Hillsville
REHABILITATION AND HEALTHCARE CENTER

July 20, 2017

Mr. Rodney L. Miller LTC Supervisor
Division of Long Term Care
Office of Licensure & Certification
Virginia Department of Health
9960 Maryland Avenue, Suite 401
Henrico, Virginia 23233-1485

RE: Plan of Correction for Hillsville Rehab and Healthcare Center
Credible Allegation of Compliance

Dr. Mr. Miller:

Enclosed you will find the State of Deficiencies (CMS 2567) completed, with the Facilities POC for the deficiencies identified in the survey completed June 29, 2017.

Please consider this letter and Plan of Correction to be the Facility's' credible allegation of of compliance. The Facility asserts substantial compliance with the applicable certification requirements on July29, 2017.

This letter is also the Facility's' request for a re-survey, if is necessary, to verify the Facility has achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance in the matter.

Sincerely,

Jerry M. Carpenter, LNHA
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495187	A. BUILDING _____ B. WING _____	C 06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSVILLE REHABILITATION & HEALTHCARE CENTER LLC	222 FULCHER STREET HILLSVILLE, VA 24343

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey inspection was conducted 6/27/17 through 6/29/17. One complaint was 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 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Resident #1 through Resident #13) and 3 closed record reviews (Resident #14 through Resident #16).	F 000	Preparation and submission of this plan of correction by **Hillsville Rehabilitation and Healthcare Center, LLC,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, facility document review and clinical record review it was determined the facility staff failed to provide care and services to assist 1 of 16 residents (Resident #1) to maintain and enhance his/her dignity, self-esteem and self-worth. The staff told the resident to urinate in her brief and they would come back and clean her up later. Findings: Facility staff failed to provide care and services to	F 241	**F 241** 1. Resident #1 was interviewed by the Director of Nursing on 6/29/17 to ensure that nursing staff are meeting her toileting needs and staff are providing care to maintain and enhance dignity, self-esteem and self-worth. 2. The current interviewable residents were interviewed by Staff Development Coordinator on 7/18/17 to ensure nursing staff are meeting their toileting needs and staff are providing care to maintain and enhance their dignity, self-esteem and self- worth.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jane M. Compton	ADMINISTRATOR	7/20/17

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 241	Continued From page 1 assist Resident #1 to maintain and enhance his/her dignity, self-esteem and self-worth. The resident's clinical record was reviewed on 6/27/17 at 3:00 PM. Resident #1 was admitted to the facility on 11/16/16. Her diagnoses included atrial fibrillation, heart failure, chronic obstructive pulmonary disease, gout and hypertension. She was admitted for surgical aftercare and physical therapy to restore mobile function. The initial MDS (minimum data set) assessment dated 11/23/17 coded the resident with slight cognitive impairment due to her inability to consistently make herself understood and her inability to consistently understand others. Her hearing was assessed as adequate on this assessment. She required assistance with all the ADLs (activities of daily living) and was frequently incontinent of bowel and bladder. The latest quarterly MDS (minimum data set) assessment, dated 4/7/17, coded the resident with moderate cognitive impairment due to her inability to recall items during a short-term memory test to assess mental status. Her memory was coded as unimpaired. The resident was coded with significant hearing impairment on this assessment. The resident was coded as not having a hearing aid. The latest MDS assessment coded the resident as requiring the assistance of nursing staff for all ADLs (activities of daily living), with the exception of eating, which required set up only. She was completely continent of bowel, but her bladder function had declined to "always incontinent".	F 241	3. The nursing staff will be reeducated by the Staff Development Coordinator by 7/28/17 related to ensuring staff is providing care to maintain and enhance resident dignity, self-esteem, and self-worth including assisting residents with toileting needs as required. 4. The Assistant Director of Nursing or the Unit Manager will complete an audit of 10 current residents weekly for 4 weeks and monthly for 2 months to ensure staff continue to provide care to maintain and enhance resident dignity, self-esteem, and self-worth including providing toileting assistance as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Compliance Date:	07/29/17

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F 241	Continued From page 2 The latest CCP (comprehensive care plan) reviewed and revised on 4/11/17 documented the resident had the following care issues concerning the complaint allegation: 1. Alteration in bowel elimination r/t (related to) decreased mobility. The interventions included: "Scheduled toileting program as ordered." 2. The resident has an ADL self-care performance deficit related to recent surgery. Interventions: "Assist with ADLs as needed....." ***The resident was careplanned for scheduled toileting every two hours or as needed. 3. Alteration in thought process (initiated 3/6/17) related to a history of hallucinations during infections and believing she is wet when in reality she is not. Interventions: ".....Ensure routines are followed as closely as possible on each shift....Provide pleasant interactions which reassure the resident when confused.....Staff to check resident every two hours and as needed for incontinence....." On 6/28/17 at 11:00 AM Resident #1 was interviewed. She told the surveyor that a nursing staff member had told her to "go in her pants and she would come back to clean her up later." The resident said she was calling for help because she had to pee and staff would not answer her call light. Resident #1 stated, "They told me to shut-up because I was wet. I never use the light unless I need something.....It hurt my feelings. I cried. I didn't say anything. I never bother anyone. Why would they be so mean when you can't help when you have to go.?" The resident told the surveyor she would sit in her chair and pray the girl would learn to talk to someone without hurting their feelings.	F 241		

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The resident told the surveyor that prior to her admission, she lived at home by herself and knew when she had to use the bathroom. She never got anxious or called her daughters in the middle of the night.

FMI (family member #1) was present during this interview. She told the surveyor the incident about being asked to pee in her pants was reported to APS (Adult Protective Services) on 2/28/17. FMI stated, "They came in to investigate, but nothing was done."

FMI acknowledged Resident #1 was happy and content living at home prior to her admission. "She never called us crying or anxious like she does now."

The surveyor reviewed the facility reported incident sent in by the ADON (assistant director of nursing) on 2/28/17 and 3/4/17. The initial report documented the resident and family members complained to APS regarding the resident's incontinence care not being performed and the staff instructing the resident to urinate in her brief instead of assisting her to the toilet.

The follow-up report, transmitted to the surveyor's office by the ADON on 3/4/17, indicated an investigation had been conducted and the allegation of "neglect" was unsubstantiated. The follow-up statement did not address the staff telling the resident to urinate in her pants.

The surveyor reviewed the investigation results and the written statements of the CNAs involved in her care.

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CNA I stated the following about the incident, which occurred on 2/27/17 during 3rd shift. "When I came in at 11 PM, after a few minutes (name of CNA II) came in and asked how (Resident #1) transferred. I questioned her why she was getting resident up, she told me in return that patient had requested to go to the bathroom, although she'd already told patient just to use her depend (name of briefs used) and she'd change her. She said resident told her she couldn't and requested to go again to the bathroom. I went down to assist her in transferring....."

CNA II's statement on the same event, "....(Name of resident #1) put her call light on. I went back there to see what she needed and she said she wanted to get up to use the bathroom.....I told her I needed to first go get help because I did not know if she was a two-person assist....I told her if she needed to go really bad, that when I got back I would change her brief...."

The facility investigation results included a mandatory in-service held for all nurses and CNAs on 3/3/17. The content and objectives included: "Under no circumstances are you allowed to instruct a resident to be incontinent. We are here to keep them continent! Not force them to be incontinent. This is unacceptable and if you are reported you will be written up"

On 6/29/17 at 12:40 PM the facility administrator and DON were informed of the findings and asked if the matter had been taken to the QA (quality assurance) committee for review and follow-up. The DON said it had not, but they had started watching CNAs closer and popping in at different hours to check on care.

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F 241	Continued From page 5 No additional information was provided prior to the survey team exit. This was a deficiency based on a complaint allegation.	F 241	**F 242**	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interview and clinical record review it was determined the facility staff failed to accommodate dietary requests/choices for 1 of 16 residents (Resident #1). Findings: Facility dietary staff failed to accommodate diet choices for Resident #1. The resident's clinical record was reviewed on 6/27/17 at 3:00 PM. Resident #1 was admitted to the facility on 11/16/16. Her diagnoses included atrial fibrillation, heart failure, chronic obstructive pulmonary	F 242	1. Resident #1 was interviewed by the Dietary Manager on 6/29/17 to ensure the resident's dietary request/choices are honored. 2. An audit was completed on 6/30/17 by the Director of Nursing of the current residents' diet orders and dietary request/ choices to ensure resident diets are followed as required. The current residents were interviewed by the Director of Nursing on 6/30/17 to ensure any additional dietary request/ choices are being addressed as required. 3. The nursing and dietary staff were reeducated by the Staff Development Coordinator by 7/28/17 related to ensuring resident diet orders and dietary request/choices are honored as required. 4. The Dietary Manager will interview 5 residents weekly for 4 weeks and monthly for 2 months to ensure resident diet orders and dietary request/choices continue to be honored as required.	

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F 242	Continued From page 6 disease, gout and hypertension. She was admitted for surgical aftercare and physical therapy to restore mobile function. The latest quarterly MDS (minimum data set) assessment, dated 4/7/17, coded the resident with moderate cognitive impairment due to her inability to recall items during a short-term memory test to assess mental status. Her memory was coded as unimpaired. The MDS assessment coded the resident as requiring the assistance of nursing staff for all ADLs (activities of daily living), with the exception of eating, which required set up only. Resident #1's CCP did not reflect dietary choices. Resident #1's physician's orders, signed and dated 6/1/17 contained a dietary order. The order was for a regular diet, regular texture and regular consistency. On 6/28/17 at 11:00 AM Resident #1 was interviewed regarding her dietary choices/selections. She told the surveyor she loved buttermilk, but her doctor wouldn't let her have any. She told the surveyor she would like to have a glass of buttermilk every day at lunch. On 6/28/17 at 11:45 AM the surveyor relayed the resident's request for buttermilk daily at lunch to DM I (local dietary manager) and DM II (corporate dietary manager). DM II told the surveyor the resident's preference would not be a problem as the resident was on a regular diet with no restrictions. On 6/28/17 at 1:30 PM the resident told the surveyor she had received her buttermilk at	F 242	The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance: 07/29/17	

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F 242	Continued From page 7	F 242		

lunch. She stated, "It was so good! I'm so happy they're going to let me have it." The resident actually clapped her hands with glee at the prospect.

On 6/29/17 at 1:30 PM the surveyor spoke to Resident #1. Resident #1 told her she did not get her buttermilk on her lunch tray, she only got regular milk.

On 6/29/17 at 2:18 PM DM I was informed of the surveyor's findings. DM I replied, "She should have gotten it at lunch. I will check on it."

At 2:20 PM DM I returned to inform the surveyor that a dietary staff member informed him that they put buttermilk on her lunch tray that day. He told the surveyor it was not on her lunch tray ticket, but someone had remembered she wanted it--so they provided it. DM I added he had entered the request into the computer and it should, thereafter, appear as a resident choice on her meal ticket.

On 6/29/17 at 2:25 PM the surveyor returned to Resident #1's room and again asked the resident and FM II (family member II) what kind of milk was on the lunch tray that day. The resident repeated "regular milk." FM II said she was in the room during lunch and the resident received sweet milk--no buttermilk. The DON was in the resident's room at this time and heard the conversation. She said she would check on it.

On 6/29/17 at 2:45 PM the findings were reported to the facility administrator, DON and corporate nurse. No additional information was provided prior to the survey team exit.

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F 272	Continued From page 8	F 272	**F 272**	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with	F 272	1. Resident #7 had a new Comprehensive MDS with ARD of 7/24/17 completed by the MDS nurse by 7/28/17 to include the date and the location of the CAA information included on section V as required. 2. An audit was completed by the Clinical Reimbursement Specialist on 07/05/17 of the current residents' last Comprehensive MDS Assessment to ensure section V has been completed to include the date and the location of the CAA information. 3. The MDS Coordinator will be reeducated by the Clinical Reimbursement Specialist by 07/25/17 related to ensuring that section V of the MDS is completed to include the date and the location of the CAA information.	

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F 272	Continued From page 9 the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA's) for 1 of 16 Residents, Resident #7. The findings included: For Resident #7 the facility staff failed to accurately name the date and location of CAA (care area assessment) documentation. Resident #7 was admitted to the facility on 09/15/15 and readmitted on 02/09/17. Diagnoses included but not limited to Alzheimer's disease, anxiety, depression, gastroesophageal reflux disease, hypertension, and thyroid disorder. The most recent comprehensive MDS with an ARD (assessment reference date) of 02/13/17 coded the Resident as having both short and long term memory impairment with severely impaired skills for daily decision making. This is a significant change MDS. Section V of the MDS, care area assessment, was reviewed. The facility staff had not identified the date and location of the CAA information used	F 272	4. The Clinical Reimbursement Specialist will audit 2 Comprehensive Assessments weekly for 4 weeks and monthly for 2 months to ensure the V section of the MDS continues to be completed to include the date and the location of the CAA information. The Administrator or Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow up. Date of Compliance: 07/29/17	

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F 272	Continued From page 10 to determine the care plans for cognitive loss or communication. The only documentation was "see CAA worksheet dated 02/21/17". The CAA worksheets were reviewed and the information could not be located. The concern of the missing documentation was discussed with the administrative team during a meeting on 06/28/17 at approximately 1600. No further information was provided prior to exit.	F 272		
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	**F 309** 1. Resident #4 was checked by the Director of Nursing on 6/28/17 to ensure that the TED hose were in place as required. An extra pair of TED Hose were ordered on 7/17/17 by Central Supply. 2. An audit was completed on 6/28/17 of the current residents by the Director of Nursing to ensure treatments and care is provided as ordered to include the application of TED hose.	

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F 309	Continued From page 11 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) 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 observation, staff interview and clinical record review, it was determined that the facility staff failed to follow physician orders for 1 of 16 Residents in the sample survey, Resident # 4. The Findings Included: For Resident #4 the facility staff failed to apply physician ordered TED hose. Resident #4 was an 85 year old female who was admitted on 9/9/16. Admitting diagnoses included, but were not limited to: violent behaviors, dysphagia, basal cell cancer, major depression, anxiety, hearing loss, hypertension and a cerebral infarction. The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/8/17. The facility staff coded that Resident #4 had short and long term memory loss (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #4 required total nursing care (4/2) with ADL's.	F 309	3. The nursing staff were reeducated by the Staff Development Coordinator on 06/28/17 related to ensuring treatments and care is provided as ordered to include the application of TED hose. 4. The Assistant Director of Nursing will complete an audit of 10 resident's weekly for 4 weeks and monthly for 4 months to ensure treatments and care continues to be provided as ordered to include the application of TED hose. The Assistant Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow up. Date of Compliance:	07/29/17

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On June 27, 2017 at 2:35 p.m. the surveyor observed Resident #4 lying on her bed on top of the bed linens. The surveyor did not observe that Resident #4 had on TED hose.

On June 27, 2017 at 3 p.m. the surveyor observed Resident #4 lying in her bed and on top of the bed linens. The surveyor did not observe that Resident #4 had on TED hose.

On June 27, 2017 at 3:30 p.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record produced signed physician orders dated 6/1/17. Signed physician orders included, but were not limited to: "TED hose to bilateral lower extremities at all times. To be removed Q HS (every evening at bedtime) every shift for edema." (sic)

On June 27, 2017 at 4:10 p.m. the surveyor observed Resident #4 sitting in her wheelchair. The surveyor did not observe that Resident #4 had on the physician ordered TED hose. The surveyor observed that Resident #4 had on white socks that came up just above her ankles.

On June 28, 2017 at 9:45 a.m. the surveyor notified the Director of Nurses (DON) that Resident #4 had a physician order for TED hose to be applied to bilateral extremities for edema. The surveyor notified the DON that on multiple occasions on June 26, 2017, Resident #4 did not have on the physician ordered TED hose.

On June 29, 2017 at 9:45 a.m. the survey team met with the Administrator (Adm), DON, and the Human Resources/Payroll Department Head. The surveyor notified the Administrative Team (AT) that Resident #4 had a physician order for

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F 309	Continued From page 13 TED hose to her bilateral lower legs for edema. The surveyor notified the AT that Resident #4 did not have on the physician ordered TED hose on multiple observations on June 27, 2017. No additional information was provided prior to exiting the facility as to why the facility staff failed to apply the physician ordered TED hose to Resident #4.	F 309		
F 319 SS=D	483.40(b)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES 483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- (b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. This REQUIREMENT is not met as evidenced by. Based on observation, resident, family and staff interview, facility document review and clinical record review it was determined the facility staff failed to provide treatment and services necessary to address the psychosocial issues (failure to adjust to the facility, anxiety, fear and depression due to loss of independence/dignity) for 1 of 16 residents (Resident #1). Findings: The facility staff failed to provide treatment and services necessary to address the	F 319	**F 319** 1. The Director of Nursing met with Resident #1 and her family on 6/29/17 to address the resident psychosocial/ adjustment issues and the resident's plan of care was reviewed and revised by the interdisciplinary team. 2. An audit was completed of the current residents on 7/14/17 by the Director of Nursing to ensure resident psychosocial/ adjustment issue are being addressed. 3. The Social Worker was reeducated on 7/12/17 by the Director of Nursing related to ensuring that the residents' plan of care address resident psychosocial and adjustment issues.	

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F 319	Continued From page 14 psychosocial/adjustment issues for Resident #1. The resident's clinical record was reviewed on 6/27/17 at 3:00 PM. Resident #1 was admitted to the facility on 11/16/16. Her diagnoses included atrial fibrillation, heart failure, chronic obstructive pulmonary disease, gout and hypertension. She was admitted for surgical aftercare and physical therapy to restore mobile function. The resident had a history of respiratory failure. The initial MDS (minimum data set) assessment dated 11/23/17 coded the resident with slight cognitive impairment due to her inability to consistently make herself understood and her inability to consistently understand others. Her hearing was assessed as adequate on this assessment. She required assistance with all the ADLs (activities of daily living) and was frequently incontinent of bowel and bladder. The latest quarterly MDS (minimum data set) assessment, dated 4/7/17, coded the resident with moderate cognitive impairment due to her inability to recall items during a short-term memory test to assess mental status. Her memory was coded as unimpaired. The resident was coded with significant hearing impairment on this assessment. The resident was coded as not having a hearing aid. The latest MDS assessment coded the resident as requiring the assistance of nursing staff for all ADLs (activities of daily living), with the exception of eating, which required set up only. She was completely continent of bowel, but her bladder function had declined to "always incontinent".	F 319	4. The Director of Nursing will complete an audit of 5 residents weekly for 4 weeks and monthly for 2 months to ensure resident psychosocial / adjustment issues continue to be addressed as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator is responsible for monitoring and follow up. Date of Compliance:	07/29/17

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F 319	Continued From page 15 The latest CCP (comprehensive care plan) reviewed and revised on 4/11/17 documented the resident had the following care issues concerning the complaint allegation: 1. Alteration in bowel elimination r/t (related to) decreased mobility. The interventions included: "Scheduled toileting program as ordered." 2. The resident has an ADL self-care performance deficit related to recent surgery. Interventions: "Assist with ADLs as needed....." ***The resident was careplanned for scheduled toileting (in bathroom) every two hours or as needed--but there was no documented evidence this schedule was followed. 3. Alteration in thought process (initiated 3/6/17) related to a history of hallucinations during infections and believing she is wet when in reality she is not. Interventions: ".....Ensure routines are followed as closely as possible on each shift....Provide pleasant interactions which reassure the resident when confused.....Staff to check resident every two hours and as needed for incontinence....." 4. Alteration in behavior (initiated 3/6/17) related to history of making false accusations against staff regarding care received. Interventions: "....Cries often and speaks in high pitched squeaky voice when requesting assistance, provide assistance as needed and speak to resident in normal voice.....social services to visit frequently to assess/review any concerns the resident might have 5. Resident is afraid of dark. The interventions included: "Staff to leave the light on at all times per the resident's request." (Subsequent interviews with the resident and family members indicate this was not consistently implemented. 6. Alteration in bowel elimination r/t (related to) decreased mobility. The interventions included:	F 319		

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F 319	Continued From page 16 "Scheduled toileting program as ordered." 7. The resident will be a long term care individual. Interventions did not include plans to address her problems adjusting to loss of independence/wish to return home or inability to adjust to long term care. (There was nothing in the CCP to address these ongoing issues.) 8. Moderately impaired hearing. Does not wear hearing aide (initiated 4/12/17). Interventions: ".....Speak directly with resident in clear audible tones. Speak slightly slower and enunciate words....." 9. The resident has an ADL self-care performance deficit related to recent surgery. Interventions: "Assist with ADLs as needed....." 10. The resident uses antidepressant medication related to insomnia. Interventions: ".....Promote quiet environment to allow sleep." ******The CCP, at no time, addressed the resident's actual anxiety/depression over being admitted permanently to the facility. The CCP did not address psychiatric intervention for her on-going psycho-social adjustment issues--other than to document her "undesirable behaviors" which were symptoms of depression and anxiety. (These "behaviors" were actually only assessed and care planned after APS (Adult Protective Services) investigated an incident on 2/28/17 that the resident had been told by a staff member to urinate in her brief instead of assisting her to the toilet. The allegation was substantiated by this surveyor--but reported to be unsubstantiated to this surveyor's office.) She was initially admitted for aftercare and physical therapy following surgery for injuries sustained from a fall in her home. On admission, she was careplanned for eventual return to her home, but, since then has become a permanent	F 319		

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resident due to lack of home services to assist with her daily care requirements.

The physician's orders, signed and dated 6/1/17, included the following medications:
1. 2/9/17 - Ativan tablet 0.5 mg. Give one tablet by mouth every 12 hours for anxiety.
2. 5/23/17 -Trazodone HCL tablet. Give 75 mg by mouth at bedtime related to insomnia.
3. 1/27/17 - May have oxygen O2 on at 2L/minute via NC (nasal cannula) as needed for SOB (shortness of breath)/maintaining O2 saturation above 90%.

On 6/28/17 at 11:00 AM Resident #1 was interviewed. She told the surveyor that a nursing staff member had told her to "go in her pants and she would come back to clean her up later." The resident said she was calling for help because she had to pee and staff would not answer her call light.

Resident #1 stated, "They told me to shut-up because I was wet. I never use the light unless I need something.....It hurt my feelings. I cried. I didn't say anything. I never bother anyone. Why would they be so mean when you can't help when you have to go?" The resident told the surveyor she would sit in her chair and pray the girl would learn to talk to someone without hurting their feelings. (The CNA was no longer at the facility and not available for interviews.)

The resident told the surveyor that prior to her admission, she lived at home by herself and knew when she had to use the bathroom. She never got anxious or called her daughters in the middle of the night. She tearfully, told the surveyor she just "wanted to go home".

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F 319	Continued From page 18 FMI (family member #1) was present during this interview. She told the surveyor the incident about being asked to pee in her pants was reported to APS (Adult Protective Services) on 2/28/17. FMI stated, "They came in to investigate, but nothing was done." FMI acknowledged Resident #1 was happy and content living at home prior to her admission. "She never called us crying or anxious like she does now." FM I said she and other family members had talked to the staff about the issues that began on her admission, and just didn't know what to do at this point. The surveyor reviewed a facility reported incident and the subsequent investigation results sent in by the ADON (assistant director of nursing) on 2/28/17 and 3/4/17. The initial report documented the resident and family members complained to APS regarding the resident's incontinence care not being performed and the staff instructing the resident to urinate in her brief instead of assisting her to the toilet. The follow-up report, transmitted to the surveyor's office by the ADON on 3/4/17, indicated an investigation had been conducted and the allegation of "neglect" was unsubstantiated. The follow-up statement did not address the staff telling the resident to urinate in her pants. The surveyor reviewed the investigation results and the written statements of the CNAs involved in her care. CNA I stated the following about the incident, which occurred on 2/27/17 during 3rd shift.	F 319		

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"When I came in at 11 PM, after a few minutes (name of CNA II) came in and asked how (Resident #1) transferred. I questioned her why she was getting resident up, she told me in return that patient had requested to go to the bathroom, although she'd already told patient just to use her depend (name of briefs used) and she'd change her. She said resident told her she couldn't and requested to go again to the bathroom. I went down to assist her in transferring....."

CNA II's statement on the same event, "....(Name of resident #1) put her call light on. I went back there to see what she needed and she said she wanted to get up to use the bathroom.....I told her I needed to first go get help because I did not know if she was a two-person assist....I told her if she needed to go really bad, that when I got back I would change her brief...."

The facility investigation results included a mandatory in-service held for all nurses and CNAs on 3/3/17. The content and objectives included: "Under no circumstances are you allowed to instruct a resident to be incontinent. We are here to keep them continent! Not force them to be incontinent. This is unacceptable and if you are reported you will be written up".

On 6/29/17 at 8:00 AM the surveyor interviewed the SW (Social Worker) about her interventions regarding the resident's on-going adjustment issues and her follow-up support after the 2/27/17 incident. The SW said Resident #1 had cried a lot since she first came in and called out begging the daughters to come back and stay with her. SW stated, "She's had trouble adjusting. I spent time with the daughters to find out what's going on. Sometimes they're ok, sometimes they aren't

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F 319	Continued From page 20 happy." The SW was asked if she'd provided counseling or comfort to the resident since her admission or the February incident. She told the surveyor, she hadn't really documented anything or actually counseled the resident, "I knew the nurses had her on rounds and she should have medication for anxiety by now. I felt she needed medication to adjust, but I haven't addressed that....I don't feel like we've done all we can for her. She should've had psych services." The SW notes were reviewed. She had addressed the family's concerns and documented them. There was no documentation she provided any support to Resident #1. On 6/29/17 at 11:00 AM, FM II was interviewed. She had numerous complaints and was primarily focused on the on-going adjustment issues and the lack of staff support and psychiatric services at the facility. FM II stated, "I have asked them if they could schedule a psychiatric eval for her. I think she needs it. She's just not happy and I'm unable to take her home and care for her by myself. They told me they are in the process of that, but its a long, drawn out process". FM II told the surveyor she asked if she could bring in a psychiatrist herself and was told she could not. She said the facility, currently, had no one to provide psychiatric services to the residents. She said the Ativan had helped some, but the resident was still anxious and fearful of being in the facility alone. She said, "They tell her to shut-up when she calls out for help. One night her oxygen fell off and she got short of breath and anxious. She called for help when no one	F 319		

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answered her call light. They finally came in and put her oxygen back on and told her only to call if it was an emergency. Isn't it an emergency if you can't breath?"

FM II said most of Resident #1's anxiety/fears focused on the night shift (3rd) after the family was gone. She told the surveyor she didn't know what else to do because she couldn't stay at the facility 24 hours a day. FM II stated, "It's always her fault, and I'm tired of them blaming it on her behaviors...They want to keep her quiet, but they are not addressing her issues."

On 6/29/17 at 12:40 PM the facility administrator and DON were informed of the findings and asked for evidence the facility had provided psychosocial support to address Resident #1's anxiety, fears and adjustment issues.

The DON stated, "We have been trying to get psychiatric services for quite some time. We're changing our doctor services but it's a long process. The new doctor is going to be more help with psychiatric services." The DON added they had started watching CNAs closer and popping in at different hours to check on care since the February incident.

No additional information was provided prior to the survey team exit. This was a complaint allegation deficiency.