approximately 12 noon, Resident #3 was lying in her Posey bed, moving slightly from right to left. Resident #3 wore a shirt and an adult incontinent brief and had on non slip socks. On 8/29/17 at approximately 12:05 p.m. the Certified Nursing Assistant (CNA # 2) entered Resident #3's room to see if her incontinent brief required changing. Resident #3's brief was dry. The surveyor observed light brown stains on the mesh side of the Posey bed approximately 1/3 up from the foot of the bed. CNA #2 left and returned at approximately 12:30 p.m. with a pureed diet. The CNA #2, unzipped the mesh side portion of the Posey bed and raised Resident #3's head of bed. The CNA #2, then sat beside Resident #3 and began to feed her. The CNA #2 was talking with Resident #3 during the time she fed her. Resident #3 was observed eating quietly during this time. Prior to eating, Resident #3's speech was heard to be grunts and groans. A large stuffed animal was in Resident #3's bed with her. Resident #3's left elbow was observed to be red without skin breakdown. On 8/30/17 at approximately 1:15 p.m., Resident #3 was observed in her room, her television was on with only fuzz showing. Resident #3, was lying in her Posey bed, quietly with eyes closed. Staining was observed on the side mesh panel of Resident #3's bed. On 8/31/17 at approximately 3:00 p.m., Resident #3, was observed in her room, wearing a shirt,	F 253		

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adult incontinent brief, with the sheet partially covering her. Resident #3 was lying quietly in her bed with eyes open. Staining on the side of mesh panel of Resident #3's bed was no longer visible.

On 8/30/17 at approximately 12:30 p.m., CNA #2 after being asked what she thought the stains were on the Posey bed side mesh panel, she stated, "That's most likely blood. We used to have her bed turned beside the wall but had to move it back to where only the headboard hits the wall as she (Resident #30) was hitting her knee through the mesh and hitting the wall. It caused her knee to bleed." Scabs and scratches were observed on Resident #3's knee.

On 8/31/17 at approximately 10:45 a.m., the Unit 1 Manager, Registered Nurse (RN) #1 was asked about the staining of the mesh panels on Resident #3's bed. RN #1 stated, "We learned of this yesterday and have put in a request to have the panels replaced." RN #1 was asked what the routine maintenance was for the bed. RN #1 stated, "We have the bed cleaned as we see a problem with it."

The Facility Policy and Procedure, titled: "Geri / Wheelchair Other Resident Equipment - Disinfecting and Cleaning" with a revision date of 1/14/14 documented the following:
"Clean assistive devices (such as walkers/quad canes), fall mats and any other resident equipment between residents and as needed."

The facility administration was informed of the findings during a pre-exit briefing on 8/31/17 at approximately 1:30 p.m. The facility did not

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present any further information about the findings.

DEFINITIONS:

(1) Huntington's Disease: Medline Plus documented the following:
Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions.

If one of your parents has Huntington's disease, you have a 50 percent chance of getting it. A blood test can tell you if have the HD gene and will develop the disease. Genetic counseling can help you weigh the risks and benefits of taking the test.

There is no cure. Medicines can help manage some of the symptoms, but cannot slow down or stop the disease.

(2) Posey Safe Bed: Posey.com documented:
RECOMMENDED USE: Patients at extreme risk of a serious injury from a fall, or unassisted bed exit. This bed has mesh panel sides and padded head and foot rails.

F 274 SS=D 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE

F 274 (Plan of Correction): F274

The facility staff must assure a MDS assessment is completed when a-

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F 274	Continued From page 9 (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual the facility staff failed to complete a significant change assessment for 1 of 21 residents (Residents #8), in the survey sample. The facility staff failed to complete a significant change Minimum Data Set (MDS) assessment for Resident #8 after staff recognized she had experienced a major improvement in 2 or more areas. The findings included: Resident #8 was originally admitted to the facility 8/23/16, and readmitted from a local hospital on 11/22/16 after an acute illness. The current diagnoses include stroke with hemiparesis, schizophrenia, intellectual disability, diabetes mellitus, and spinal stenosis. Resident #8 had a quarterly MDS (minimum data set) assessment completed with an ARD	F 274	significant improvement in condition has occurred. 1. A MDS assessment for resident #8 has been completed and submitted on 9/13/17. 2. All residents identified for a significant change in condition are at risk. 3. The IDT group will discuss any changes in resident conditions weekly to determine need for MDS assessments. Records of reviews will be maintained by the MDS coordinator. 4. Weekly reviews will be monitored by the DON x 90 days. A summary will be provided to the QAPI committee for additional oversight or recommendations. 5. Date certain: 10/15/17	

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(assessment reference date) of 8/14/17. It coded the resident as completing the Brief Interview for Mental Status and scoring 15 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were intact. This MDS assessment also coded the resident in section "G" Functional Status, as requiring supervision of 1 person with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident was also coded as independent after set-up with locomotion and eating. In section "H" Bladder and Bowel, the resident was coded as always continent of bowels and bladder.

Resident #8's admission MDS assessment with an assessment reference date (ARD) of 11/29/16 coded the resident as completing the Brief Interview for Mental Status with a score of 15/15. This assessment also coded the resident in section "G" Functional Status, as requiring extensive assistance of 2 persons with bed mobility, transfers, dressing, toileting, personal hygiene and off unit locomotion, extensive assistance of 1 person with bathing, limited assistance with walking, and on unit locomotion. In section "H" Bladder and Bowel the resident was coded as always incontinent of bowels and bladder.

Review of all of Resident #8's MDS assessments revealed the significant change (an improvement of functional status and bowel/bladder control) was initially captured on the 02/20/17 quarterly MDS assessment. This assessment was coded in section "G" Functional Status, as requiring supervision of 1 person with bed mobility, transfers, dressing, toilet use and personal

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hygiene. The resident was also coded as independent after set-up with locomotion and eating. In section "H" Bladder and Bowel, the resident was coded as always continent of bowels and occasionally incontinence of bladder.

On 8/31/17 at approximately 12:10 p.m., an interview was conducted with the MDS Coordinator. The MDS Coordinator stated comparison of the MDSs indicated a significant change assessment should have been completed but she was unable to give a rationale why it was not completed. The MDS Coordinator provided a document showing a significant change MDS had been scheduled for 9/7/17 on 8/31/17.

On 8/31/14 at approximately 3:00 p.m., the above findings were shared with the Administrator, and Director of Nursing. No additional information was provided.

The MDS 3.0 RAI manual states a significant change is a decline or improvement in the resident's status: Resident #8 experienced improvements in two or more of the following:

- Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
- Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
- Resident's decision making changes for the better;
- Resident's incontinence pattern changes for the

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F 274	Continued From page 12 better; - Overall improvement of resident's condition. RAI user's manual, Chapter 2 page 2-26, October 2016)	F 274		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278	F278 Social service staff must assure accurate MDS coding for PASRR conditions. 1. A MDS assessment has been completed and submitted for resident #8 on 9/13/17 to accurately reflect her PASRR condition. 2. All residents identified for PASRR conditions are at risk. 3. All resident face sheets will be reviewed by the Social worker to identify any Level II conditions that require coding. 4. The Director of Social work will audit MDS coding for sections A1500 and A1510 for all new admisisons x 90 days. A summary will be provided to the QAPI committee for additional oversight or recommendations. 5. Date certain: 10/15/17	

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(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual the facility staff failed to accurately code all Minimum Data Set (MDS) assessments for 1 of 21 residents (Residents #8), in the survey sample.

The facility staff failed to accurately code Resident #8's Admission MDS assessment at "A1500" and "A1510".

The findings included;

Resident #8 was originally admitted to the facility 8/23/16 and readmitted 11/22/16 after an acute hospitalization. The current diagnoses include mild intellectual disability (ID) and schizophrenia.

Resident #8 had a quarterly MDS assessment completed with an ARD of 8/14/17. It coded the resident as completing the Brief Interview for Mental Status and scoring 15 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were intact.

Review of the clinical record revealed a Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions completed on 8/15/16 by a representative from a local community service board. The screening identified Resident #8 as having a serious mental illness and a diagnosis of mental retardation/intellectual disability which manifested before age 18; therefore, the resident

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was referred for a secondary screening, a Level II.

Review of the clinical record also revealed a psychological evaluation conducted 2/2/17 revealing Resident #8 had a mental health history of schizophrenia and psychosis and when she was enrolled in school she was placed in the special education program.

According to the RAI manual the following is required: (MDS 3.0, RAI users manual, chapter 3 section A pages A18-20 October 2016)

"Health-related Quality of Life

· All individuals who are admitted to a Medicaid certified nursing facility must have a Level I Preadmission Screening and Resident Review (PASRR) completed to screen for possible mental illness (MI), intellectual disability (ID), ("mental retardation" (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the resident's method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).

· Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.

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F 278	Continued From page 15 · A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when a Significant Change in Status Assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change. Resident #8 admission MDS assessment dated 8/30/16 was coded at section "A1500" PSARR as "NO" the resident is currently considered by the state PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition, at section "A1510" the MDS assessment asks does the resident have A. a serious mental illness. B. Intellectual Disability or C. Other related condition. The facility staff didn't code anything at section "A1510". Resident #8 had another admission MDS assessment completed 11/29/16, after an acute hospital stay. Again sections "A1500" and "A1510" were not coded to identify the ID and schizophrenia diagnosis. On 8/31/17 at approximately 12:10 p.m., an interview was conducted with the MDS Coordinator. The MDS Coordinator stated she didn't code sections "A1500", "A1510" and "A1550" but after review of the sections she felt	F 278		

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F 278	Continued From page 16 they were not coded correctly. Documents were provided showing the MDS assessments had been modified to correct sections "A1500", "A1510" and "A1550". On 8/31/17 at approximately 3:00 p.m., the above findings were shared with the Administrator, and Director of Nursing. No additional information was provided.	F 278		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309	F309 Facility staff must assure physician orders are clearly stated and followed. 1. The wound care order for resident #2 was clarified by the physician on 8/30/17. Resident #17 was discharged 9/20/16; no correction is possible. 2. All residents with wound care orders are at risk. All residents with orders for blood glucose monitoring are at risk. 3. Staff will be inserviced 9/27/17-9/30/17 regarding what constitutes a compelete wound care order and what acceptable timeframes are for BGM. A 100% audit of wound care orders was conducted by the clinical managers for clarity. Any discrepancies were corrected immediately. Audits will be conducted weekly x 90 days by the clinical managers for any new orders to assure the order is complete. 20% of orders for BGM will be reviewed by the clinical manager weekly x 90 days to assure the order is followed timely.	

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consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility documentation the facility staff failed to clarify physician orders for 2 of 21 residents (Resident #2 and #17) in the survey sample.

1. The facility staff failed to clarify physician orders for a stage 3 (1) right heel pressure ulcer (2) wound treatment for (Resident #2).

2. The Facility failed to follow Physician orders for glucometer checks and insulin injections for 1 Resident (Resident #17).

The findings included:

1. Resident #2 was originally admitted to the facility on 6/7/17. Diagnoses for Resident #2 included, but not limited to: Type 2 Diabetes (3) and Peripheral Vascular Disease (PVD) (4).

Resident #2's Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/2017 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #2 requiring extensive assistance of two

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4. Audits will be reviewed, summarized and presented by the DON to the QAPI committee for additional oversight or recommendations.

5. Date certain: 10/15/17

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with bed mobility and transfers, extensive assistance of one with dressing, toilet use and personal hygiene and supervision with one assist with eating of Activities of Daily Living care. Resident #2 was coded always incontinent of bowel and bladder. Under section "M" (Skin Condition - M0100) was coded: Resident has a stage 1 or greater. (M0150) at risk for developing pressure ulcers was coded yes, (M0210) for unhealed pressure ulcers was coded yes, (M0300) for having stage 1 pressure ulcer and unstageable pressure was coded yes. (M0610) for dimension of unhealed stage 3 or 4 pressure ulcers or eschar was to identify the pressure ulcer with the largest surface area (length x width) was measured (0.5 cm x 0.6 cm x 0.1 cm). (M0700) most severe tissue type for any pressure ulcer was coded 4 for eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges), under (M1030) coded for infection of foot and under section (M1200) for skin and treatments was coded for having pressure reducing device for chair and bed, turning /repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer care, application of dressings to feet.

Review of the Physician Order Sheet and the August 2017 Treatment Administration Record (TAR) starting on 08/25/17 read: Bactroban (5) to be mixed with Santyl (6) for the right heel wound.

On 08/30/17 at approximately 1:05 p.m., the surveyor reviewed the treatment order for the right heel wound with LPN #1, then the surveyor asked, "Doing the observation with the right heel wound dressing change on 08/30/17 at 9:45 a.m., the wound to Resident #2's right heel was cleansed with Dermal Wound Cleanser (DWC)

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(7), applied Santyl mixed with Bactroban and covered with a Primapore (8) dressing. Can you tell me after reviewing the current order written on 08/25/17, how did you knew what to clean the wound with and what type of dressing should be used to cover the wound? The LPN stated, "It doesn't say it on there does it, I guess I should write an order to clarify the wound treatment for the right heel to include a wound cleanser and Primapore dressing."

An interview was conducted with Director of Nursing (DON) on 08/301/7 at approximately 1:30 p.m., who stated, "The treatment order should contain a cleanser to the clean the wound and a dressing to cover the wound."

The facility administration was informed of the findings during a briefing on 08/31/17 at 1:30 p.m. The facility did not present any further information about the findings.

The facility's policy: "Life Care - Verification of Orders (Last Revision Date: 03/23/17).
Purpose: Accurate Transcription of all orders.

MAR: Medication Administration Record / TAR: Treatment Administration Record
4. Verify accuracy of ALL orders on MAR and TAR"

Definitions:

1). Pressure Injury - Stage 3 (Full-thickness skin loss)
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth

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of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

2). Pressure Injury is an injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)
.

3). Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

4). PVD is any abnormal condition that affects the blood vessels and lymphatic vessels, except those that supply the heart (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

5). Bactroban is an antibiotic used to treat impetigo as well as other skin infections caused by bacteria

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(https://medlineplus.gov/ency/article/007365.htm).

6). Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths).

7). Dermal Wound Cleanser (DWC) is an over-the-counter, non-toxic, non-irritating, no-rinse, first-aid antiseptic product (http://www.smith-nephew.com/professional/products/advanced-wound-management/dermal-wound-skin-wound-cleanser/).

8). Primapore is a conformable adhesive dressing consisting of a breathable non-woven top layer and a low-adherent absorbent pad (www.smith-nephew.com/key-products/advanced-wound-management/primapore/).

2. Resident #17 was admitted to the facility on 11/6/13. Diagnoses for Resident #17 included but are not limited to Hypertension, Diabetes Mellitus, Hyperlipidemia, Hip Fracture, and Non Alzheimer's dementia.

Resident #17's Significant Change Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 9/20/16 coded Resident #17 with both short and long term memory problem and severely impaired cognitive skills for daily decision making. Resident #17 was coded as being totally dependent with 2 staff

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F 309	Continued From page 22 person assistance for transfers, and was coded as being totally dependent with 1 staff person assistance for dressing, hygiene, bathing and toileting. Resident #17 was coded as always incontinent of bowel and bladder functioning. An 8/26/16 Physician Progress note documented the following: "Patient with diabetes and dementia....Plan no changes. Patient has been switched to my services per Power of Attorney." An 8/31/17 Physician Progress note documented the following: "Assessment/Plan: Diabetes Controlled today at 108 (glucose) A1c 6.7 on 1/5/16 Continue to monitor lab and A1c Continue medication Regimen" Lab work of 9/2/15 documented the following: Hemoglobin A1C: 6.1 High Lab work of 3/7/16 documented the following: Hemoglobin A1C: 7.0 High Lab work of 8/31/16 documented the following: Hemoglobin A1C: 6.5 High (Normal Range 4.8-5.9) Physician Orders documented the following: 7/30/14 Humalog 100 units/milliliter (Per Sliding Scale) For DM (Diabetes Mellitus), sliding scale insulin: Blood Sugar is 150-200 - 2 units subcutaneous (sq) 201-250 - 4 units sq	F 309		

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F 309	Continued From page 23 251-300 - 6 units sq 301-350 - 8 units sq 351-400 - 10 units sq Blood sugar greater than 400 give 12 units sq Physician Order documented the following: 11/6/13 Monthly weights and vital signs There was no routine order for pulse oximetry checks. Resident #17's Care Plan of 9/1/16 documented the following: Problem: Potential for hypo/hyperglycemia Interventions included but were not limited to: Administer medication per MD (Medical Doctor) order Monitor accuchecks per MD order Review of the 2016 July Medication Administration Record (MAR) document administration times of Sliding Scale Insulin to be twice daily at 6:30 a.m. and at 16:30 (4:30 p.m.) The July 2016 MAR documents times insulin administered was at 6:30 am and 4:30 p.m. Review of the 2016 August MAR administration times of Sliding Scale Insulin to be twice daily at 6:30 a.m. and at 16:30 (4:30 p.m.) The August 2016 MAR documents times insulin administered was at 6:30 am and 4:30 p.m. Review of the 2016 September MAR documented Resident #3 was admitted to the facility on 11/28/14 with a readmission on 5/29/17. The September 2016 MAR documents times insulin administered was at 6:30 am and 4:30 p.m.	F 309		

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Review of a Document titled, "Blood Sugar History" documented the exact times glucoses were checked from 6/21/16 to 9/12/16.

The "Blood Sugar History" documented the following dates that glucose checks were done greater than 1 hour after the scheduled times of 6:30 a.m. or 4:30 p.m.

6/21/16 19:13 (7:13 p.m.) Glucometer check 126
6/23/16 21:38 (9:21 p.m.) Glucometer check 110
6/25/16 18:51 (6:51 p.m.) Glucometer check 110
6/26/16 17:55 (5:55 p.m.) Glucometer check 126
6/27/16 18:04 (6:04 p.m.) Glucometer check 135
6/29/16 17:42 (5:42 p.m.) Glucometer check 113
6/30/16 18:47 (6:47 p.m.) Glucometer check 102

7/1/16 9:11 (9:11 a.m.) Glucometer check 97
7/1/16 18:01 (6:01 p.m.) Glucometer check 119
7/2/16 17:54 (5:54 p.m.) Glucometer check 125
7/3/16 18:40 (6:40 p.m.) Glucometer check 125
7/5/16 18:40 (6:40 p.m.) Glucometer check 109
7/6/16 19:12 (7:12 p.m.) Glucometer check 159
7/8/16 17 19:03 (7:03 p.m.) Glucometer check 109
7/10/17 19:58 (7:58 p.m.) Glucometer check 105

8/1/16 19:06 (7:06 p.m.) Glucometer check 153
8/30/16 19:08 (7:08 p.m. Glucometer check 215

9/1/16 17:53 (5:53 p.m.) Glucometer check 155
*Required Sliding Scale Insulin

A facility Food Tray Delivery Time documented the following:

Breakfast Delivery 7:45-8:35 a.m.
Dinner/Supper Delivery 5:30-6:30 p.m.

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An interview was conducted with RN #3 on 8/30/17 at approximately 4:00 p.m. RN #3 was asked if the Blood Sugar history times were within the 1 hour before/1 hour after time frame. RN #3 stated, "No."

The Facility Policy and Procedure titled, "Life Care-Medication Administration" with a revision date of 2/21/17 documented the following:
"Unless the facility is utilizing a "patient Centric" dosing schedule, Medications must be given within one (1) hour prior to, or within one (1) hour after scheduled time of administration unless specific orders are given (e.g., before meals or after meals). Policy Statement: Medications will be administered in accordance with prescribed orders, manufacturers' specifications regarding the preparation and administration of the drug or biological and accepted professional standards and principles.

Diabetes Care in the Hospital, Nursing Home, and Skilled Nursing Facility, from Diabetes Care 2015; 38(Suookenebt, 1): S80-S85 documented the following:
All patients with diabetes admitted to the hospital should have their diabetes type clearly identified in the medical record. A1C values greater than or equal to 6.5% suggest, in undiagnosed patients, that diabetes preceeded hospitalization.

Diabetes.org documented the following:
Insulin shots are most effective when you take them so that insulin goes to work when glucose from your food starts to enter your blood. For example, regular insulin works best if you take it 30 minutes before you eat.
The A1C test measures your average blood

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F 309	Continued From page 26 glucose for the past 2 to 3 months. The advantages of being diagnosed this way are that you don't have to fast or drink anything. Diabetes is diagnosed at an A1C of greater than or equal to 6.5% The facility administration was informed of the findings during a pre-exit briefing on 8/31/17 at approximately 1:30 p.m. The facility did not present any further information about the findings.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323	F323 Facility staff must assure supervision for residents while smoking when necessary to prevent accidents. 1. A re-assessment of resident #8's smoking ability was conducted on 9/12/17. 2. All residents who smoke are at risk. 3. All smokers will be assessed quarterly and with each significant change for supervision needs. An audit will be conducted by the clinical manager weekly x 90 days to determine changes with residents that may incicate a need for supervision while smoking. 4. The DON will review audits, summarize and present to the QAPI committee for additional oversight or recommendations. 5. Date certain: 10/15/17	

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F 323	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and clinical record review the facility staff failed to ensure the resident environment remained free of accident hazards for one of 21 residents (Resident #8), in the survey sample. The facility staff failed to ensure Resident #8 was supervised when smoking to prevent accidents. The findings included: Resident #8 was originally admitted to the facility 8/23/16, and readmitted from a local hospital on 11/22/16 after an acute illness. The current diagnoses include stroke with hemiparesis, schizophrenia, intellectual disability, diabetes mellitus, and spinal stenosis. Resident #8 had a quarterly Minimum Date Set assessment (MDS) completed with an Assessment Reference Date (ARD) of 8/14/17. It coded the resident as completing the Brief Interview for Mental Status and scoring 15 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were intact. This MDS assessment also coded the resident in section "G" Functional Status, as requiring supervision of 1 person with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident was coded as independent after set-up with locomotion and eating. In section "H" Bladder and Bowel, the resident was coded as always continent of bowels and bladder. The clinical record revealed a Smoking Assessment. It stated Resident #8 was assessed	F 323		

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F 323	Continued From page 28 to smoke at the facility on 10/6/16. The assessment read; a member of the interdisciplinary team has assessed the resident's cognitive, physical and visual ability to carry out the responsibility of smoking in the facility smoking area and be in possession of smoking materials. The assessment findings revealed the resident had some limitations cognitively, physically and or visually and is able to smoke with supervision only. Resident #8's care plan dated 8/21/17 problem read; (name of resident) smokes, declines smoking cessation assistance and education. The goal read; (name of resident) will be smoke free while a resident. The interventions included; assist and educate resident on smoking cessation aids, had patch discontinued related to smoking with patch in place. Educated resident and family that smoking on the premises is prohibited. Patient difficult to redirect, continues to smoke on campus including sidewalks and near the front door. Continue to remind resident and family that smoking is not permitted on the campus and attempt to redirect. Social work to find alternate placement where smoking is permitted. Throughout the survey and during arrivals and departures from the facility the resident was observed on the sidewalk at the front door or seated in a wheelchair with a yellow flag flying at the driveway smoking. Several times a male resident was observed seated in his wheelchair smoking with Resident #8. An interview was conducted with Resident #8 on 8/30/17 at approximately 11:40 a.m. Resident #8 stated she enjoyed living at the nursing facility but the Administrator informed her she would be discharged from the facility 9/20/17 for smoking	F 323		

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on the facility grounds. She stated the facility staff had the physician order a nicotine patch to aid her in ceasing to smoke but she decided against use of the patch when she was informed by a facility nurse of an increased risk for stroke with use of the patch. The resident further stated she enjoyed smoking and the decision to stop smoking would not have been an issue if the impending discharge had not been presented.

Facility documents revealed a notice of Transfer or Discharge to Resident #8 dated 8/21/17. The notice read; the purpose of the letter was to inform you that after careful consideration, it is our plan to transfer or discharge you for the following reasons:
The safety of individuals in the facility is endangered due to the clinical or behavioral status exhibited by you (name of resident) as evidenced by continuing to smoke on the property after repeated notices regarding our smoke free campus.
The letter further stated the facility will assist you with a safe and orderly discharge. If discharge does not occur within the next 30 days, it is the intent of the facility to discharge you on 9/20/17 to your brother's home at (address). Information was also provided to contact the Department of Medical Assistance to appeal the decision prior to the discharge date.

An interview was conducted with Resident #8's brother on 8/30/17 at approximately 11:45 a.m. He stated he had received a letter from the facility stating the resident was scheduled for discharge from the facility secondary to her smoking on the campus after the staff had repeatedly educated her that effective March 1, 2017 the facility's smoking policy which stated they were a smoke

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F 323	Continued From page 30 free campus would be enforced. Resident #8's brother also stated on another date, during a meeting the Social Worker again informed him of the planned discharge of his sister for failure to comply with the facility's smoking policy. The brother stated he did not have a safe place for the resident to discharge to because his apartment had stairs which the resident couldn't climb. An interview was conducted with Social Worker #2 on 8/31/17 at approximately 12:35 p.m. Social Worker #2 stated she delivered the letter to Resident #8 that she was being discharged for non-compliance with the smoking policy and she was identifying facilities which permit smoking for placement. Social Worker #2 also stated the resident was unsafe sitting alongside the driveway to smoke. She further stated if a facility was not identified, the intention had been to discharge the resident to her brother's home until he notified social services that placement in his home was not an option. Social Worker #2 was asked if PASRR authorities (to have a Level II screening) had been notified of Resident #8's pending discharge for evaluation of needed community supports and appropriate treatment. Social Worker #2 stated she had made two phone calls to the local community service board but had not spoken with anyone concerning Resident #8's status or pending discharge. Documentation of whom was contacted and why the call was made was not provided to the surveyor. Social Worker #2 stated notices of the residents discharge for non-compliance had been submitted to the resident, resident representative, local Ombudsman and at least 3 other agencies.	F 323		

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F 323	Continued From page 31 An interview was conducted with the Administrator on 8/31/17 at approximately 1:45 p.m. The Administrator stated on 2/2017 everyone received a notice that the facility's smoking policy would be enforced not changed. The Administrator explained the facility had been smoke free since 2008 but it was not enforced. She went on to say all residents who smoked could smoke at the bus stop and they were offered help with smoking cessation or would be aided to find other placement. It was brought to the Administrator's attention that the wishes of the resident concerning this aspect of her life was not honored and the resident's safety was not considered as she was told she had to smoke at the bus stop or off the facility's property with no facility staff supervision. During the 8/31/17 interview with the Administrator at approximately 1:45 p.m., she stated she was not aware the resident required supervision with smoking and she could not provide staff supervision for the resident to smoke. She stated the interdisciplinary team would have to re-evaluate her smoking/safety and have further discussions about how to meet Resident #8 needs. The Administrator and Social Worker #2 stated they were unable to provide documentation that the resident or the resident representative signed upon admission which acknowledged the facility was smoke free and they agreed to comply with the policy. The above findings were shared with the Administrator and Director of Nursing. No additional information was provided.	F 323		

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F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328	F328 Facility staff must assure assistance with activities of daily living to include nail care. 1. Nail care was provided for resient #10 on 8/30/17. Resident #6 has been scheduled for a podiatry visit on 9/29/17 2. All residents are at risk. 3. A 100% audit was conducted for nail care needs on 8/30/17. Staff will be inserviced on 9/27/17-9/30/17 on proper nail care. The clinical managers or designee will conduct weekly audits x 90 days to assure nail care is being consistently provided. 4. The DON will review audits, summarize and present to the QAPI committee for additional oversight or recommendations. 5. Date certain: 10/15/17	

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(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed to ensure 2 residents out of 21 (Resident #10 and #6) in the survey sample who was unable to carry out activities of daily living receives the necessary services to maintain toenail care.

1. The facility staff failed to ensure Resident #10 received podiatry services for overgrown toe nails.

2. The facility staff failed to ensure Resident #6 received podiatry services for overgrown toe nails.

The findings included:

1. Resident #10 was admitted to the facility on 06/14/16. Diagnosis included but not limited to:

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Multiple Sclerosis (MS) (1) and Muscle weakness (2).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 08/06/17 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #10 requiring extensive assistance of two with bed mobility, extensive assistance of one with dressing, total dependence of two with transfers and total dependence of one with eating, toilet use and personal hygiene. Resident #10 was coded always incontinent of bowel and bladder and impairment on both sides for upper and lower extremities.

Resident #10's comprehensive care plan indicated a problem with bathing and hygiene related to (R/T) decreased mobility. The goals the facility staff set for the resident's skin is to be clean, dry and free from odor through care. Some of the interventions included but not limited to: clean and check fingers and toenails daily and report refusal of care.

On 08/30/17 at approximately 4:30 p.m., LPN #3 and the surveyor went to inspect the toenails of Resident #10. After the LPN inspected his toenails she replied, "Oh yes, they need to be cut if you ask me." The surveyor asked LPN #3 who is responsible in making sure the residents are seen by the podiatrist (3) or receives podiatry (4) services as needed, she replied, "The nurses should when they do their weekly assessment and the CNAs when they do their daily care." The surveyor asked how is a resident placed on the podiatry list, she replied, "We will inform the

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clinical manager and she will put the residents on the podiatry list to be seen."

An interview was conducted with CNA #1 on 08/30/17 at approximately 4:40 p.m., who stated she informed a nurse that Resident #10 needed his toenails cut and trimmed but couldn't recall who she told. The CNA also stated she asked the nurse if Resident #10 was a diabetic because she would cut his toenails; the nurse replied, "I'm not sure." The CNA then stated, "I'm not sure why Resident #10 didn't get his toenail cut because they really need it."

On 08/30/17 at approximately 6:00 p.m., the clinical manager and the surveyor went to inspect the toenails of Resident #10. The clinical manager stated, "His toenails need to be cut and trimmed." The surveyor asked who is responsible for making the residents receive podiatry services as needed, she replied "Anyone really, but mainly the CNAs and nurses when they are providing daily care. The surveyor asked how is a resident placed on the podiatry list, she replied,"The staff will inform the unit secretary or me and we will put the resident on the podiatry list to be seen."

The facility administration was informed of the findings during a briefing on 08/31/17 at 1:30 p.m. The facility did not present any further information about the findings.

The facility's policy: "Life Care - Podiatry Services (Last revision: 01/2017)
Policy Statement: It is the policy of the facility to provide services to patients and residents to ensure proper treatment and care to maintain mobility and good foot health.

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-The facility ensures that podiatry services are available to patients and residents as necessary.

-The facility will develop an integrated comprehensive person-centered care plan that meets the goals, objectives, and preferences of the patient or resident."

Definitions:
1). Multiple Sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS (https://medlineplus.gov/ency/article/007365.htm).

2). Muscles weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm).

3). Podiatrist is a health professional who diagnoses and treats disorders of the feet (Mosby's Dictionary of Medicine, Nursing & Health Professions).

4). Podiatry is diagnosis and treatment of diseases and other disorders of the feet (Mosby's Dictionary of Medicine, Nursing & Health Professions).

2. Resident #6 was originally admitted to the facility 5/22/17 and had never been discharged. The current included venous insufficiency, peripheral vascular disease (PVD) and coronary artery disease.

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The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/18/17 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired decision making abilities. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance to total care with bed mobility, personal hygiene, bathing, dressing, and toileting.

On 8/30/2017 at approximately 10:30 a.m., the surveyor accompanied Licensed Practical Nurse (LPN) #1 and Certified Nurse Assistant (CNA) #12 into Resident #6's room to observe wound care. After wound care the resident's skin was observed to bilateral feet. Both feet were severely dry with flaking yellow skin and the resident's toenails were sharp, hard and very long, protruding far beyond the toes and a large callous was observed to the right great toe.

Review of the clinical record revealed no podiatry progress notes for the resident. This indicated the resident had never been seen by the podiatrist since admission.

The current Care plan dated 8/23/17 read: "PVD." The goal read; "Resident will have optimal circulatory function with no further complications times 90 days, 11/20/17." Interventions included; "Assess extremities for discoloration, edema, deep muscle tenderness, dry shiny skin, poor capillary refill, absence of peripheral pulse, etc. Ensure protective footwear as indicated. Avoid tight fitting socks/shoes."

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An interview was conducted with LPN #1 after wound care on 8/30/17. LPN #1 stated Resident #6's nails were too hard for staff to cut them; therefore, she would check the podiatry list to see if the resident was scheduled for services, and if she wasn't she would add her name to be seen when the podiatrist is in the facility again.

An interview was conducted with the Unit Manager on 8/31/17 at approximately 11:00 a.m.. The Unit Manager stated Resident #6's toenails were too long and she was on the list to be seen the last time the podiatrist was in the facility but she didn't receive services. The Unit Manager further stated no one was sure why the resident was not seen by the podiatrist but she will be seen next week when the podiatrist returns to the facility. The Unit Manager also stated, that the process was for someone to recognize the resident's need for podiatry services and inform the nurse on duty. The nurse on duty would ensure an order was present afterwhich the resident's name would be added to the podiatry visit log. This informed the podiatrist of resident needing the service when he visited the facility.

The facility's policy titled "Podiatry Services" with a revision date of 1/37/17 read; "It is the policy of the facility to provide podiatry services to patients and residents to ensure proper treatment and care to maintain mobility and good foot health. The facility will ensure that podiatry services are available to patients and residents as necessary."

Mayo Clinic also stated to prevent thick toenails to wash your hands and feet regularly and keep your nails short and dry and relatively minor injury to your feet - including a nail fungal infection - can

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F 328	Continued From page 39 lead to a more serious complication. (http://www.mayoclinic.org/diseases-conditions/nail-fungus/basics/complications/con-20019319). On 8/31/17 at approximately 3:00 p.m., the above findings were shared with the Administrator, and Director of Nursing. The Director of Nursing stated an appointment had been scheduled with the podiatrist for Resident #6.	F 328		
F 354 SS=E	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure a Registered Nurse (RN) coverage for 8 hours, 7 days a week. The facility staff failed to ensure RN coverage for 8 hours for several days from June 2016 through August 29, 2016. The findings included:	F 354	F354 Facility Administration must ensure RN staffing coverage for 8 hours daily. 1. No immediate correction is possible for dates cited. 2. All residents are at risk for inadequate RN staffing. 3. The clinical managers will provide RN coverage for dates direct care RN's may not be available. 4. The DON will review weekly schedules to assure adequate RN coverage. Staffing needs will be communicated weekly with Human Resources for recruitment efforts. Staffing efforts will be reported by the DON to the QAPI committee for additional oversight or recommendations. 5. Date certain: 10/15/17	

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F 354	Continued From page 40 On 8/30/17 at approximately 3:00 PM, the facility's actual worked schedule was reviewed and revealed there was no RN coverage for the following dates: 6/10/17, 6/11/17, 6/24/17, 7/2/17, 7/8/17, 7/9/17, 7/22/17, 7/23/17, 8/5/17, 8/6/17, and 8/20/17. On 8/31/17 at 9:10 AM, an interview was conducted with the Director of Nursing (DON) and she stated that it was an oversight on the part of the facility Staffing Coordinator, not accurately completing the schedule to have an RN coverage each day. She stated that the Staffing Coordinator had been in performance improvement through Human Resources Department. She stated, "There should have been an RN each day for eight hours. The Staffing Coordinator failed to pay attention to detail and should have provided appropriate staffing". On 8/31/17 at 9:45 AM, the DON verified the days with no RN coverage as listed above. On 8/30/17, a copy of the policy and procedure for RN Coverage was requested and the DON stated that the facility did not have a policy; their practice is based on the regulations. The Administrator and the DON were made aware of these findings on 8/31/17 at approximately 1:30 PM. No further information was provided.	F 354		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 431	F431 Facility staff must ensure medications are stored securely and discarded by the expiration date.	

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F 431	Continued From page 41 them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	1. The expired PPD solution was discarded 8/29/17. The medication cart observed to be unlocked was locked immeidately. 2. All residents are at risk. 3. Staff will be inserviced 9/27/17-9/30/17 on proper storage of medications as well as the facility policy of discarding expired medications. The clinical manager or designee will audit medication carts for security and presence of expired medication weekly x 90 days. 4. The DON will review audits, summarize, and present to QAPI for additional oversight or recommendations. 5. Date certain: 10/15/17	

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(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to ensure medications and biologicals were secure and discarded in accordance with the manufacturer's expiration date.

1. The facility staff failed to discard an expired multiple dose of Aplisol Tuberculin PPD (Purified Protein Derivative) (1) solution, opened and dated 7/24/17, for 1 of 2 units (Unit 1).

2. The facility staff failed to ensure 1 medication cart was secure for 1 of 2 units (Unit 2).

The findings included:

1. On 8/29/17 at 3:50 PM, an inspection of the medication storage room on Unit 1 was conducted with RN #1 and found a multi-dose vial of Aplisol Tuberculin PPD 5 ml. (50 tests), lot #802082, in the medication refrigerator. It was opened and dated 7/24/17. RN #1 was asked how long the PPD was good for once opened and she stated that opened Tuberculin PPD Solution must follow the manufacturer's expiration date as printed on the label which was 11/2017; this date was the expiration dated as long as the vial

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remained unopened. The manufacturer drug insert indicated, "...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." She stated that staff nurses monitor the medication storage rooms weekly and responsible for discarding expired medications and biologicals.

On 8/30/17 at 3:25 PM, the Director of Nursing was interviewed and was aware of the finding regarding the expired vial PPD found on Unit 1. She stated, "Nurses should be checking expiration dates of medications every shift as they are giving medications, including the mediations in the medication room. The Unit Manager audits the medication room weekly for expired medications."

On 8/29/17, the facility provided a copy of the policy and procedure titled, "Life Care - Medication: Expiration Dates" with an original date of 2/18/04 and a revision date of 1/17/17. It stated, in part, "Policy Statement: All "Time-Dated" medications have an expiration date printed on the container. Refer to the Manufacturer Product Information or contact Dispensing Pharmacy...Expiration Dates (suggested): ...PPD - 30 Days From Opening."

The Administrator and the DON were made aware of these findings on 8/31/17 at approximately 1:30 PM. No further information was provided.

Definition:

(1) Aplisol Tuberculin PPD - Tuberculin purified protein derivative (PPD) is used in a skin test to

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help diagnose tuberculosis (TB) infection in persons at increased risk of developing active disease. (Source: https://www.drugs.com/search.php?searchterm=aplisol)

2. On 08/30/17 at approximately 8:40 a.m., LPN #1's medication cart was unlocked and left unattended when not in direct site of the nurse. The surveyor informed the clinical manager that the medication cart was unlocked when not in direct view by LPN #1. The clinical nurse manager locked the medication cart and stated, "She should have locked her medication cart when not in direct site." On the same day at approximately 8:45 a.m., the LPN returned to her medication cart, the surveyor informed LPN #1 that she had left her medication cart unlocked when it was not in direct view. The surveyor asked, "Should your medication cart have been locked", she replied, "Yes, I should have locked her cart."

An interview was conducted the Director of Nursing (DON) on 08/30/17 at approximately 1:30 p.m., The surveyor asked, "What is your expectation for your nurses when the medication cart is not in their direct view, the DON stated, "I expected for the medication cart to be locked when it's not in direct view."

The facility administration was informed of the findings during a briefing on 08/31/17 at 1:30 p.m. The facility did not present any further information about the findings.

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F 431	Continued From page 45 The facility's policy: "Life Care - Storage of Medications (Last Revision Date: 01/17/17). Policy Statement: Medications, treatments, and biologicals are stored safely, securely, and properly following manufacture's recommendations or facility policy. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized are allowed to access to medications. Medication rooms, carts and medication supplies are locked or attended by persons with authorized access."	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not	F 441	F441 Facility staff must establish a clean surface for wound care supplies. 1. No immediate correction is possible. 2. All residents with wound care needs are at risk. 3. The nurse involved in providing wound care to resident #2 has been educated regarding the need to establish a clean surface for wound care products on 8/31/17. Staff will be inserviced 9/27/17-9/30/17 on proper wound care procedures. The clinical managers will directly observe 1 wound care procedure weekly x 90 days for proper procedure.	

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F 441	Continued From page 46 limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store,	F 441	4. The DON will review audits, summarize and present to the QAPI committee for additonal oversight or recommendations. 5. Date certain: 10/15/17	

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process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interviews and review of the facility documentation the facility staff failed to maintain an infection control program to provide a safe, sanitary environment to prevent the development and transmission of disease and infection for one of 21 residents (Resident #2) in the survey sample.

The facility staff failed to disinfect the over bed table used for a wound care procedure for Resident #2.

The findings included:

Resident #2 was originally admitted to the facility on 6/7/17. Diagnoses for Resident #2 included, but not limited to: Type 2 Diabetes (1) and Peripheral Vascular Disease (PVD) (2). Resident #2 Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/2017 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #2 requiring extensive assistance of two with bed mobility and transfers, extensive assistance of one with dressing, toilet use and personal hygiene and supervision with one assist with eating of Activities of Daily Living care. Resident #2 was coded always incontinent of bowel and

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bladder.

On 08/30/17 at approximately 9:45 a.m., Resident #2 was observed lying in bed in supine position with heels up and prevalon (5) boots to bilateral feet. Prior to starting wound care, LPN #1 removed a plastic bag from the medication cart containing all of Resident #2's treatment supplies. The LPN entered Resident #2's room, removed all supplies from the plastic bag and placed them on the over bed table without disinfecting it or placing a barrier. The treatment supplies consisted of: Santyl (6), Mupirocin (Bactroban) (7), Dermal Wound Cleanser (DWC) (8), 4x4 gauzes, a 30 ml (milliliter) medication cup and a Primapore dressing (9). The LPN washed her hands for 26 seconds; donned gloves then put the Santyl and Bactroban in the 30 ml plastic cup. The LPN then sprayed Dermal Wound Cleanser (DWC) to the dressing on right heel then removed the dressing and put in trash can; the right heel wound was noted to be without odor or drainage. LPN #1 removed gloves then washed hands for 21 seconds. LPN #1 used a gloved finger; mixed the Santyl and Bactroban together then applied to the wound using the gloved finger then covered the wound with Primapore dressing. The nurse then removed her gloves, washed hands, placed treatment supplies back into the clear plastic bag, washed hands then put the plastic bag back into the medication cart. LPN did not disinfect the over bed table after performing wound care.

An interview was conducted with LPN #1 on approximately 1:05 p.m., who stated, "I should have put down a blue pad over the over bed table before the treatment supplies on it but I didn't have a blue barrier to put down. The surveyor

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asked if the over bed table been disinfected prior to and after usage, she replied "Yes, I should have cleaned the over bed table before and after wound care and used a blue protective barrier for the table."

An interview was conducted with Director of Nursing (DON) on 08/30/17 at approximately 1:30 p.m., who stated that a barrier should have been placed on the bedside table and the over bed table should have been disinfected before and after wound care.

The facility administration was informed of the findings during a briefing on 08/31/17 at 1:30 p.m. The facility did not present any further information about the findings.

The facility's policy: "Infection Prevention & Control for General Clinical Practice Area (Revision Date: 05/2017)

Purpose: To ensure general infection prevention strategies are followed when caring for the hospital environment for the safety of all patients, visitors and staff."

Definitions:

1). Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

2). PVD is any abnormal condition that affects the blood vessels and lymphatic vessels, except those that supply the heart (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th

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F 441	Continued From page 50 Edition). 3). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/). 4). A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/). 5). Prevalon boots give patients the most advanced protection against heel pressure ulcers and foot drop. Prevalon helps minimize pressure, friction and shear on your patient's feet, heels and ankles. By elevating the foot and separating the	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 51 heel from the mattress, it delivers total heel pressure relief (http://www.sageproductsglobal.com/en/prevalon.cfm). 6). Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts). 7). Bactroban is an antibiotic used to treat impetigo as well as other skin infections caused by bacteria (https://medlineplus/gov/drugingfo/meds/a682514.html). 8). DWC is an over-the-counter, non-toxic, non-irritating, no-rinse, first-aid antiseptic product (http://www.smith-nephew.com/professional/products/advanced-wound-management/dermal-wound-skin-wound-cleanser/). 9). Primapore is a conformable adhesive dressing consisting of a breathable non-woven top layer and a low-adherent absorbent pad (www.smith-nephew.com/key-products/advanced-wound-management/primapore/).	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional,	F 465	F465 Resident room doors must be maintained in good repair.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. BUILDING ______ B. WING ______	C 08/31/2017

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SENTARA NURSING CENTER PORTSMOUTH	4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701

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F 465	Continued From page 52 sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview, the facility staff failed to ensure bedroom, activity room and shower room doors were maintained in good repair for two of two units. The findings included: During the General observation inspection The following bedroom doors on the One Hundred Unit were observed to be in disrepair. The doors were observed to have large chipped edges: Bedroom doors on the One Hundred unit included rooms: 101, 103, 104, 106, 107, 108, 109, 110, 112, 113, 114, 115, 117, 119, 123, 127, 130, 131, 132, 133, and room 134. The Unit One Hundred Shower Room and the Unit One Hundred Hall Way Exit Door. Bedroom doors on the Two Hundred Unit included rooms: 200, 201, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 221, 224, 226, 227, 229, 231, and bedroom door 232. The Activity Room door on the Two Hundred Unit was observed to have large chipped edges. During an interview on 8/31/17 at 10:22 A.M. with the Maintenance Director, he stated, "I was not aware of the doors condition."	F 465	1. No immediate correction is possible. 2. All residents are at risk. 3. A 100% audit has been conducted for all doors needing repair. Doors identified in the survey report will be resurfaced or repaired. Any additional doors identified will be scheduled for repair if necessary. 4. The facility Administrator will monitor door integrity weekly x 90 days. A summary of the report will be presented to the QAPI committee for additional oversight or recommendations. 5. Date certain: 10/15/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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