STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5-1-18 through 5-3-18. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/1/18 through 5/3/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 50 at the time of the survey. The survey sample consisted of 14 current resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	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.	F 550		6/8/18

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

Electronically Signed | 05/24/2018

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F 550	Continued From page 1 §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. §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 observation, staff interview and clinical record review, the facility failed to for one resident, Resident #25, in a survey sample of 17 residents, to provide a dignified dining experience. Resident #25 was not served her food at the dining room table until other residents were fed. The findings included: Resident #25 was admitted to the facility on 8/23/12. Diagnoses included, but not limited to,	F 550	F 550 Resident Rights/Exercise of rights Cross Tag VAC 5-371-150 (B) (1) 1. The CNA was immediately educated by DON on Thursday, May 3, 2018, to ensure that all residents at a table are served and offered assistance at the same time. Re-education for same topic was also completed with the dining staff by dining manager on Thursday, May 3, 2018. 2. All residents will be monitored during the serving of meals by the dietary team to ensure each resident table is served at	

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F 550	Continued From page 2 Alzheimer's dementia, aphasia and osteoarthritis. Resident #25's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/28/18 was coded as an annual assessment. Resident #25 was coded as having both short and long term memory impairments. Resident #25 was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. Resident #25 required total assistance with eating and is fed by staff. On 05/01/18 at 12:15 PM, Resident #25 was observed sitting at the Dining Room table. There was no food in front of her. All other residents at the table had a tray. CNA (certified nursing assistant) C was noted be to feeding the resident next to her. At 12:35 PM, Resident #25's tray was delivered when the resident being fed was finished. CNA (C) began to feed Resident #25. All other residents had completed their meal. On 5/2/18 at 8:40 AM, Resident #25 was in the Dining Room with no other residents at the table. The resident was being fed by staff. Resident #25 was neat and groomed. On 05/03/18 at 10:20 AM, an interview was conducted with CNA (C) . He stated he was the restorative CNA, but on Tuesday he was not at the restorative table. When asked about Resident #25's meal not being delivered until he had finished feeding another resident, the CNA stated, "I was feeding only one at a time. I found out I can feed two at a time." Review of the care plan dated 12/8/16 to present revealed the resident requires assistance with	F 550	the same time starting May 3, 2018. 3. The DON or designee will provide in-service training to nursing and dining staff on Tuesday, May 22, 2018 and ongoing. Nursing and Dietary staff will monitor meals for all residents being served and fed at same time. 4. The DON or designee will observe 3 meals per week for 4 weeks then 1 meal per week for 8 weeks to ensure that all residents receive a dignified dining experience by being served and fed at the same time. The results of the meal observation audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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F 550	Continued From page 3 eating. On 5/3/18 at 9:45 AM, the Corporate Nurse Consultants and the DON (director of nursing) were notified of above findings.	F 550		
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 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	F 580		6/8/18

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F 580	Continued From page 4 (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 observation, staff interview, facility documentation and clinical record review, the facility staff failed for 2 Residents, Resident #29 and #41, in a survey sample of 17 residents, to notify the physician of a change in condition. 1. Resident #29 had a PVR (post void residual) of 180 cc (cubic centimeters) that was not reported to the physician as ordered by the physician to rule out urinary retention. 2. For Resident #41, the facility staff failed to notify the physician that Namenda (for dementia) was unavailable for administration from the pharmacy. The facility was notified on Saturday morning (4/7/18) that the medication would not be available until Monday (4/9/18). The findings included:	F 580	F 580 Notify of Changes Cross Tag VAC 5-371-220 (H) 1. On Thursday, May 3, 2018 the physician was notified of the PVR results of resident #29. No new orders were received. The nurse was educated May 3, 2018 by the supervisor on requirements of provider notification. On Thursday, May 3, 2018 the clinical manager notified the physician of the unavailability of Namenda from the pharmacy for resident #41. The Supervisor was educated 1:1 by the DON on notification of MD for medication changes. 2. MAR□s and TAR□s on current residents will be reviewed by DON or designee for past 7 days for provider notification of meds unavailable notifications and other ordered provider notifications. Notification will be made by	

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F 580	Continued From page 5 Resident #148 was admitted to the facility on 4-17-16. Diagnoses included, but not limited to, Dementia delusions and psychosis, BPH (benign prostatic hypertrophy) and Alzheimer's. BPH is a condition that causes the prostate to become enlarged and may block the flow of urine. Resident #29's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/10/18 was coded as a significant change in status assessment. Resident #29 was coded as having a BIMS (brief interview of mental status) of "0" out of a possible 15 or severe cognitive impairments. Resident #29 was coded as requiring extensive assistance of two staff members to perform activities of daily living. Resident #29 was not coded for any behaviors in the last seven days. 05/03/18 10:45 AM: Resident #29 was observed in the activity room on the unit in his chair with a newspaper in his lap. Resident was pleasant, but when writer walked away, Resident #29 began to say "Help me." When asked what can I do for you, the resident made no comment. 05/03/18 05:04 PM: Review of the clinical records revealed in January the resident had a UTI (urinary tract infection) and frequent yelling to toilet. Review of the psychiatric PA (physician's assistant) notes dated 1/23/18 read as followed: "He says that he is able to stay pretty happy most of the time except that he is filled up with piss. He oftentimes state that he needs to use the bathroom." On 1/24/18, the attending physician wrote a note reading: "Pt (patient) has been significantly more restless and agitated past few weeks....There	F 580	DON or designee if none are documented. 3. The DON or designee will review the 24 hour report during morning meeting to identify new orders requiring provider notifications, change of condition and verify notifications are communicated and documented to the provider. Clinical educator/designee will provide education to nursing staff on compliance with provider notifications as ordered and process for Managing Unavailable Medications June 8, 2018. 4. The DON or designee will conduct audits on 10 residents per week for 4 weeks then 4 residents per week for 8 weeks to verify that new orders that include provider notifications are have documentation of notification. The DON or designee will review 6 MAR□s per week for 4 weeks, then 3 MAR□s per week for 8 weeks to monitor for meds not available and actions taken by the nurse. The results of the audits will be reported quarterly at the QA meeting by the DON for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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F 580	Continued From page 6	F 580		

was some thought of patient retaining urine and causing him to feel like urinating attempting to get to the bathroom and falling- he is on Flomax (for BPH) 0.4 mg (milligrams) at bedtime- I ordered PVR (post void residual- procedure of either inserting a catheter or using a bladder scan after the patient voids to check for residual urine left in the bladder after voiding) times 4 yesterday for him but have not received any numbers from nursing yet."

Review of the January, 2018 TAR (treatment administration record) revealed the following: "1/24/18 7 a-7 p 21.00 (cubic centimeters). 1/24/18 7 am-7 pm 0.00 (cc), 1/25/18. The treatment note dated 1/23/18 for 7p-7a read: "Supposed to be done by night shift (not done)." 1/25/18 for 7am -7pm has no notation of PVR being done. For 1/25/18 for 7pm-7am showed 180 cc residual. Review of the physician's notes and memos to the physician show that only the 21 cc PVR was reported. In addition, there was no documentation that all four of the physician ordered PVR's were completed. Potter-Perry 7th edition- page 1133 defines urinary retention "as an accumulation of urine resulting from an inability of the bladder to empty properly... causing feelings of pressure, discomfort, tenderness over the symphysis pubis, restlessness and diaphoresis (sweating)."

The Merck Manual describes urinary retention as incomplete emptying of the bladder or cessation of urination. Incomplete retention is diagnosed by a post void residual volume > 50 ml (> 100 ml in patients > 65)."

Review of the nurse's notes for January, 2018, revealed the resident had fallen twice, and

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F 580	Continued From page 7	F 580		

received prn (as needed) Haldol (antipsychotic) at least six times for yelling behaviors during January.

Review of the care plan with a goal date of 7/10/18 for behaviors revealed the following: "Frequently calls out for help for no apparent reason. Resident becomes agitated and distressed." One intervention contained the following: 'Continued behaviors of yelling out, cursing, yelling help me. Resident often says he has to go to the bathroom when he is agitated. New order for PVR X4 and possible urology consult depending on PVR results."

On 5/3/18 at 5:40 PM, the DON (director of nursing) stated, "There is no documentation of a urology consult", and that there was no further documentation of the MD being notified.

2. For Resident #41, the facility staff failed to notify the physician that Namenda (for dementia) was unavailable for administration from the pharmacy. The facility was notified on Saturday morning (4/7/18) that the medication would not be available until Monday (4/9/18).

Resident #41, a 97 year old, was admitted to the facility on 9/1/15. Diagnoses included dementia, depression, and osteoporosis.

The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 2/26/18. Resident #41 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required extensive assistance with activities of daily living.

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Resident #41 had a physician order dated 10/2/17 for Namenda oral solution 5 milligrams twice a day.

The April 2018 Medication Administration Record (MAR) was reviewed. While the Namenda is documented as having been administered on 4/6/18-4/9/18, notes at the end of the MAR document that the medication was not administered. The notes read:
4/6/18 HS (evening) "pharmacy notified. Medication will be sent out"
4/6/18 HS "Not Administered"
4/7/18 Morning "medication not on cart/called (pharmacy) and liquid form is unavailable until Monday. Nursing supervisor (name) ok'd medication in pill form until liquid arrives"
4/8/18 HS "not available. pharmacy notified"
4/9/19 HS "medication is on route according to pharmacy"
4/9/18 HS "Not Administered"

The unavailable medication was reviewed with the Director of Nursing (DON) and Corporate staff at the end of day meeting on 5/3/18. At this time, the DON was asked for the title of the nurse referenced in the 4/7/18 nursing note. The DON stated the nurse was the Registered Nurse (RN) Supervisor. When asked if it was ok that the RN Supervisor gave permission to change a physician order to allow the medication to be given in pill form rather than the unavailable liquid form, the DON stated no. When asked if the RN Supervisor notified the physician that the order was changed or that the medication was unavailable, the DON stated that she needed to check. After reviewing the clinical record, the DON stated that physician was not notified. The

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F 580	Continued From page 9 DON stated that she asked the RN Supervisor about the nursing note. The DON stated that it was the practice of the last company that RN Supervisor worked at to switch medication forms when medications were unavailable. The DON stated that the practice was not acceptable at her facility.	F 580		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		6/8/18

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F 645	Continued From page 10 services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on Clinical Record Review and Staff	F 645	F 645 PASSAR Screening for MD & ID	

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F 645	Continued From page 11 Interview, facility staff failed to complete a Pre-admission Screening and Resident Review for one Resident (Resident #9), in a sample of 17 Residents. For Resident #9, Facility Staff did not complete a Pre-Admission Screening and Resident Review (PASARR). The findings included: Resident #9 was admitted on 6/24/16. His diagnoses included: dementia, seizures, muscle weakness, dysphagia, psychotic disorder with delusions, repeated falls, gastro-esophageal reflux disease, hypertension, hyperlipidemia, benign prostatic hypertrophy, and major depressive disorder. His most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 2/27/18. The Brief Interview for Mental Status (BIMS) Assessment scored him a 5, indicating significant impairment. Resident #9 required the extensive assistance of 2+ staff for transfers and bed mobility, and the extensive assistance of 1 staff member for Locomotion, dressing, eating, and hygiene. On 5/2/2018, a review of Resident #9's clinical record was conducted. It was noted that Resident #9's diagnoses included a significant mental illness "psychotic disorder with delusions". No PASARR was found in the resident's clinical record. Facility staff were asked to locate the PASARR I and/or II for Resident #9. On 5/3/2018 at 3:30p.m., the Director of Nursing	F 645	1. The PASARR was completed for resident #9 on date May 2, 2018 by the social worker. 2. The Administrator or designee will perform an audit of 100% of current residents to ensure a PASSAR form is present. All residents without PASARR□s will have them completed by facility staff by 5/31/2018. Any needing Level 2 recommendations will be referred to Ascend for assessment by the Social Worker. 3. The Administrator or designee will educate the Admission Department and the Social Service department on the PASSAR requirement for all admissions by 5/31/2018. As of June 1, 2018 the administrative assistant will assure that all new admissions have a PASSAR on admission. 4. All new admissions will be audited by the Social Worker or designee for a completed PASSAR for four weeks, then 3 admissions for eight weeks. The results of the audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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F 645	Continued From page 12 stated that no PASARR for Resident #9 could be found. The Administrator and DON were informed of the findings at the end of day meeting on 5/3/18. No further documents were provided.	F 645		
F 656 SS=D	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 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	F 656		6/8/18

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F 656	Continued From page 13 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on Observation, Clinical Documentation Review, and Staff Interview, facility staff failed to implement a comprehensive person-centered care plan for 1 Resident (Resident #28) in a sample of 17 Residents. For Resident #28, facility staff failed to implement the feeding assistance intervention outlined in the Comprehensive Care Plan. The findings included: Resident #28 was admitted on 9/4/2012. Her diagnoses included alzheimers disease, dementia, arthritis, gastro-esophageal reflux disease, vitamin D deficiency, major depressive disorder, psychotic disorder with delusions, anxiety, anemia, and constipation. Resident #28's most recent Minimum Data Set (MDS) Assessment was an Annual assessment with an Assessment Reference Date (ARD) of 3/29/18. The Brief Interview for Mental Status (BIMS) scored a 1, indicating severe impairment. Resident #28 required extensive assistance of 1 staff member for bed mobility, transfers,	F 656	F 656 Development Comprehensive Care Plan Cross Tag VAC5-371-250 (G) 1. Clinical staff were re-educated by DON on feeding assistance needed for resident #28 on Thursday, May 3, 2018. 2. Residents identified as needing assistance with feeding have been reviewed with staff to assure proper assistance and implementation of care by the DON on May 22, 2018. 3. The DON or designee will conduct staff in-service training on the Comprehensive Care Plan and the importance of ensuring we are providing care as outlined in the Comprehensive Care Plan by May 22, 2018. 4. The DON or designee will observe 3 meals per week for 4 weeks then 1 meals per week for 8 weeks to ensure that all residents are providing feeding assistance as outlined in the comprehensive care plan and that all residents are being served and fed at the same time. The results of the audits will be reported at the quarterly QA meeting by the DON or	

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F 656	Continued From page 14 ambulation, dressing, eating, and hygiene. On 5/1/18, Resident #28 was observed in the dining room at lunch time. Resident #28 was sitting in a high-backed wheelchair (Geri-Chair) at a table with one other resident. Staff placed a meal tray in front of Resident #28, who appeared to be sleeping. Resident #28's food sat untouched for approximately 5 minutes while Resident #28 slept. Eventually a Dining Services staff member gently shook Resident #28's shoulder, saying "[NAME], you need to eat your lunch!" Resident #28 woke and replied, "I can't", before nodding off to sleep again. During the remainder of surveyor observation, Resident #28's food was untouched as she slept at her chair. On 5/3/18 at 9:51a.m., the DON was informed of the observations. The DON stated "staff should have stepped in if the daughter wasn't there." On 5/3/18 at 2:14p.m., an interview was conducted with CNA D. CNA D was asked to describe how Aides find out what assistance a resident requires with Activities of Daily Life (ADLs). CNA D stated that the Nurses will let the Aides know what level of assistance a resident requires. She also stated the Electronic Health Record has a section for each resident's ADL assistance needs. CNA D was asked how Resident #28 eats and replied "she eats independently in the dining room". A review of Resident #28's clinical record was conducted. Resident #28's Care Plan contained the following: Problem: [RESIDENT] requires assistance with: eating	F 656	designee for evaluation of compliance and ongoing monitoring for the continuous improvement.	

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F 656	Continued From page 15 Intervention: Eating: assist with feeding as needed when daughter is not here. The Administrator was informed of the findings on 5/3/18. No further documents were provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (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:	F 657		6/8/18

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F 657	Continued From page 16 Based on staff interview, facility documentation, clinical record review, and in the course of a complaint investigation, the facility staff failed to, for one residents (Resident #148), in a survey sample of 17 residents, to review and revise the plan of care. This resident no longer resided in the facility. 1. Resident #148's care plan was not revised to include the intervention to offer Tylenol before giving a narcotic as the family requested. The findings included: Resident #148 was admitted to the facility on 4-17-16. Diagnoses included, but not limited to, Dementia, chronic obstructive pulmonary disease (COPD) and anxiety. Resident #148's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6-26-17 was coded as a quarterly assessment. Resident #148 was coded as having a BIMS (brief interview of mental status) or no cognitive impairments. Resident #148 was coded as requiring extensive assistance of two staff members to perform activities of daily living. Resident #148 required extensive assistance with transferring of two staff members. Review of the resident's MAR (medication administration record) for October revealed the medication orders for Resident #148. The resident's RP (responsible party) had requested the resident receive Tylenol before a narcotic was given. There was no physician orders to offer Tylenol first. On 10/13/18 at 2:19 PM, the resident was given Tramadol 50 mg (milligrams) for a pain scale of "8". There was no	F 657	F 657 Care Plan Timing and Revision Cross Tag VAC5-371-250 (E) 1. The facility failed to review and revise the plan of care for resident #148 regarding the family request that the resident be offered Tylenol prior to administration of a narcotic. The resident no longer resides in the facility. 2. The DON or designee will interview all current residents or resident representatives to ensure the care plan aligns with personal preferences. Care plans will be updated as indicated MDS coordinator by June 1, 2018. 3. The DON or designee will conduct staff education on the Comprehensive Care Plan and how to ensure they are following the resident specific preferences by June 1, 2018. 4. The DON or designee will audit care plan interventions on 6 residents weekly for 4 weeks, then 1 residents weekly for 8 weeks. The results of the audits will be reported at the quarterly QA meeting by the DON or designee for evaluation of compliance and ongoing monitoring for the continuous improvement.	

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F 657	Continued From page 17 documentation that Tylenol was offered prior to administering Tramadol. Review of the care plan dated 1/31/18 revealed no addition to the care plan category of pain to attempt Tylenol for pain before administering a narcotic. There was a section on the care plan for family requests on this resident, but the care plan did not address pain medication requests. On 5/3/18 at 3:20 PM, an interview was conducted with the DON (director of nursing). She stated, "The family did want Tylenol given before a narcotic was given." She also stated, "There were so many requests from the family I am not surprised we missed it." On 5/3/18 at , the Corporate Nurse Consultants and the DON were notified of the above findings.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. 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 professional standards of quality were met for two residents (Resident # 41 and #25) in a survey sample of 17 residents. 1. For Resident #41, liquid Namenda was unavailable for administration. Facility nursing	F 658	F 658 Services Provided Meet Professional Standards Cross Tag VAC5-371-200 (B) (1) (ii) 1. On Thursday, May 3, 2018 the clinical manager notified the physician of the unavailability of Namenda from the pharmacy for resident #41. The Supervisor was educated 1:1 by the DON	6/8/18

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F 658	Continued From page 18 staff administered Namenda in the pill form without obtaining a physician order. 2. The Program Manager for Rehabilitation produced a screen for Resident #25 that was future dated for 12/5/18. Findings included: 1. For Resident #41, liquid Namenda was unavailable for administration. Facility nursing staff administered Namenda in the pill form without obtaining a physician order. Resident #41, a 97 year old, was admitted to the facility on 9/1/15. Diagnoses included dementia, depression, and osteoporosis. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 2/26/18. Resident #41 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. Resident #41 had a physician order dated 10/2/17 for Namenda oral solution 5 milligrams twice a day. The April 2018 Medication Administration Record (MAR) was reviewed. While the Namenda is documented as having been administered on 4/6/18-4/9/18, notes at the end of the MAR document that the medication was not administered. The notes read: 4/6/18 HS (evening) "pharmacy notified. Medication will be sent out"	F 658	on notification of MD for medication changes. 2. MAR□s on current residents will be reviewed by DON or designee for past 7 days for provider notification of meds unavailable notifications and other ordered provider notifications. Notification will be made by DON or designee if none are documented. 3. The DON or designee will review the 24 hour report during morning meeting to identify new orders requiring provider notifications, change of condition and verify notifications are communicated and documented to the provider. Clinical educator/designee will provide education to nursing staff on compliance with provider notifications as ordered and process for Managing Unavailable Medications June 8, 2018. 4. The DON or designee will review 6 MAR□s per week for 4 weeks, then 3 MAR□s per week for 8 weeks to monitor for meds not available and actions taken by the nurse. The results of the audits will be reported quarterly at the QA meeting by the DON for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 1. On May 4, 2018 the Rehab Director was provided 1:1 Education by Senior Director of Therapy on legible handwritten documents and immediate use of EMR screens to eliminate risks for discrepancies in dates. 2. Between May 4-9, 2018 the Rehab	

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F 658	Continued From page 19 4/6/18 HS "Not Administered" 4/7/18 Morning "medication not on cart/called (pharmacy) and liquid form is unavailable until Monday. Nursing supervisor (name) ok'd medication in pill form until liquid arrives" 4/8/18 HS "not available. pharmacy notified" 4/9/19 HS "medication is on route according to pharmacy" 4/9/18 HS "Not Administered" The unavailable medication was reviewed with the Director of Nursing (DON) and Corporate staff at the end of day meeting on 5/3/18. At this time, the DON was asked for the title of the nurse referenced in the 4/7/18 nursing note. The DON stated the nurse was the Registered Nurse (RN) Supervisor. When asked if it was ok that the RN Supervisor gave permission to change a physician order to allow the medication to be given in pill form rather than the unavailable liquid form, the DON stated no. When asked if the RN Supervisor notified the physician that the order was changed or that the medication was unavailable, the DON stated that she needed to check. After reviewing the clinical record, the DON stated that physician was not notified. The DON stated that she asked the RN Supervisor about the nursing note. The DON stated that it was the practice of the last company that RN Supervisor worked at to switch medication forms when medications were unavailable. The DON stated that the practice was not acceptable at her facility. The DON stated that the facility used Mosby's as their nursing standard. Fundamentals of Nursing, 6th Edition, Potter-Perry, p. 419, provides the following	F 658	Director completed EMR therapy screens on all current residents not on therapy caseload. 3. Rehab Director will educate rehab staff on use of EMR therapy screening tool utilizing electronic signatures and time stamping by May 25, 2018. 4. The Rehab Manager will audit 2 therapy screens per week for 4 weeks and then 1 screen per week for 8 weeks to assure EMR form utilized, completed and electronically signed. The results of the audits will be reported at the quarterly QA meeting by the Rehab Director or designee for evaluation of compliance and ongoing monitoring for the continuous improvement.	

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F 658	Continued From page 20	F 658		

guidance regarding physicians' orders, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary. "

The facility policy "Medication Administration" was reviewed. The section titled "N. Medication Error Reporting and Monitoring" read "-Medications must be given accurately and appropriately for the resident to receive the intended therapeutic effect. -Incorrect administration of certain drugs can result in harmful side effects. -This may be due to other preparation or administration of drugs that are not in accordance with physician orders, manufacturers specifications or accepted professional standards of practice."

2. The Program Manager for Rehabilitation produced a screen for Resident #25 that was future dated for 12/5/18.

Resident #25 was admitted to the facility on 8/23/12. Diagnoses included, but not limited to, Alzheimer's dementia, aphasia and osteoarthritis.

Resident #25's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/28/18 was coded as an annual assessment. Resident #25 was coded as having both short and long term memory impairments. Resident #25 was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. Resident #25 required total assistance with eating and is fed by staff.

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F 658	Continued From page 21	F 658		

On 05/02/18 at 10:15 AM, Resident #25 was observed in hallway, moving self in wheelchair. Poor positioning in chair, sacral sitting.

On 05/03/18 at 10:39 AM, Resident #25 was observed in the hallway, was leaned back in the chair, remains sacral sitting.

On 05/03/18 at 11:15 AM, an interview was conducted with the Rehabilitation Manager regarding Resident #25's seating. He stated, "She is mobile in her wheelchair and propels with her legs." He went on to state they had attempted several cushions, we want to keep her mobile and she finds comfort in that position. He also stated, "Screening has not been done for a couple of years."

On 05/03/18 at 2:35 PM, The Rehabilitation Manager presented a screen for Resident #25 dated 12/5/18. The note read, "No additional needs." The Director was questioned about the future date on the screen and he responded, "Is that an 8 or a 6?, my writing is scribbly." The date of 12/5/18 was legible and clearly an "18".

The Rehabilitation Manager was asked to bring the original screen. The Director brought a screen on which the date of 12/5/18, had a blurred 8 for the number 18. In other words, the number 18 was more legible on the copy than on the original. The Director had no response to this difference in the two documents.

On 5/3/18 at 6:00 PM, the Corporate Nurse Consultants and the DON (director of nursing) were notified of the future date of a rehabilitation screen for Resident #25.

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on Observation, Clinical Documentation Review, and Staff Interview, facility staff failed to provide necessary activities of daily living assistance for 1 Resident (Resident #28) in a sample of 17 Residents. For Resident #28, facility staff failed to provide feeding assistance during a meal. The findings included: Resident #28 was admitted on 9/4/2012. Her diagnoses included alzheimers disease, dementia, arthritis, gastro-esophageal reflux disease, vitamin D deficiency, major depressive disorder, psychotic disorder with delusions, anxiety, anemia, and constipation. Resident #28's most recent Minimum Data Set (MDS) Assessment was an Annual assessment with an Assessment Reference Date (ARD) of 3/29/18. The Brief Interview for Mental Status (BIMS) scored a 1, indicating severe impairment. Resident #28 required extensive assistance of 1 staff member for bed mobility, transfers, ambulation, dressing, eating, and hygiene. On 5/1/18, Resident #28 was observed in the dining room at lunch time. Resident #28 was sitting in a high-backed wheelchair (Geri-Chair) at a table with one other resident. Staff placed a	F 677	F677 ADL Care Provided for Dependent Cross Tag VAC5-371-220 (D) 1. The CNA was immediately educated by DON on Thursday, May 3, 2018, to ensure that all residents at a table are served and offered assistance at the same time. Re-education for same topic was also completed with the dining staff by dining manager on Thursday, May 3, 2018. 2. All residents will be monitored during the serving of meals by the dietary team to ensure each resident table is served at the same time starting May 3, 2018. 3. The DON or designee will provide in-service training to nursing and dining staff on Tuesday, May 22, 2018 and ongoing. Nursing and Dietary staff will monitor meals for all residents being served and fed at same time. 4. The DON or designee will observe 3 meals per week for 4 weeks then 1 meal per week for 8 weeks to ensure that all residents receive a dignified dining experience by being served and fed at the same time. The results of the meal observation audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	6/8/18

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meal tray in front of Resident #28, who appeared to be sleeping. Resident #28's food sat untouched for approximately 5 minutes while Resident #28 slept. Eventually a Dining Services staff member gently shook Resident #28's shoulder, saying "[NAME], you need to eat your lunch!" Resident #28 woke and replied, "I can't", before nodding off to sleep again. During the remainder of surveyor observation, Resident #28's food was untouched as she slept at her chair.

On 5/3/18 at 9:51a.m., the DON was informed of the observations. The DON stated "staff should have stepped in if the daughter wasn't there."

On 5/3/18 at 2:14p.m., an interview was conducted with CNA D. CNA D was asked to describe how Aides find out what assistance a resident requires with Activities of Daily Life (ADLs). CNA D stated that the Nurses will let the Aides know what level of assistance a resident requires. She also stated the Electronic Health Record has a section for each resident's ADL assistance needs. CNA D was asked how Resident #28 eats and replied "she eats independently in the dining room".

A review of Resident #28's clinical record was conducted. Resident #28's Care Plan contained the following:
Problem:
[RESIDENT] requires assistance with: eating
Intervention:
Eating: assist with feeding as needed when daughter is not here.

The Administrator was informed of the findings on 5/3/18. No further documents were provided.

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record, the facility staff failed to, for one resident, Resident #25 in a survey sample of 17 residents, provide treatment to provide the highest practicable wellbeing. Resident #25 had multiple observations of being slumped in her Broda chair in a sacral sitting (sitting flat on the sacrum) position. The findings included: Resident #25 was admitted to the facility on 8/23/12. Diagnoses included, but not limited to, Alzheimer's dementia, aphasia and osteoarthritis. Resident #25's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/28/18 was coded as an annual assessment. Resident #25 was coded as having both short and long term memory impairments. Resident #25 was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. Resident #25 required total assistance with eating and is fed by	F 684	F 684 Quality of Care Cross Tag VAC5-371-220 (A) 1. Resident #25 had a therapy screen by Rehab Director on May 9, 2018 for evaluation of seating device. There were no positioning needs identified and, resident was able to self-propel. The resident continues to be able to propel herself in the wheelchair and has no skin breakdown. 2. All residents who are not on therapy caseload were screened by therapy by May 9, 2018 3. The DON or designee will in-service all nursing staff by May 22, 2018 on repositioning techniques to ensure all residents are positioned appropriately. Staff will complete Stop and Watch when positioning challenges are identified. Routine therapy screens will be established following the MDS OBRA schedule and completed by the members of the therapy department starting week of May 21, 2018. 4. The DON or designee will audit positioning of 3 wheelchair residents	5/31/18

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F 684	Continued From page 25 staff. On 05/02/18 at 10:15 AM, Resident #25 was observed in hallway, moving self in wheelchair with poor positioning in chair, sacral sitting. On 05/03/18 at 10:39 AM, Resident #25 was observed in the hallway, was leaned back in the chair and, remained sacral sitting. Review of the care plan dated 12/8/16 to present revealed the resident had a Broda scoot chair. On 05/03/18 at 11:15 AM, an interview was conducted with the Rehabilitation Manager regarding Resident #25's seating. He stated, "She is mobile in her wheelchair and propels with her legs." He went on to state they had attempted several cushions, we want to keep her mobile and she finds comfort in that position. He also stated, "Screening has not been done for a couple of years." The Journal of Physical Therapy Science (2016) stated: "Sacral sitting in a wheelchair increases the maximum contact pressure on the back, contact areas of the buttocks and back, and the shear force generated by sliding the ischial region forward." On 05/03/18 at 2:35 PM: The Rehabilitation Manager presented a screen for Resident #25 dated 12/5/18. The note read, "No additional needs." The Director was questioned about the future date on the screen and he responded, "Is that an 8 or a 6?, my writing is scribbly." The date of 12/5/18 was legible and clearly an "18". The Rehabilitation Manager was asked to bring	F 684	weekly for 4 weeks, then 1 resident weekly for 8 weeks. The Rehab Director will audit of 2 therapy screens per week for 4 weeks and then 1 screen per week for 8 weeks for timely completion and signature by rehab staff. The results of the observation audits will be reported by the DON and Rehab Director quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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F 684	Continued From page 26 the original screen. The Director brought a screen on which the date of 12/5/18, had a blurred 8 for the number 18. In other words, the number 18 was more legible on the copy than on the original. The Director had no response to this difference in the two documents. On 5/3/18 at 10:45 AM, the Corporate Nurse Consultants and the DON (director of nursing) were notified of the resident's positioning in chair.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		6/8/18

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F 690	Continued From page 27 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility and clinical record documentation, the facility staff failed to, for one resident, Resident #29 in a survey sample of 17 residents, ensure the resident received care and services to address urinary function. Resident #29 exhibited signs and symptoms of urinary retention which was not addressed. The findings included: Resident #29 was admitted to the facility on 4-17-16. Diagnoses included, but not limited to, Dementia delusions and psychosis, BPH (benign prostatic hypertrophy) and Alzheimer's. BPH is a condition that causes the prostate to swell, and may block the flow of urine. Resident #29's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/10/18 was coded as a significant change in status assessment. Resident #29 was coded as having a BIMS (brief interview of mental status) of "0" out of a possible 15 or severe cognitive impairments. Resident #29 was coded as requiring extensive assistance of two staff members to perform activities of daily living.	F 690	F690 Bowel/Bladder Incontinence, Catheter Cross Tag VAC5-371-220 (C) (3) 1. On Thursday, May 3, 2018 the physician was notified of the PVR results of resident #29. No new orders were received. The nurse was educated May 3, 2018 by the supervisor on requirements of provider notification. 2. TAR□s on current residents will be reviewed by DON or designee for past 7 days for provider ordered provider notifications. Notification will be made by DON or designee if none are documented. 3. The DON or designee will review the 24 hour report during morning meeting to identify new orders requiring provider notifications, change of condition and verify notifications are communicated and documented to the provider. Clinical educator/designee will provide education to nursing staff on compliance with provider notifications as ordered June 8, 2018. 4. The DON or designee will conduct audits on 10 residents per week for 4 weeks then 4 residents per week for 8	

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F 690	Continued From page 28 Resident #29 was not coded for any behaviors in the last seven days. 05/03/18 10:45 AM: Resident #29 was observed in the activity room on the unit in his chair with a newspaper in his lap. Resident was pleasant, but when writer walked away, Resident #29 began to say "Help me." When asked what can I do for you, the resident made no comment. 05/03/18 05:04 PM: Review of the clinical records revealed in January the resident had a UTI (urinary tract infection) and frequent yelling to toilet. Review of the psychiatric PA (physician's assistant) notes dated 1/23/18 read as followed: "He says that he is able to stay pretty happy most of the time except that he is filled up with piss. He often times state that he needs to use the bathroom." On 1/24/18, the attending physician wrote a note reading: "Pt (patient has been significantly more restless and agitated past few weeks....There was some thought of patient retaining urine and causing him to feel like urinating attempting to get to the bathroom and falling- he is on Flomax (for BPH) 0.4 mg (milligrams) at bedtime- I ordered PVR (post void residual- procedure of either inserting a catheter or using a bladder scan after the patient voids to check for residual urine left in the bladder after voiding) times 4 yesterday for him but have not received any numbers from nursing yet." Review of the January, 2018 TAR (treatment administration record) revealed the following: "1/24/18 7 a-7 p 21.00 (cubic centimeters). 1/24/18 7 am-7 pm 0.00 (cc), 1/25/18. The treatment note dated 1/23/18 for 7p-7a read:	F 690	weeks to verify that new orders that include provider notifications are have documentation of notification. The DON or designee will review 6 TAR□s per week for 4 weeks, then 3 TAR□s per week for 8 weeks to monitor for requirements of provider notification. The results of the audits will be reported quarterly at the QA meeting by the DON for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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"Supposed to be done by night shift (not done)." 1/25/18 for 7am -7pm has no notation of PVR being done. For 1/25/18 for 7pm-7am showed 180 cc residual. Review of the physician's notes and memos to the physician show that only the 21 cc PVR was reported. In addition, there was no documentation that all four of the physician ordered PVR's were completed. Potter-Perry 7th edition- page 1133 defines urinary retention "as an accumulation of urine resulting from an inability of the bladder to empty properly... causing feelings of pressure, discomfort, tenderness over the symphysis pubis, restlessness and diaphoresis (sweating)."

The Merck Manual describes urinary retention as incomplete emptying of the bladder or cessation of urination· Incomplete retention is diagnosed by a post void residual volume > 50 ml (> 100 ml in patients > 65)."

Review of the nurse's notes for January, 2018, revealed the resident had fallen twice, and received prn (as needed) Haldol (antipsychotic) for yelling behaviors at least five times during January.

Review of the care plan with a goal date of 7/10/18 for behaviors revealed the following: "frequently calls out for help for no apparent reason. Resident becomes agitated and distressed." One intervention contained the following: 'Continued behaviors of yelling out, cursing, yelling help me. Resident often says he has to go to the bathroom when he is agitated. New order for PVR X4 and possible urology consult depending on PVR results."

On 5/3/18 at 5:40 PM, the DON (director of

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F 690	Continued From page 30 nursing) stated, "There is no documentation of a urology consult", and that there was no further documentation of the MD being notified.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 observation, resident interview, staff interview, and clinical record review the facility staff failed to provide pain management for 1 resident (resident #26) of 17 residents in the survey sample. For Resident #26, the facility staff failed to ensure pain medications ordered by hospice were available for administration. The findings included: Resident #26, a 95 year old, was admitted to the facility on 3/21/18. Diagnoses included dementia, hypotension, coronary artery disease, spinal stenosis, glaucoma, and hyperlipidemia. Resident #26's most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 3/29/18. She was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment and required extensive assistance with activities of daily living.	F 697	F 697 Pain Management 1. On May 21, 2018 the order for morphine was received from the provider and entered by the clinical manager. 2. The DON or designee will audit 100% hospice charts and ensure that all pain management orders are in place by May 31, 2018 3. The DON or designee will conduct in-service training for licensed nurses on pain management including orders, assessment and appropriate treatment on May 22, 2018. The Clinical Manager will review all hospice notes and care plans with each hospice nurse visit by May 25, 2018. 4. The DON or designee will audit 3 hospice residents weekly for 4 weeks, then 1 resident weekly 8 weeks to ensure that residents have orders coordinated with hospice care and are receiving appropriate pain management. The results of the observation audits will be reported by the DON at the quarterly QA	6/8/18

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F 697	Continued From page 31 Resident #26 was observed on 5/2/18 at 8:20 a.m. She was lying in bed asking to be changed and waiting for breakfast. When asked how she was feeling, Resident #26 stated she was confused but feeling fine. Resident #26 had a physician order dated 3/21/18 for Acetaminophen 500 milligrams three times per day for spinal stenosis. Resident #26's April 2018 Medication Administration Record (MAR) was reviewed. In addition to the administration documentation, a "pain index" was also documented each time the acetaminophen was administered. In total, the pain index was documented on 90 occasions in April 2018. The pain index ranged from 1-10, with 10 being the highest level of pain. Out of the 90 occasions pain was measured, Resident #26 rated her pain as a "10" on 62 occasions. The following notes were documented in the notes section of the acetaminophen administration on the April 2018 MAR: 4/2/18: pain index 8, non pharmacological intervention= repositioning, results 1 hour later= effective- pain subsiding 4/9/18: pain index 6, non pharmacological intervention= repositioning, results 1 hour later= relief 4/11/18: pain index 8, non pharmacological intervention= repositioning, results 1 hour later= relief 4/12/18: pain index 7, non pharmacological intervention= repositioning, results 1 hour later= pain level 0 4/18/18: pain index 7, non pharmacological	F 697	meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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intervention= repositioning, results 1 hour later= relief

The following notes were all documented by the same nurse (Employee D) at the end of the April 2018 MAR:

4/6/18: resident usually says she is in a little pain and classify the level at a 0 out of a 10
4/7/18: always classify her pain as 10 out of 10 but is not in that much pain.
4/9/18: resident classify her pain as 10 of 10 but says its not much pain
4/10/18: resident states not that much pain but classifies it as a 10
4/15/18: resident stated that she isn't in that much pain and also rated her pain as a 10 out of 10

Resident #26's also had a physician order for acetaminophen 325 milligram as needed three times per day. This medication was administered once on 4/30/18 at 1:46 p.m.

On 5/3/18 at 10:00 a.m., Resident #26's pain ratings of a level 10 were reviewed with the Director of Nursing (DON). It was explained that Resident #26 frequently had a pain rating of 10 and it did not appear that she was provided with a medication stronger than acetaminophen. The DON stated that Resident #26 says her pain is a 10 but staff reported that it didn't seem that Resident #26's pain was at an intensity of 10. The DON was asked if a physician had assessed the pain. The DON stated that Resident #26 was on hospice and the hospice notes were in the hard chart.

Resident #26 was certified for hospice care on

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F 697	Continued From page 33 3/29/18. The "Hospice Plan of Care" was reviewed. Section 21 "Orders of Discipline and Treatment" read "pain and symptom management". The following pain management medications were included on the Hospice Plan of Care: 1. Acetaminophen Extra Strength 500 milligram tablet three times per day for pain 2. Morphine 0.25- 2.0 milliliter every hour as needed for pain 3. Voltaren 1% topical gel apply 2 grams by topical route 4 times per day every day for osteoarthritis The Corporate Nurse (Employee A) was notified that the Morphine was not included on Resident #26's physician order sheet as a current order. On 5/3/18 at 4:00 p.m. the Corporate Nurse (Employee A) stated that the morphine should be a current active order. In addition, Voltaren was not included on the physician order sheet. The Voltaren was not discussed with the facility staff. A hospice note dated 4/18/18 assessed Resident #26's pain. It was documented that Resident #26 could communicate pain through a verbal descriptor. Pain was documented as aching, chronic, generalized pain at a 3 (Noticeable Mild). A hospice note dated 4/25/18 assessed Resident #26's pain. It was documented that Resident #26 could communicate pain through a verbal descriptor. Pain was documented as generalized pain.	F 697		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		6/8/18

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F 744	Continued From page 34 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to for one Resident, Resident #29, in a survey sample of 17 residents, ensure that Resident #29 received appropriate care and services for the treatment of dementia. Resident #29 exhibited signs and symptoms of urinary retention however the facility did not rule out physiological causes resulting in yelling behaviors. The findings included: Resident #148 was admitted to the facility on 4-17-16. Diagnoses included, but not limited to, Dementia delusions and psychosis, BPH (benign prostatic hypertrophy) and Alzheimer's. BPH is a condition that causes the prostate to enlarge and may block the flow of urine. Resident #29's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/10/18 was coded as a significant change in status assessment. Resident #29 was coded as having a BIMS (brief interview of mental status) of "0" out of a possible 15 or severe cognitive impairments. Resident #29 was coded as requiring extensive assistance of two staff members to perform activities of daily living. Resident #29 was not coded for any behaviors in	F 744	F 744 Treatment/Services for Dementia Cross Tag VAC5-371-220 (A) 1. On Thursday, May 3, 2018 the physician was notified of the PVR results of resident #29. No new orders were received. The nurse was educated May 3, 2018 date by supervisor on requirements of provider notification. On Thursday, May 3, 2018 the clinical manager notified the physician of the unavailability of Namenda from the pharmacy for resident #41. The Supervisor was educated 1:1 by the DON on notification of MD for medication changes. 2. All residents with behaviors will be reviewed by Interdisciplinary Team (IDT) by June 8, 2018 for evaluation of physiological conditions that could be related to behavior. All concerns will be presented to the provider for assessment by June 8, 2018. 3. On May 26, 2018 the weekly IDT At Risk Meeting will include a review all escalations in behavior to evaluate for possibility of physiological conditions contributing to the behaviors. All concerns will be presented to the provider for assessment. The DON or designee will conduct in-service training with nursing staff on appropriate evaluation of	

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F 744	Continued From page 35 the last seven days. 05/03/18 10:45 AM: Resident #29 was observed in the activity room on the unit in his chair with a newspaper in his lap. Resident was pleasant, but when writer walked away, Resident #29 began to say "Help me." When asked what can I do for you, the resident made no comment. 05/03/18 05:04 PM: Review of the clinical records revealed in January the resident had a UTI (urinary tract infection) and frequent yelling to toilet. Review of the psychiatric PA (physician's assistant) notes dated 1/23/18 read as followed: "He says that he is able to stay pretty happy most of the time except that he is filled up with piss. He often times states that he needs to use the bathroom." On 1/24/18, the attending physician wrote a note reading: "Pt (patient) has been significantly more restless and agitated past few weeks....There was some thought of patient retaining urine and causing him to feel like urinating attempting to get to the bathroom and falling- he is on Flomax (for BPH) 0.4 mg (milligrams) at bedtime- I ordered PVR (post void residual- procedure of either inserting a catheter or using a bladder scan after the patient voids to check for residual urine left in the bladder after voiding) times 4 yesterday for him but have not received any numbers from nursing yet." Review of the January, 2018 TAR (treatment administration record) revealed the following: "1/24/ 7 am-7 pm: 21.00 (cubic centimeters). 1/24/18 7 am-7 pm 0.00 (cc), 1/25/18. The treatment note dated 1/23/18 for 7pm-7am read: "Supposed to be done by night shift (not done)."	F 744	escalating behaviors to include urinary retention by June 1, 2018. 4. The DON or designee will observe 4 residents weekly for 4 weeks, then 1 resident weekly for 8 weeks for evaluation of behaviors related to physiological conditions and ensure that any concerns are communicated to the provider. The results of the observation audits will be reported monthly at the QA meeting by the DON for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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1/25/18 for 7am -7pm has no notation of PVR being done. For 1/25/18 for 7pm-7am showed 180 cc residual. Review of the physician's notes and memos to the physician show that only the 21 cc PVR was reported. In addition, there was no documentation that all four of the physician ordered PVR's were completed. Potter-Perry 7th edition- page 1133 defines urinary retention "as an accumulation of urine resulting from an inability of the bladder to empty properly... causing feelings of pressure, discomfort, tenderness over the symphysis pubis, restlessness and diaphoresis (sweating)."

The Merck Manual describes urinary retention as incomplete emptying of the bladder or cessation of urination· Incomplete retention is diagnosed by a post void residual volume > 50 ml (> 100 ml in patients > 65)."

Review of the nurse's notes for January, 2018, revealed the resident had fallen twice, and received prn (as needed) Haldol (antipsychotic) at least six times for yelling behaviors during January.

Review of the care plan with a goal date of 7/10/18 for behaviors revealed the following: "Frequently calls out for help for no apparent reason. Resident becomes agitated and distressed." One intervention contained the following: 'Continued behaviors of yelling out, cursing, yelling help me. Resident often says he has to go to the bathroom when he is agitated. New order for PVR X4 and possible urology consult depending on PVR results."

On 5/3/18 at 5:40 PM, the DON (director of nursing) stated, "There is no documentation of a

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F 744	Continued From page 37 urology consult", and that there was no further documentation of the MD being notified.	F 744		
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- §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:	F 755		6/8/18

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F 755	Continued From page 38 Based on staff interview, resident interview, facility documentation review and clinical record review, the facility staff failed to ensure medications were available for administration for two residents (Residents # 20 and 87) in a survey sample of 17 residents. 1. For Resident # 20, the facility staff failed to provide medications as ordered by the physician. The medications were listed as medication unavailable. 2. For Resident #41, facility staff failed to ensure Namenda (for dementia) was available for administration 4/6/18 (Friday evening) until 4/10/18 (Tuesday morning). The findings include: 1. For Resident # 20, the facility staff failed to provide medications as ordered by the physician. The medications were listed as medication unavailable. Resident # 20 was admitted to the facility on 3/13/18 with diagnoses of but not limited to Glaucoma, Osteoarthritis Sciatic Nerve Pain, Gastro-Esophageal Reflux, Dementia, and Diabetes. The most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 3/30/18. Review of the clinical record was conducted on 5/2/2018 at 10:45 am. Review of the March 2018 Medication Administration Record (MAR) revealed missing	F 755	F 755 Pharmacy Services/Procedures/Pharmacist/Records Cross Tag VAC5-371-300 (A) 1. Resident #20□s medications were reviewed May 3, 2018 by clinical manager and all were available for administration. Resident #41□s medications were reviewed on May 3, 2018 by the clinical manager and all were available for administration. Neither resident had negative effects noted from medications not administered. 2. All current residents will have their MAR compared to available medications. Discrepancies will be immediately called to pharmacy and provider will be notified June 1, 2018. 3. Clinical educator/designee will provide education to nursing staff on process for Managing Unavailable Medications by June 1, 2018. 4. The DON or designee will review 6 MAR□s per week for 4 weeks, then 3 MAR□s per week for 8 weeks to monitor for meds not available and actions taken by the nurse. The results of the observation audits will be reported monthly at the QA meeting by the DON for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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documentation of administration of medications.

Cosopt 23.3 (mg) milligrams -6.8 milligrams per milliliter Eye Drops one drop to both eyes two times a day- 8 doses were not documented:
3/19/2018 at 9:00 AM
3/19/2018 at 5:00 PM
3/20/2018 at 9:00 AM
3/20/2018 at 5:00 PM
3/21/2018 at 9:00 AM
3/21/2018 at 5:00 PM
3/22/2018 at 9:00 AM
3/22/2018 at 5:00 PM
Notes to MAR dated 3/19/18 stated - Note administered will call pharmacy
Note to MAR dated 3/20/18 stated Not Administered pharmacy called
Note to MAR dated 3/21/18 stated not administered not available
Note on MAR dated 3/22/18 stated Not administered (enter administration note)

Medrol (Pak) 4 mg tablets in dose pack One time daily 4 days starting 3/14/2018 - 3 doses not documented:
3/13/2018 at 9:00 AM
3/13/2018 at 12:00 PM
3/13/2018 at 9:00 PM
Note in MAR stated 3/13/18 Not administered need clarification

Famotidine 20 mg. tablet one time daily for Gastro-Esophageal Reflux Disease 1 dose not documented:
3/23/2018 at 6:00 AM
Note in MAR dated 3/23/18 stated Not administered will notify family

Bactrim DS 800 mg-160 mg (an antibiotic) two

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times daily for 7 days for (urinary tract infection) UTI 1 dose not documented:
3/28/2018 at 9:00 AM
Note on MAR dated 3/28/18 stated not given- will notify pharmacy

Neurontin 100 mg one capsule by mouth three times a day for Neuropathic pain, beginning 3/26/2018 -1 dose not documented:
3/31/2018 at 9:00 PM
Note in MAR dated 3/31/18 stated - None in stat box will notify pharmacy.

Review of the April 2018 Medication Administration Record (MAR) revealed missing documentation of administration of medications.

Miacalcin 200 Intranasal Spray once a day starting 4/10/2018 for Hypercalcemia (high blood calcium level) 2 doses not documented:
4/11/2018 at 9:00 AM
4/14/2018 at 9:00 AM
Note in MAR dated 4/11/18 stated -Not administered, waiting on med from pharmacy will be here this afternoon for future administration.
Note to MAR on 4/14/18 stated not administered Pharmacy Notified and will be coming on next run

Neurontin 100 mg one capsule by mouth three times a day for Neuropathic pain, beginning 4/4/2018 -1 dose not documented:
4/12/2018 at 6:00 AM
Note in MAR dated 4/12/18 stated - None in stat box will notify pharmacy.

An interview was condcuted with Employee B (LPN) on 5/3/2018 at 12:55 pm. Employee B stated that she had called the pharmacy and the son to get the needed meds on two occasions.

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She stated "The family is usually good about bringing her meds".

Review of the Facility Policy on Medication Administration dated 3/1984 revised 2/2018 stated medications should be given accurately and appropriately for resident to receive intended therapeutic effect. The policy also stated nurses should check the emergency supply of medications (stat box) according to your facility policy / procedure.

Review of the Stat Box contents revealed the list of medications available included medications listed as not administered because the medication was unavailable.

Neurontin 100 (mg) milligram
Famotidine 10 mg

On 5/3/2018 at 2 PM, an interview was conducted with the Director of Nursing (DON) who stated medications should be administered as ordered by the physician. She also stated the nurses were supposed to get the medications from the STAT box if the Resident did not have any more and notify the Resident family she further went on to say if there is none in the Stat box they are to notify the Pharmacy immediately to refill it. The DON also stated the nurses were expected to document the administration of the medications at the time of administration.

During the end of day debriefing, the Director of Nursing, Corporate Consultants (Admin C and Admin D) were informed of the findings.

No further information provided.

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2. For Resident #41, facility staff failed to ensure Namenda (for dementia) was available for administration 4/6/18 (Friday evening) until 4/10/18 (Tuesday morning).

Resident #41, a 97 year old, was admitted to the facility on 9/1/15. Diagnoses included dementia, depression, and osteoporosis.

The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 2/26/18. Resident #41 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required extensive assistance with activities of daily living.

Resident #41 had a physician order dated 10/2/17 for Namenda oral solution 5 milligrams twice a day.

The April 2018 Medication Administration Record (MAR) was reviewed. While the Namenda is documented as having been administered on 4/6/18-4/9/18, notes at the end of the MAR document that the medication was not administered. The notes read:
4/6/18 HS (evening) "pharmacy notified. Medication will be sent out"
4/6/18 HS "Not Administered"
4/7/18 Morning "medication not on cart/called (pharmacy) and liquid form is unavailable until Monday. Nursing supervisor (name) ok'd medication in pill form until liquid arrives"
4/8/18 HS "not available. pharmacy notified"
4/9/19 HS "medication is on route according to pharmacy"
4/9/18 HS "Not Administered"

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F 755	Continued From page 43 The unavailable medication was reviewed with the Director of Nursing (DON) and Corporate staff at the end of day meeting on 5/3/18. At this time, the DON was asked for the title of the nurse referenced in the 4/7/18 nursing note. The DON stated the nurse was the Registered Nurse (RN) Supervisor. When asked if it was ok that the RN Supervisor gave permission to change a physician order to allow the medication to be given in pill form rather than the unavailable liquid form, the DON stated no. When asked if the RN Supervisor notified the physician that the order was changed or that the medication was unavailable, the DON stated that she needed to check. After reviewing the clinical record, the DON stated that physician was not notified. The DON stated that she asked the RN Supervisor about the nursing note. The DON stated that it was the practice of the last company that RN Supervisor worked at to switch medication forms when medications were unavailable. The DON stated that the practice was not acceptable at her facility.	F 755		
F 760 SS=D	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 staff interview, facility documentation review, clinical record review, the facility staff failed to ensure one resident (Resident # 20) in a survey sample of 17 residents were free of significant medication errors.	F 760	F 760 Residents are Free of Significant Med Errors Cross Tag VAC5-371-220 (B) 1. Resident #20 medication supply was checked on May 3, 2018 by the clinical manager and Cosopt eye drops were	6/8/18

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F 760	Continued From page 44 For Resident # 20, the facility staff failed to ensure medications were available for administration as ordered by the physician. Cosopt Eye drops, used to reduce the increased pressure in the eyes caused by Glaucoma were listed as medication unavailable for March 19-22, 2018. Findings included: Resident # 20 A 94 yr old female was admitted to the facility on 3/13/18 with diagnoses of but not limited to Glaucoma, Osteoarthritis, Sciatic Nerve Pain, Gastro-Esophageal Reflux, Dementia, and Diabetes. The most recent MDS was a Quarterly Assessment with an ARD of 03/30/18. Resident # 20 was coded as requiring limited to extensive assistance of 1-2 staff persons with Activities of Daily Living. Review of the clinical record was conducted on 5/2/2018 at 10:15 AM. Resident #20 had a physician order for Cosopt 23.3 (mg) milligrams -6.8 milligrams per milliliter Eye Drops one drop to both eyes two times a day-for treatment of Glaucoma (aids in prevention of blindness due to increased intraocular pressure from Glaucoma). Review of the medication administration record showed the following 8 doses were not given: 3/19/2018 at 9:00 AM 3/19/2018 at 5:00 PM 3/20/2018 at 9:00 AM 3/20/2018 at 5:00 PM	F 760	available. The provider was notified on May 3, 2018 by the clinical manager that Cosopt was not administered 3/19/18 to 3/22/18. No new orders were provided. 2. The DON or designee will compare all current residents MAR□s to available medications by June 1, 2018. All discrepancies will be immediately called to the pharmacy the provider will be notified if the medication is unavailable for administration. 3. Clinical educator/designee will provide education to nursing staff on process for Managing Unavailable Medications by June1, 2018. 4. The DON or designee will review 6 MAR□s per week for 4 weeks, then 3 MAR□s per week for 8 weeks to monitor for meds not available and actions taken by the nurse. The results of the observation audits will be reported quarterly at the QA meeting by the DON for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(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 760	Continued From page 45 3/21/2018 at 9:00 AM 3/21/2018 at 5:00 PM 3/22/2018 at 9:00 AM 3/22/2018 at 5:00 PM Notes to MAR dated 3/19/18 stated - Note administered will call pharmacy Note to MAR dated 3/20/18 stated Not Administered pharmacy called Note to MAR dated 3/21/18 stated - Not administered not available Note on MAR dated 3/22/18 stated Not administered (enter administration note) On 5/3/2018 at 2 PM, an interview was conducted with the Director of Nursing (DON) who stated medications should be administered as ordered by the physician. The DON also stated the nurses were expected to document the administration of the medications at the time of administration. During the end of day debriefing, the Director of Nursing, Corporate Consultants (Admin C and Admin D) were informed of the findings. No further information was provided.	F 760		