PRINTED: 05/22/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495177	A. BUILDING _____ B. WING _____	C 05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970 REVISED

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/08/18 through 05/10/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000	**This Plan of Correction is respectfully submitted as evidence of compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with the requirements of participation.**	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/8/18 through 5/10/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 140 certified bed facility was 94 at the time of the survey. The survey sample consisted of twenty-one current resident reviews and two closed record reviews.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657	**F 657 Care Plan Revision** **Corrective Measure for Residents Affected** Resident # 36's care plan has been revised to reflect measurable goals and specific interventions regarding contractures and the joints/extremities involved. Non-pharmacological interventions have been revised to include specific approaches. Comfort measures related to positioning have been added. Interventions for regurgitation of oral intake and assistive	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Virginia Williams | TITLE: Administrator | (X6) DATE: 5/24/18

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

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F 657	Continued From page 1 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for eight of 23 residents in the survey sample, Residents #36, #46, #72, #67, #5, #54, #25, and #73. 1. Resident #36's care plan did not have measurable interventions to address contractures, comfort measures, non-pharmacological interventions, assistive devices or her NPO (nothing by mouth) status. 2. Resident #46's care plan did not have measurable interventions to address non-pharmacological interventions, urinary status or verbalization of self harm. 3. Resident #72 's care plan did not have measurable interventions to address restorative therapy, comfort measures or non-pharmacological interventions. 4. Resident #67 did not have a care plan to address her PEG (percutaneuous endoscopic	F 657	device have been discontinued as these are not appropriate at this time. Resident # 46 was discharged from the facility on 5/11/18 and the comprehensive care plan cited during survey is no longer in use. He was re-admitted on 5/17 and a new comprehensive care plan will be developed based on his assessed needs. Resident # 72's care plan has been revised to address restorative therapy interventions. Non-pharmacological interventions for pain and other comfort measures now include specific approaches. The care plan for resident # 67 has been revised to reflect the use of PEG tube for nutrition and hydration and the pureed food and thickened liquids provided orally for pleasure. It also reflects feeding assistance being provided by staff. The care plan for Resident # 5 was reviewed and interventions for fall prevention were present.	

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F 657	Continued From page 2 gastrostomy) tube, tube feedings, the use of a puree diet, or that she was total assistance for feeding. 5. Resident #54 care plan was not revised to include measurable interventions for falls. Resident #54 has encountered multiple unwitnessed falls indicating lack of supervision. 6. The facility staff failed to review and revise the comprehensive care plan (CCP) for falls for Resident # 5. 7. Facility staff failed to revise Resident #25's plan of care with interventions for fall/injury prevention. 8. Resident #73's care plan was not revised to include use of plastic utensils. Findings included: 1. Resident #36 was originally admitted to the facility on 03/04/2011 and readmitted on 10/05/2016 with diagnoses including, but not limited to: Hypertension, Sacral Pressure Ulcer-Stage 3 with MRSA (methicillin resistant staphylococcus aureus), Dementia, Parkinson's Disease, Schizophrenia and Dysphagia. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 03/12/18. Resident #36 was assessed as severely impaired in her short and long term memory and daily decision making skills. Resident #36's CCP was reviewed on 05/09/18 at 10:30 a.m. The following areas were noted	F 657	Other interventions are being added: a chair/bed alarm to remind her not to get out of bed or wheelchair unassisted, PT/OT evaluation to assess positioning or need for wheelchair adaptations, place personal items within reach, closer supervision and scheduled toileting. Resident # 25 was assessed for continued use of the reclining chair. It was discontinued based on the assessment. Additional interventions will be implemented based on fall investigation and root cause analysis. Additional interventions have been or will be added to Resident # 54's care plan: increased supervision by staff and family, tray for his wheelchair to allow him to work on a "busy board", scheduled toileting, chair and bed alarm with voice instruction not to get up without assistance, visual checks every 30 -40 minutes, pharmacy and physician review for appropriateness of pharmacological interventions, and referral to a dementia unit with a more	

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F 657	Continued From page 3 without personalized interventions or measurable goals: "...Prevent further deterioration of contractures...Evaluate effectiveness of comfort measures...Provide [Name] with non pharmacological interventions...Utilize assistive devices for function and independence...Observe for regurgitation with oral intake..." These statements were written as noted above. Nothing was personalized specific to Resident #36. Resident #36 had numerous contractures that were not listed on the CCP. No specific comfort measures or non-pharmacological interventions were listed. No specific assistive devices were listed. Resident #36 was NPO and received all nutrition and oral medications via a feeding tube in her abdomen. RN #3 (registered nurse) was interviewed on 05/10/18 at 10:50 a.m. regarding care plans. RN #3 stated, "Care plans are a joint effort. We are responsible." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 05/10/18 at approximately 2:30 p.m. No further information was received by the survey team prior to the exit conference on 05/10/18. 2. Resident #46 was admitted to the facility on 12/21/17 with diagnoses including, but not limited to: Diabetes, Alzheimer's, BPH (benign prostatic hypertrophy), Glaucoma, Diverticulitis, and Mild Intellectual Disability. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment	F 657	structured environment and activities. Resident # 73 was provided regular flatware on a trial basis and she was observed to be using them appropriately. The use of plastic flatware was thus discontinued. **Identification of Other Residents with Potential To Be Affected** Other residents with potential to be affected will be identified through review of physician's orders, fall logs and care plans. Any variances identified will be addressed. **Measures to Prevent Recurrence** The care plan application for the EMR implemented in November has more flexibility for individualization than originally thought. In-service/re-training of nursing staff will be conducted on this application and to reiterate the requirement that care plans be updated based on post fall assessment and resident centered care necessary to meet residents' needs.	

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F 657	Continued From page 4 reference date) of 03/26/18. Resident #46 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #46's CCP was reviewed on 05/09/18 at 12:25 p.m. Included in this resident's CCP were general, non-specific, non measurable interventions and goals. These included: "...Provide [Name] with non-pharmacological intervention, evaluate effectiveness...Anchor drainage tube of Foley to prevent tension. Eval for symptoms of UTI [urinary tract infection], promote hydration, proper cleansing. Support skin care, catheter needs while promoting independence. Check for physician diagnosis of urinary retention/other medical justification for continuous Foley...Change urinary catheter bag and tubing per policy...Address self injury verbalizations immediately..." No specific non-pharmacological interventions were included on this resident's CCP. Resident #46's Foley catheter was discontinued on 04/09/18. Resident #46 was voiding on his own during the survey. There was no mention of any verbalizations by Resident #46 of self injurious behavior in his clinical record. RN #3 (registered nurse) was interviewed on 05/10/18 at 11:00 a.m. regarding Resident #46's CCP. RN #3 stated, "Care plans are a joint effort. We are responsible. It would have been nice if the nurse who dc'd [discontinued] the Foley would have taken it out of the computer. I am speculating someone checked this in error. I have no recollection of him ever saying he would harm himself." The Administrator and DON (director of nursing)	F 657	**Monitoring:** The Director of Nursing or designee will review care plans to ensure they are being updated/revised to reflect fall prevention interventions and other appropriate interventions to meet resident needs. Monitoring of staff implementation of care plan interventions on a sample of residents will also be conducted. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted weekly X 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 657	Continued From page 5 were informed of the above during a meeting with the survey team on 05/10/18 at approximately 2:30 p.m. No further information was received by the survey team prior to the exit conference on 05/10/18. 3. Resident #72 was originally admitted to the facility on 07/27/2004 and readmitted on 04/14/2018 with diagnoses including, but not limited to: Anemia, Hypertension, Diabetes, Hemiparesis and Depression. The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 04/21/18. Resident #72 was assessed as severely impaired in her short and long term memory and daily decision making skills. Resident #72's CCP was reviewed on 05/09/18 at 9:30 a.m. The CCP included general, non-specific, non-measurable goals and interventions. These included: "...Functions at Optimal Level with ADLs [activities of daily living]...Provide assistance to support level of needs...Evaluate effectiveness of comfort measures...Provide [Name] with non pharmacological interventions..." This CCP was not individualized to Resident #72's needs. There was no mention of her restorative nursing on the CCP. This resident was maximum assist with all ADL's. Also, no specific comfort measures or non-pharmacological interventions were stated on the CCP. RN #3 (registered nurse) was interviewed on	F 657		

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F 657	Continued From page 6 05/10/18 at 10:50 a.m. regarding care plans. RN #3 stated, "Care plans are a joint effort. We are responsible." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 05/10/18 at approximately 2:30 p.m. No further information was received by the survey team prior to the exit conference on 05/10/18. 4. Resident #67 was admitted to the facility on 03/27/2018. Her diagnoses included but were not limited to: Stage IV pressure ulcer of the sacrum, sepsis, dementia, and body mass index 19.9 or less (adult). The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 04/03/2018. Resident #67 was assessed as being impaired with both long and short term memory, and severely impaired with daily decision making skills. During the initial tour of the facility on 05/08/2018 at approximately 11:45 a.m., Resident #67 was observed lying in her bed. CNA (certified nursing assistant) #4 was sitting beside the bed feeding Resident #67 a pureed diet for lunch. A tube feeding pump was observed beside the bed. The pump was attached to a pole and not turned on; a container of Jevity 1.2 was hanging above the pump. The tubing from the pump was capped and secured to the pole. At approximately 1:00 p.m., CNA #4 was in the hallway. This surveyor asked her how much lunch Resident #67 had consumed. She stated, about	F 657		

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F 657	Continued From page 7 25 %. CNA #4 was asked if Resident #67 could feed herself at all. She stated, "No, we feed her at every meal." The clinical record was reviewed at approximately 2:30 p.m. Observed on the physician orders were orders for the administration of the tube feeding, cleaning of the PEG site, and a diet order for a modified diet, texture restricted with nectar thick liquids. The care plan was reviewed. A focus area for "LTC [long term care] Nutritional Status" was observed. There were no interventions listed for Resident #67's PEG tube, PEG tube care, tube feeding, her puree diet or that she needed assistance to be fed. The other focus areas were reviewed and did not contain the interventions listed. The DON (director of nursing) was interviewed on 05/09/2018 at approximately 10:00 a.m., regarding the care plan for Resident #67. She looked at the care plan and stated, "I don't see them [interventions previously named]. The DON was asked if the interventions should be listed. She stated, "Yes." The above information was discussed during a meeting with the DON, the administrator and the unit manager on 05/10/2018 at approximately 2:30 p.m. No further information was provided prior to the exit conference on 05/10/2018. 5. Resident # 5 was admitted to the facility 8/24/17 with diagnoses to include, but were not limited to: dementia, anxiety, depression, GERD, and high blood pressure.	F 657		

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F 657	Continued From page 8 The most recent MDS (minimum data set) was a quarterly review dated 1/29/18 and had Resident # 5 assessed with severe impairment in cognition with a total summary score of 03 out of 15. During review of the electronic medical record (EMR), it was noted the care plan documented as "IPOC (individual plan of care): LTC (long term care) Falls (Initiated). Last updated on: 5/8/18....." The EMR identified under "Outcomes: Free from injury (GOAL); Description of Fall activity LTC; MDS Nurse Reviewed." Under "Interventions was documented "Morse fall risk standard precautions." The items were identified as "activated" and dated 5/9/18. The care plan documentation in the EMR consisted of check marks beside typed notes written as "Goal Met." There was no description located of specific problems, goals, or interventions. On 5/9/18 at 12:00 p.m. LPN (licensed practical nurse) # 5 was asked for assistance with the care plan. LPN # 5 stated there were no specific areas in the current software to include documentation other than to check off the area under the heading. LPN # 5 was asked how an area could be checked off if there was no documentation of what was to be done. LPN # 5 did not have an answer. LPN # 5 was then asked what was the "Morse fall risk standard precaution." LPN # 5 stated "I think it's actually a form that's filled out at the time of a fall that gives a numerical score of the risk for falls." This surveyor then asked if there were any other interventions for falls included in the care plan. LPN # 5 stated there were not.	F 657		

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F 657	Continued From page 9 On 5/10/18 at 11:30 a.m. this surveyor discussed the care plan with the DON (director of nursing) and asked if she knew what the "Morse fall risk standard precautions" were. The DON stated "I don't know- I can find out." This surveyor then went to the unit where Resident # 5 resided and interviewed staff about the fall precautions as written on the care plan. LPN # 1 stated "Well, I think it's assessing and monitoring anything that could cause a fall...at least, I think that's what that is." CNA (certified nursing assistant) # 1 stated "I have never heard of that; I have no idea!" CNA # 2 also stated that she had no idea what the Morse fall risk precaution was, but she could find out. LPN # 2 stated, "The Morse fall risk precaution isn't an intervention; it's a form that is to be filled out when the resident has a fall. When it's activated if there's a fall, it brings up a list of questions and tally's up the score as you go and then gives you the fall risk numerical value. It's basically like a fall risk assessment." During a meeting with facility staff 5/10/18 beginning at 2:30 p.m. with the administrator, DON, and several nursing staff, it was agreed that the current care plan for falls did not include interventions for falls. No additional information was provided prior to the exit conference. 6. Resident #54 was admitted to the facility originally on 05/18/16, with diagnoses that included dementia. The most current MDS (minimum data set) was an annual quarterly assessment dated 04/6/18. Resident #54 was assessed with long and short-term memory loss and severe loss of cognitive status.	F 657		

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F 657	Continued From page 10 A family interview was conducted on 05/08/18 at 12:21 PM. During the interview Resident #54's son verbalized that Resident #54 had fallen multiple times and Resident #54 does not use the call bell and tries to get out of bed and out of the wheelchair. Resident #54's son verbalized that Resident #54 does were an alarm and has a fall mat, but felt that a shortage of staff was the main reason for the falls because the certified nursing assistants (CNA) have so much to do. On 05/09/18 3:30 p.m. Resident #54 was observed within 10 feet of the nurses station by 2 surveyors. Three staff members were at the nurses station, but were unaware that Resident #54 was attempting to get out of the wheelchair. This observation continued for 15 minutes. No staff member attempted to assist Resident #54 until one staff member observed the surveyors and then started interacting with Resident #54, trying to get Resident #54 to scoot back In the wheelchair. Resident #54 did not want to slide back In the wheelchair after being asked, resulting In 2 CNA's physically scooted Resident #54 back in the wheelchair. Review of Resident #54's care plan for fall interventions included: Bed alarm, Chair alarm frequent observations, low bed with mat, remind to use the call light. These interventions were all dated on 2/4/18. The most recent updated intervention was dated 5/9/18 and included, keep in sight during risk hours. According to documentation, Resident #54 had fallen a total of 7 times between 2/4/18 and 5/8/18. On 05/10/18 at 08:51 AM registered nurse (RN #3), clinical coordinator was interviewed	F 657		

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F 657	Continued From page 11 regarding Resident #54's care plan. RN #3 verbalized that Resident #54 was continuously trying to get out of bed or out of the wheelchair, does not call for help, and has had multiple falls. RN #3 verbalized that the facility has tried to put interventions into place, but short of putting Resident #54 on one to one, the staff doesn't know what else to do. This surveyor explained that some of Resident #54's interventions does not seem individualized and specific, for example, frequent observations and keep in sight during risk hours. This surveyor asked RN #3 how often was frequent observation and when were the risk hours. RN #3 verbalized that those interventions were not specific to time because that would make the staff have to document when and how often Resident #54 was being observed. On 05/10/18 10:49 AM the director of nursing was informed of the concerns regarding revising the care plan to reflect more measurable interventions. No other information was provided prior to exit conference on 5/10/18. 7. Resident #25 was admitted to the facility on 5/31/17 with diagnoses that included Parkinson's disease, cerebrovascular accident (stroke), peripheral vascular disease, anemia and depression. The minimum data set (MDS) dated 2/28/18 assessed Resident #25 with severely impaired cognitive skills. Resident #25's clinical record documented a post fall evaluation note dated 5/4/18 stating the resident fell from a reclining chair in his room. The record documented no further details about the fall or any description of events leading up to or surrounding the incident. Interventions listed	F 657		

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F 657	Continued From page 12 to prevent further falls made no mention of the reclining chair. Interventions documented to prevent further falls included adequate room lighting, bed in low position, non-slip footwear, wheels locked, bed alarm, floor mat and clutter free room. The resident's plan of care (revised 5/8/18) was not updated with any new interventions for fall prevention following the fall on 5/4/18. Care plan interventions listed included were: note positioning and location while out of bed in wheelchair, Morse fall risk standard precautions, sensory pad while in bed or chair, evaluate room for clutter, frequent rounds, call bell accessible, low bed, monitor more frequently, remove from harmful objects and monitor as needed while in wheelchair. The care plan made no mention of the 5/4/18 fall or of any use of a reclining chair. On 5/10/18 at 9:48 a.m., the licensed practical nurse (LPN #6) working on Resident #25's living unit was interviewed about the fall on 5/4/18. LPN #6 stated the resident had Parkinson's disease and tried to get up and reached out for things frequently from the wheelchair. LPN #6 stated when the resident was more alert he was usually seated in a standard wheelchair. LPN #6 stated when Resident #25 was more restless and "fidgety" they sometimes placed him in a reclining chair. LPN #6 stated she did not know if the recliner was part of the care plan On 5/10/18 at 10:12 a.m., the registered nurse responsible for quality assurance (RN #1) was interviewed about Resident #25's fall from the reclining chair. RN #1 stated she reviewed and investigated all falls to ensure interventions were implemented. RN #1 stated she had no report of	F 657		

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F 657	Continued From page 13 the fall on 5/4/18 so she had not investigated or reviewed the circumstances surrounding the fall. On 5/10/18 at 10:31 a.m., LPN #7 caring for Resident #25 was interviewed about use of the reclining chair. LPN #7 stated the resident was typically out of bed in a standard wheelchair. LPN #7 stated she was not aware of Resident #25 using a reclining chair. LPN #7 stated she did not know if the care plan had been updated following the fall on 5/4/18. On 5/10/18 at 12:05 p.m., LPN #5 responsible for care plan updates was interviewed about Resident #25's fall on 5/4/18. LPN #5 stated she updated care plans when MDS assessments were completed and that the floor nurses were responsible for updating the care plan as needed between assessments. LPN #5 reviewed Resident #25's care plan and stated she did not see any revisions in response to the 5/4/18 fall. These findings were reviewed with the administrator and director of nursing during a meeting on 5/10/18 at 2:30 p.m. 8. Resident #73 was admitted to the facility on 1/13/12 with a re-admission on 3/1/18. Diagnoses for Resident #73 included diabetes, high blood pressure, cerebrovascular accident (stroke), hemiplegia, dementia and anxiety. The minimum data set (MDS) dated 4/23/18 assessed Resident #73 with moderately impaired cognitive skills. On 5/8/18 at 11:40 a.m., Resident #73 was observed eating lunch in the dining room. Resident #73 was eating using plastic utensils.	F 657		

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F 657	Continued From page 14 On 5/9/18 at 9:18 a.m., Resident #73 was observed in her room eating a cup of applesauce using a plastic spoon. Resident #73 was interviewed at this time about the plastic utensils. Resident #73 stated she was always given plastic utensils but she did not know why. Resident #73's plan of care (revised 5/9/18) made no mention of plastic eating utensils. On 5/9/18 at 9:20 a.m., the licensed practical nurse (LPN #8) caring for Resident #73 was interviewed about the plastic utensils. LPN #8 stated she was aware the resident had plastic utensils and thought they were used due to a safety issue with the resident. On 5/9/18 at 9:25 a.m., LPN #2, working on Resident #73's living unit, was interviewed about the plastic utensils. LPN #2 stated the resident at one time hoarded the stainless silverware in her reclining chair and the utensils were sticking the resident causing a safety concern. LPN #2 stated the hoarding behavior started several months ago and the plastic utensils were used as a safety precaution. LPN #2 reviewed Resident #73's care plan and stated there was nothing on the care plan about the utensils or the hoarding behavior On 5/10/18 at 8:52 a.m., LPN #5, responsible for MDS assessments and care plans, was interviewed about the plastic utensils. LPN #5 stated she knew the resident used plastic eating utensils but did not see any updates to the care plan about the plastic utensils. These findings were reviewed with the administrator and director of nursing during a	F 657		

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F 657	Continued From page 15 meeting on 5/10/18 at 2:30 p.m.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34, Resident #5, Resident #187, Resident #25 and Resident #54. This is a complaint deficiency. 1. Facility staff failed to lock the brakes on Resident #34's bed, when providing personal care. Resident #34 was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident # 5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning	F 689	**F 689 Free From Accidents/Hazards; Supervision; Devices** **Corrective Measure for Residents Affected** The brakes on Resident # 34's bed are being locked. A bed rail assessment was conducted and the bilateral ½ rails were discontinued and are no longer in use. The top bilateral ½ rails continue to be used per physician order. A fall mattress has been added. There has been no additional fall at this time. Additional fall prevention interventions will be added for Resident # 5: a chair/bed alarm to remind her not to get out of bed or wheelchair unassisted, PT/OT evaluation to assess positioning or need for wheelchair adaptations, place personal items within reach, closer supervision and scheduled toileting. Because of her dementia, potential for falls from bed or toilet is also being addressed. Post fall assessment now includes assessment for pain.	

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F 689	Continued From page 16 locking system. Resident #187 was found on the ground floor landing and diagnosed with a fractured left upper arm as a result of the fall (Harm). 4. Resident #25, with a history of falls, fell from a reclining chair and experienced an abrasion above his right eye. The resident had not been assessed for use of the reclining chair. There was no prompt review and/or investigation of the fall by facility staff. 5. Resident #54 sustained multiple unwitnessed falls indicating lack of supervision. Findings were: 1. Resident #34 was originally admitted to the facility on 01/30/1996 and readmitted on 05/17/2017. Her diagnoses included but were not limited to: Spastic Quadriplegia, Cerebral vascular accident, contractures, dysphagia and seizures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/09/2018. Section B - Hearing, Speech, and Vision assessed Resident #34 as being "Comatose Persistent vegetative state/no discernible consciousness"; therefore, no cognitive status was assessed. Resident #34 was added to the survey sample after being named in a FRI (facility reported incident) received at the State Agency in December 2017. On 05/08/2018 during initial tour of the facility Resident #34 was observed lying in bed. Bilateral	F 689	Elopement prevention interventions were implemented for Resident # 187. He was discharged home on 6/10/17 with no further incidents. Resident # 25 was assessed by rehabilitation therapy staff on 5/10/18 and the use of recliner chair was discontinued per recommendation. Additional fall prevention interventions for Resident # 54 have been or will be implemented: increased supervision by staff and family, tray for his wheelchair to allow him to work on a "busy board", scheduled toileting, chair and bed alarm with voice instruction not to get up without assistance, visual checks every 30 -40 minutes, pharmacy and physician review for appropriateness of pharmacological interventions, and referral to a dementia unit with more structured environment and activities. **Identification of Other Residents with Potential To Be Affected** Other residents with potential to be affected will be identified through	

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F 689	Continued From page 17 full padded side rails were in the up position on her bed. Bilateral fall mats were beside her bed. The facility reported incident was reviewed on 05/09/2018 at approximately 10:00 a.m. Per the FRI, "On 12/4/2017 at 3:05 a.m., CNA [certified nursing assistant] came to the nursing station and reported resident fell in the floor. CNA was changing resident, bed began rolling, and CNA was unable to grasp resident. The resident fell off the bed onto the floor, with her face hitting the floor. Resident suffered a 4.5 cm stellate laceration to mid forehead which was closed with two layers of Dermabond...Interview with staff revealed the fall was caused by a failure of staff to lock the brakes on the resident's bed. Based on the information gathered, we believe this fall could have been prevented." Review of the clinical record included a final report from the emergency department where Resident #34 was treated. Information included, but was not limited to: "The patient presents following a fall...rolled out of bed...The character of symptoms is swelling and laceration...Head: On exam: Swelling, laceration, stellate, 4.5 cm, forehead...Procedure notes: 4.5 cm stellate laceration mid forehead closed with 2 layers of DERMABOND using sterile technique..." A copy of the facility's investigation of the incident was requested and received. The "Post Fall Huddle" form contained the following: Contributing factors: "Improper bed height and bed unlocked." Witness statements were reviewed. The CNA statement contained the following information: "While giving daily care, I turned her over so I could reach the back side while washing and changing she began to come	F 689	review of fall logs and physician orders for bed rails. Interventions for fall prevention will be developed and implemented as appropriate for those identified with variances. The brakes on all the beds were inspected shortly after Resident # 34's fall and none were found defective. **Measures to Prevent Recurrence** The fall investigation tool has been re-designed to make it more effective in identifying root cause. The use of the Morse fall investigation tool has been discontinued as it is not appropriate for this setting. A policy and procedure for post fall assessment for pain is being implemented. In-service to nursing staff will be conducted on these changes and to reiterate the need for thorough and timely fall investigation and implementation of appropriate interventions to prevent recurrence and harm. They will also be informed that deviation from standard or policy will result in disciplinary action.	

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F 689	Continued From page 18 forward. When she started coming forward I attempted to keep her on her bed but with her weight I couldn't hold her up and she fell on the floor." A second witness statement completed by the night shift nurse, contained the following: "CNA [name] came running to nursing station stating [name] fell in the floor...found lying face down in the floor-large amount of dark red blood noted from forehead-turned res [resident] over on her side and noted a 4 cm X 3 cm laceration in center of forehead and bleeding from her mouth...lifted back to bed and body check done-no bruises or redness noted...facial swelling noted and cool compresses and pressure dressing applied to laceration...911 called and resident to ER for eval and tx [treatment]...the bed was up in the air with top side rail down and CNA stated he was changing resident and bed started rolling and he couldn't hold her and res slip [sic] off side of bed..." The administrator was interviewed on 05/10/2018 at approximately 1:00 p.m. regarding the incident. She stated, "The CNA no longer works here...he told the nurse what happened, he didn't have the bed locked, she rolled out and got a laceration on her head." The above information and the recommendation of a possible harm level deficiency was discussed during a meeting with the DON (director of nursing) and the administrator on 05/10/2018 at approximately 2:30 p.m. No further information was obtained prior to the exit conference on 05/10/2018. 2. Resident # 5 was admitted to the facility 8/24/17 with diagnoses to include, but were not limited to: dementia, anxiety, depression, GERD,	F 689	**Monitoring:** The Risk/QA nurse or designee will review falls to ensure post fall investigations are properly completed and care plans are being updated/revised to reflect appropriate fall prevention interventions and that pain assessments are performed after a fall. Observations to determine compliance with physician orders relative to bedrails or other interventions will also be conducted. Fall prevention interventions for a sample of patients will also be monitored for staff compliance. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits and observations will be conducted daily X 10 days then weekly times 8 weeks if audits show significant compliance. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 689	Continued From page 19 and high blood pressure. The most recent MDS (minimum data set) was a quarterly review dated 1/29/18 and had Resident # 5 assessed with severe impairment in cognition with a total summary score of 03 out of 15. Under "Section G- Functional Status" included under "G0110'Activities of Daily Living (ADL) Assistance: E. Locomotion on unit: how resident moves between locations in room and adjacent corridor on same floor...If in wheelchair, self-sufficiency once in chair." This section was coded under "Self Performance" as "7. Activity occurred once or twice." Under "Support" was coded as "2. One person physical assist." "F. Locomotion off unit- how resident moves to and returns from off-unit (activities, dining, therapy). If in wheelchair, self-sufficiency once in chair." This section was coded under "Self Performance" as "7. Activity occurred once or twice." Under "Support" was coded as "2. One person physical assist." The electronic medical record (EMR) was reviewed on 5/9/18 at 7:45 a.m. Nursing narrative notes were as follows: (It should be noted here there was no times given for the events; just a time stamp for when the documentation was entered in the computer system): 12/8/17: "New order to obtain xray of left hip and left shoulder due to extreme pain/ hollering out..." 12/8/17: Informed MD of pain/hollering out, obtained new order for xrays, created orders, and put in transportation slip. Awaiting update from MD to see if they are to be sent via 911 today or wait until Monday since radiology doubts they can fit her in today."	F 689	investigations are properly completed and care plans are being updated/revised to reflect appropriate fall prevention interventions and that pain assessments are performed after a fall. Observations to determine compliance with physician orders relative to bedrails or other interventions will also be conducted. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits and observations will be conducted daily X 10 days then weekly times 8 weeks if audits show significant compliance. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 689	Continued From page 20 On 5/9/18 at 11:00 a.m. RN (registered nurse) # 1 was asked about the documentation of Resident # 5's pain, and what had happened. RN # 1 stated the resident had fallen on 11/30/17 out of her wheelchair, but did not appear at the time to have incurred any injury. This surveyor asked where the documentation about the fall was located in the nurses' notes. RN # 1 stated "Well, we have been told not to document any notes in the computer as the new program is not set up for that type of documentation. We have forms that are checked off and entered; there are some notes but those are usually if there's a significant event...we do documentation by exception, so unless there's something out of the ordinary we are told not to make daily notes." RN # 1 was then asked for the investigation of the fall, a copy of the care plan at the time of the fall, physician orders at the time of the fall. On 5/9/18 at 2:45 p.m. RN # 1 gave this surveyor a copy of the care plan in place at the time of the fall. RN # 1 stated the administrator had told her a copy of the investigation was not allowed to be copied for this surveyor. RN # 1 was told a copy was not needed, but a review of the investigation could be conducted. The care plan, dated as implemented 9/5/17 was reviewed. Under "Problems" was documented "Risk for injury: bruises, skin tears, scratches, falls...related to dementia..." Under "Goals" was documented "No fall related injuries..." "Interventions" included: "Call bell within easy reach...Keep objects in easy reach...Non-skid footwear when out of bed." "If (name of resident) has a fall assess each shift for 72 hours for pain,	F 689		

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F 689	Continued From page 21 injury..." There were no interventions noted for use of the wheelchair. An xray report from the hospital dated 12/8/17 documented "Clinical History: Pain after fall...Findings: ...Proximal left femur is suspicious for a minimally impacted subcapital fracture..." The ER (emergency room) physician notes attached to the xray report documented "History of Present illness: Pt. unable to provide much history. Onset 5 days ago. The course/duration of symptoms is constant. Type of injury: fall. Location: left hip/shoulder. The character of symptoms is pain..." "Diagnosis: Hip fracture." RN # 1 also provided a copy of an Incident form completed at the time of Resident # 5's fall. The incident form dated 11/30/17 revealed the following: "Brief factual description: She (Resident # 5) had been observed leaning forward in her wheelchair looking into her drawers and was cautioned to get help. Resident observed a short time later to be on the floor on her left side. She had slipped out of her wheelchair onto the floor. Her wheelchair was not locked to allow for resident mobility. Call light within reach, room lights on, personal items within reach." Under "Specific Incident Details" was documented: "Precaution: bed in low position, call bell in reach. Contributing factors: confused/disoriented. Current diagnosis/condition." Under "Outcome Details" was documented: "Investigation completed by staff onsite." The incident report did not document whether Resident # 4 was wearing non-skid footwear as per her care plan. On 5/9/18 at 4:20 p.m. the administrator informed this surveyor there was no investigation for the	F 689		

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F 689	Continued From page 22 fall. She stated "Should there be one? Yes. But we are unable to find it if it was done. From what we could tell at the time, it looked like the fracture was a result of the fall from the wheelchair." The administrator was asked if there was a policy on what was to be done after a fall. She stated there was, and gave this surveyor a copy of a document entitled "Fall management: Long term care." Under "Documentation" included the following: "After a fall, complete a detailed incident report to help track frequent resident falls so your facility can implement prevention measures for high-risk residents. In the incident report, note where and when the fall occurred, how you found the resident, and in what position. Include the events preceding the fall, the names of witnesses, the resident's reaction to the fall, and a detailed description of the resident's condition based on the findings. Include the resident's statement of the event..." On 5/10/18 at 8:30 a.m. the DON (director of nursing) gave this surveyor a copy of the physician orders in place at the time of the resident's fall. The orders were reviewed and noted to include an order dated 11/12/17 for "Patient to sit up on wheelchair as tolerated, everyday supervised from time to time." On 5/10/18 at 11:15 a.m. this surveyor asked the administrator and DON about the above order, and what was meant by "from time to time" as written. The administrator and DON stated there should be an actual time on the order. The DON explained "There should be a time specified, like from 1 p.m. to 2 p.m., or however long she was to be in the wheelchair, specified, and she should be supervised during that time. I'm not sure why	F 689		

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F 689	Continued From page 23	F 689		

that order was put in that way; I know that at that time we were switching to the new computer system, and nurses from the OB (obstetrics) unit came over and put in a lot of the orders, so that may be why it's like that. I can see if I can get clarification on the order."

On 5/10/18 at 11:50 a.m. the nurse who filled out the incident form, identified as RN # 5, was interviewed. She stated "I am not the one who observed her; a CNA saw her and then reported the fall to me; I don't remember who the CNA was now...that was a while back."

The administrator, DON (director of nursing), and several nursing staff were made aware of the above findings during a meeting with facility staff 5/10/18 beginning at 2:30 p.m. It was discussed at that time of the potential for harm associated with the deficiency, and if there were any questions or additional information they could provide. The administrator stated "No, I don't think so."

No further information was provided prior to the exit conference.

3. Resident #187 was admitted to the facility on 4/20/17, was re-admitted on 3/13/18 and died in the facility on 4/15/18. Diagnoses for Resident #187 included renal cancer, atrial fibrillation, heart failure and chronic obstructive pulmonary disease. The minimum data set (MDS) dated 3/20/18 assessed Resident #187 with moderately impaired cognitive skills.

Resident #187's closed clinical record documented a nursing note dated 6/7/17 at 1:30 p.m. stating, "I was alerted by another employee that the resident had fallen down South hall stairs.

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F 689	Continued From page 24 When I arrived to the scene his wheelchair was at the top of the stairs, wandergaurd [Wanderguard] was still in place on his chair, and so was his sensory pad. He was lying with his arm hanging off the step...took his vital signs and placed him on a stretcher to be transported to the ER [emergency room]...." A note dated 6/7/17 at 11:30 p.m. stated, "Report was called from the E.R...was told that the resident had an abrasion to his lt [left] elbow, non displaced fracture of the left humerus, contusion of abd. [abdominal] wall..." The emergency room report dated 6/7/17 documented, "...was rolling down the hallway in his wheelchair like he normally does, and he opened the door to the stairwell and fell down two flights of stairs...Assessment....approximately 7 cm [centimeter] skin tear noted to L [left] elbow...Abrasion of elbow - Left, Nondisplaced fracture (avulsion) of lateral epicondyle of left humerus - Suspected, Contusion of abdominal wall..." The facility's investigation report to the state agency dated 6/8/17 documented, "Resident found at Ground Level Landing having exited from first Floor Door (south exit). Transferred to ED [emergency department] for evaluation and returned to facility. Finding of nonDisplaced fracture of left humerus." The facility's investigation stated on 6/7/17 at 1:30 p.m., dietary staff heard the resident hollering for help and found the resident on the ground at the stairwell on the ground level landing. This report documented, "Investigation revealed that the resident left the first floor unit and went out of the south stairwell exit door. He then got up from his wheelchair and by using the handrail, went down	F 689		

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F 689	Continued From page 25 the steps. He got to the ground floor landing and slipped or fell...His wheelchair was found on the first floor landing...The resident's Wander guard bracelet activated the alarm system but the door did not lock upon activation...Nurse assigned to the resident stated that she had heard the alarm on the south stairwell door go off about 20 minutes before the incident. She checked the stairwell and did not find anything amiss...South door Wander guard system's automatic locking mechanism was not functioning properly..." Resident #187's clinical record documented a physician's order dated 5/1/17 for a Wanderguard bracelet with functioning to be checked weekly. Resident #187's fall risk assessments completed in April 2017 and June 2017 documented the resident as a high risk for falls due to a history of falls, wandering, incontinence, unsteady gait, poor balance, health conditions and multiple medications. The clinical record documented a history of falls and recent confusion prior to the elopement incident on 6/7/17. A nursing note on 6/2/17 documented the resident attempted to get up without assistance throughout the day and was found on 6/2/17 at 8:10 p.m. in the floor by his bed. A follow up note regarding this fall dated 6/5/17 documented, "...Investigation completed. Resident is confused and got out of bed unassisted, stated, 'I was trying to leave,' falling to fall mat..." Resident #187's plan of care (June 2017) documented the resident was at risk of injury for bruises, skin tears, scratches due to anticoagulation therapy and previous back surgery. The only interventions listed for injury prevention were call bell within easy reach and adequate staffing to assist the resident out of	F 689		

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F 689	Continued From page 26 bed. The care plan had no problem, goals and/or interventions regarding wandering, elopement prevention or use of the Wanderguard device. There were no revisions to the care plan following the fall on 6/2/17. The nurse assigned to Resident #187 and the director of nursing employed at the time of the elopement/fall on 6/7/17 were not available for interview as they no longer worked at the facility. On 5/9/18 at 2:00 p.m., the administrator was interviewed about Resident #187's elopement and fall in the stairwell. The administrator stated the resident had a pressure seat alarm and Wanderguard as interventions prior to the elopement/fall on 6/7/17. The administrator stated their investigation revealed the nurse caring for Resident #187 did not check the stairwell for the resident when the door alarm sounded. The administrator stated the resident's wheelchair was found at the top of the stairs. The administrator stated if the nurse checked or searched in the stairwell, she would have seen the wheelchair and known the resident was in the stairwell. The administrator stated the Wanderguard bracelet was supposed to activate the door alarm and the door lock to prevent the resident from going into the stairwell. The administrator stated the alarm sounded but the door did not lock. The administrator stated maintenance checked the door after the incident and found a defective part. The administrator stated the nurse caring for Resident #187 had no explanation of why she did not see the wheelchair at the top of the stairs or why she did not search or account for the resident in response to the alarm. The administrator stated the protocol for door and/or Wanderguard alarms was for staff	F 689		

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F 689	Continued From page 27 members to immediately check and account for residents. On 5/9/19 at 5:10 p.m., the maintenance director was interviewed about the south hall door lock malfunction found when Resident #187 fell on 6/7/17. The maintenance director stated the door was inspected after the incident and found with a power supply failure. The maintenance director stated the alarm sounded at the nursing station but the magnet door lock did not activate allowing the resident to get into the stairwell. The maintenance director stated prior to Resident #187's elopement/fall the door locks were checked for proper function every 6 months. The maintenance director stated the door locks were lasted checked on 5/15/17 prior to the fall. The facility's policy titled Resident Elopement (revised 9/8/17) stated, "The Hundley Center is equipped with security alarm and wander guard systems to alert the staff of unauthorized entry or exit through the doors and elevators..." This policy included in procedures for elopement prevention, "...Respond to audio alarms immediately. This is the responsibility of all staff. When responding to an alarm: the person closest to the alarm panel shall ascertain which door has been opened...find out who/what activated the alarm before turning it off...check the area around the activated door, including stairwell and the outside vicinity...nursing staff check the whereabouts of residents identified as 'wanderers' or 'elopement risks' to ensure they are accounted for..." These findings were reviewed with the administrator and director of nursing during a meeting on 5/10/18 at 2:30 p.m.	F 689		

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F 689	Continued From page 28 This was a complaint deficiency. 4. Resident #25 was admitted to the facility on 5/31/17 with diagnoses that included Parkinson's disease, cerebrovascular accident (stroke), peripheral vascular disease, anemia and depression. The minimum data set (MDS) dated 2/28/18 assessed Resident #25 with severely impaired cognitive skills. Resident #25's clinical record documented a post fall evaluation note dated 5/4/18 stating the resident fell from a reclining chair in his room. The record documented no further details about the fall or any description of events leading up to or surrounding the incident. The form listed the resident expressed no pain at the time of the fall and documented vital signs (temperature, blood pressure, respiratory rate, pulse rate). There was no mention of any injuries on the post fall note. The clinical record documented no assessment or indication for the resident's use of a reclining chair. The resident's plan of care (revised 5/8/18) listed interventions for injury prevention as: note his positioning and location while out of bed in wheelchair, Morse fall risk standard precautions, sensory pad while in bed or chair, evaluate room for clutter, frequent rounds, call bell accessible, low bed, monitor more frequently, remove from harmful objects and monitor as needed while in wheelchair. The care plan made no mention of using a reclining chair with Resident #25. On 5/10/18 at 9:48 a.m., the licensed practical nurse (LPN #6) working on Resident #25's living unit was interviewed about the fall on 5/4/18. LPN #6 stated the resident had Parkinson's	F 689		

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F 689	Continued From page 29 disease and tried to get up and reached out for things frequently from the wheelchair. LPN #6 stated when the resident was more alert he was usually seated in a standard wheelchair. LPN #6 stated when Resident #25 was more restless and "fidgety" they sometimes placed him in a reclining chair. LPN #6 stated she did not know why the resident was in the reclining chair on 5/4/18. On 5/10/18 at 10:12 a.m., the registered nurse responsible for quality assurance (RN #1) was interviewed about Resident #25's fall from the reclining chair. RN #1 stated she reviewed and investigated all falls to ensure interventions were implemented. RN #1 stated when a resident fell, staff members were supposed to complete a fall report, get statements from any witnesses and perform neurological checks if needed. RN #1 stated her records indicated Resident #25 had previous falls on 1/16/18, 2/19/18 and 2/24/18. RN #1 stated she had no report of the fall on 5/4/18 so she had not investigated or reviewed the circumstances surrounding the fall. RN #1 was asked for any assessments regarding Resident #25's use of a reclining chair. On 5/10/18 at 10:31 a.m., LPN #7 caring for Resident #25 was interviewed about use of the reclining chair. LPN #7 stated the resident was typically out of bed in a standard wheelchair. LPN #7 stated she was not aware of Resident #25 using a reclining chair. On 5/10/18 at 10:39 a.m., RN #1 stated the resident had no assessment for use of the reclining chair. When asked if the resident was injured from the 5/4/18 fall, RN #1 stated the resident got a "scratch" above his right eyebrow but no other injuries.	F 689		

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F 689	Continued From page 30 These findings were reviewed with the administrator and director of nursing during a meeting on 5/10/18 at 2:30 p.m. 5. Resident #54 was admitted to the facility originally on 05/18/16, with diagnoses that included dementia. The most current MDS (minimum data set) was an annual quarterly assessment dated 04/6/18. Resident #54 was assessed with long and short-term memory loss and severe loss of cognitive status. A family interview was conducted on 05/08/18 at 12:21 PM. During the interview Resident #54's son verbalized that Resident #54 had fallen multiple times and Resident #54 does not use the call bell and tries to get out of bed and out of the wheelchair. Resident #54's son verbalized that Resident #54 does were an alarm and has a fall mat, but felt that a shortage of staff was the main reason for the falls because the certified nursing assistants (CNA) have so much to do. On 05/09/18 3:30 p.m. Resident #54 was observed within 10 feet of the nurses station by 2 surveyors. Three staff members were at the nurses station, but were unaware that Resident #54 was attempting to get out of the wheelchair. This observation continued for 15 minutes. No staff member attempted to assist Resident #54 until one staff member observed the surveyors and then started interacting with Resident #54, trying to get Resident #54 to scoot back in the wheelchair. Resident #54 did not want to slide back in the wheelchair after being asked, resulting in 2 CNA's physically moving Resident #54 back in the wheelchair.	F 689		

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F 689	Continued From page 31 Review of Resident #54's care plan for fall interventions included: Bed alarm, Chair alarm frequent observations, low bed with mat, remind to use the call light. These interventions were all dated on 2/4/18. The most recent updated intervention was dated 5/9/18 and included, keep in sight during risk hours. According to documentation, Resident #54 had fallen a total of 7 times between 2/4/18 and 5/8/18. Review of Resident #54's post fall evaluation notes with a date range from 2/4/18 through 5/8/18 documented unwitnessed falls on 2/4/18, 2/20/18, 4/4/18, 4/11/18, 4/30/18, and 2 falls on 5/8/18. On 05/10/18 at 08:51 AM registered nurse (RN #3), was interviewed regarding Resident #54's frequent falls. RN #3 verbalized that Resident #54 is continuously trying to get out of bed or out of the wheelchair, does not call for help and has had multiple falls. RN #3 verbalized that the facility has tried to put interventions into place, and felt the Resident # 54 would benefit from more supervision. RN #3 verbalized that the facility does not provided one on one monitoring and has asked the family if they could have a sitter to come into the facility to be able to monitor Resident #54 more closely. RN #3 verbalized that the family was unable to provide a sitter. On 05/10/18 10:49 AM the director of nursing was informed of the concerns regarding lack of supervision resulting in multiple falls. No other information was provided prior to exit conference on 5/10/18.	F 689		

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F 690 F 690 SS=D	Continued From page 32 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690 F 690	**F 690 Bowel Bladder Incontinence, Catheter Care** **Corrective Measure for Residents Affected** A physician order for the care and maintenance of Resident # 36's Foley catheter has been obtained and his care plan was revised to reflect this. **Identification of Other Residents with Potential To Be Affected** Other residents with potential to be affected will be identified through review of medical records. If the same issues are identified, physician order for care and maintenance of Foley catheter will be obtained and care plan revised as appropriate. **Measures to Prevent Recurrence** In-service to nursing staff will be conducted to reiterate the policy and procedure for maintenance and care of a Foley catheter.	

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F 690	Continued From page 33 Based on observation, staff interview, and clinical record review, facility staff failed to obtain physician orders for the care and maintenance of a Foley catheter for one of 23 residents in the survey sample, Resident #36. Findings included: Resident #36 was originally admitted to the facility on 03/04/2011 and readmitted on 10/05/2016 with diagnoses including, but not limited to: Hypertension, Sacral Pressure Ulcer-Stage 3 with MRSA (methicillin resistant staphylococcus aureus), Dementia, Parkinson's Disease, Schizophrenia and Dysphagia. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 03/12/18. Resident #36 was assessed as severely impaired in her short and long term memory and daily decision making skills. Resident #36 was observed on 05/08/18 at 3:00 p.m. lying in bed with her Foley catheter in a privacy bag. A fall mat was in place at the bedside. Resident #36's clinical record was reviewed on 05/09/18 at 10:30 a.m. On the physician order sheet dated May 2018 was the following order: "...St 3/4 [Stage 3 - Stage 4] press [pressure] ulcer worse by incontinence, Foley cath [catheter] 16 Fr. [french] with 10 cc [cubic centimeter] bulb, Start: 02/07/18..." There were no other physician orders pertaining to Resident #36's Foley catheter care and maintenance. RN #3 (registered nurse) was interviewed on	F 690	**Monitoring:** The Director of Nursing (DON) or designee shall audit medical records of residents with Foley catheter to ensure there is a physician order for their maintenance and care. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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	495177	A. BUILDING _____ B. WING _____	C 05/10/2018

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F 690	Continued From page 34 05/10/18 at 11:15 a.m. This surveyor and RN #3 reviewed Resident #36's physician orders. RN #3 stated, "I agree there are no specific orders for care and maintenance of a Foley catheter." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 05/10/18 at 2:30 p.m. The DON stated, "There should be specific orders to change and care for a Foley catheter." No further information was received by the survey team prior to the exit conference on 05/10/18.	F 690		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or Ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to provide care and treatment to prevent reddened skin areas under an ostomy bag for one of 23 residents, Resident #28. Resident #28's ostomy bag was lying horizontally across her abdomen, the skin underneath the bag was red and described by the resident to "burn and itch."	F 691	**F 691 Colostomy, Urostomy or Ileostomy Care** **Corrective Measure for Residents Affected** Resident # 28 is receiving care and treatment for the reddened skin around the stoma. Because of the resident's medical condition, she is prone to skin irritation as her ileostomy bag is replaced (rather than emptied) several times a day per resident's preference. Staff will continue to monitor and administer treatment as necessary. This resident also preferred her ostomy bag to be placed on a lateral rather than ventral orientation and staff complied with resident's request. This preference will be reflected in her care plan.	

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F 691	Continued From page 35 Findings were: Resident #28 was readmitted to the facility on 05/31/2017. Her diagnoses included, but were not limited to: Hypertension, Chronic kidney disease, Chrohn's disease with ileostomy placement, atrial fibrillation and chronic dehydration. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/05/2018. Resident #28 was assessed as being cognitively intact with a summary score of "15". A medication pass and pour observation was conducted on 05/09/2018 beginning at approximately 8:00 a.m., with LPN (licensed practical nurse) #4. Medications were administered to Resident #28. While in the room, this surveyor spoke with Resident #28. She pulled her gown up and showed this surveyor her ileostomy. She stated, "It comes off all the time and leaks...I've always had trouble with it." A one piece ostomy bag was observed laying horizontally across her abdomen with her brief over it. LPN #4 undid the side of Resident #28's brief so this surveyor could better visualize the ostomy bag and the surrounding area. The skin under the bag and on Resident #28's mid abdomen was reddened. Resident #28 was asked if her the skin on her abdomen bothered her. She stated, "It itches and burns all the time." When LPN #4 and this surveyor left the room, LPN #4 stated, "She picks at her bag all the time...I don't think she even realizes she is doing	F 691	**Identification of Other Residents with Potential To Be Affected** Other residents with potential to be affected will be identified through review of medical records. Those with ostomies will be provided skin care and treatment as appropriate. **Measures to Prevent Recurrence** In-service to nursing staff will be conducted to reiterate the policy and procedure for care of ostomies and prevention of skin breakdown around the stoma. **Monitoring:** The Director of Nursing (DON) or designee shall audit medical records of residents with ostomies to ensure appropriate skin care and treatment to prevent skin breakdown. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined.	

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F 691	Continued From page 36 It...sometimes we have to change it several times a day because it will start to leak, and I think sometimes the hole around her stoma gets cut too big and that irritates the skin too..." The care plan for Resident #28 was reviewed. There were no interventions or documentation observed regarding Resident #28 picking at her ostomy bag. On 05/10/2018 at approximately 8:15 a.m., this surveyor spoke with the wound nurse, LPN #3. The reddened area on Resident #28's abdomen that was observed the previous morning was discussed. LPN #3 stated, "She picks at that...some days we change it five or six times." This surveyor asked what the facility was doing to address the "picking" and what were they doing to treat the skin that was reddened. She stated, "We can look at it." This surveyor and LPN #3 went to Resident #28's room. LPN #3 spoke with Resident #28 and explained that she was going to change her ostomy bag. Resident #28 replied that was okay and that the bag needed to be emptied. Resident #28 stated, "That's what happened yesterday, it didn't get emptied and then it started to leak so they had to change it." This surveyor asked Resident #28 how often her ostomy bag needed to be emptied. She stated, "Sometimes every couple of hours...I have what they call a straight gut...whatever I eat goes straight through...If I've got to go somewhere I don't eat because my bag will get full and I won't be able to get it emptied." LPN #3 stated, "We may need to empty that every four hours." LPN #3 lifted Resident #28's gown, the ostomy bag was observed laying horizontally across her abdomen full of liquid	F 691	Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date: 6/24/2018**	

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F 691	Continued From page 37 feces. When the ostomy bag was lifted by LPN #3, the area on Resident #28's abdomen was less red than when observed on 05/09/2018. LPN #3 stated, "The bag shouldn't be laying this way, we'll educate the nurse to apply it so that it is going down and not across." LPN #3 then removed the old bag and applied the new. Resident #28 was asked how the reddened area of her abdomen felt. She stated that it burned and itched. LPN #3 applied skin protectant over the reddened areas. Resident #28 was asked if she knew of anything that had been used that had helped the itching and burning on her abdomen. She stated, "They used nystatin cream for a while and that helped." The above information was discussed during a meeting with the DON (director of nursing) and the administrator on 05/10/2018 at approximately 2:30 p.m. No further information was provided prior to the exit conference on 05/10/2018.	F 691		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to obtain physician orders for the care of a PICC (peripherally inserted central catheter) line for one	F 694	**F 694 Parenteral/IV Fluids** **Corrective Measure for Residents Affected** A physician order for flushing Resident # 2's PICC line has been obtained and appropriate amount of flushing solution is being administered pursuant to facility policy. **Identification of Other Residents with Potential To Be Affected** Other residents with intravenous lines will be identified through review of medical records. Physician order for	

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F 694	Continued From page 38 of 23 residents, Resident #28. Resident #28 did not have physician orders to flush her PICC line. Findings were: Resident #28 was readmitted to the facility on 05/31/2017. Her diagnoses included, but were not limited to: Hypertension, Chronic kidney disease, Chrohn's disease with ileostomy placement, atrial fibrillation and chronic dehydration. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/05/2018. Resident #28 was assessed as being cognitively intact with a summary score of "15". A medication pass and pour observation was conducted on 05/09/2018 beginning at approximately 8:00 a.m., with LPN (licensed practical nurse) #4. Medications were prepared for administration to Resident #28. This surveyor looked into Resident #28's room during the preparation. Observed beside Resident #28's bed was an IV (intravenous) pole with an IV pump and an empty bag of IV fluids on the pole. LPN #4 was asked if Resident #28 received IV fluids. She stated, "Yes, she gets them every night...she has an ileostomy and she needs the fluids." LPN #4 was asked how the fluids were administered. She stated, "She has a PICC line." LPN #4 was asked how often the line was flushed. She stated, every shift. She was asked when the next flush was due. She checked the electronic record and the medication screen. She stated, "I don't see an order for the flush." She was asked if she had	F 694	care and maintenance of the line will be obtained as indicated and pursuant to facility policy. **Measures to Prevent Recurrence** In-service to nursing staff on the policy/protocol for care and maintenance of intravenous lines will be conducted. **Monitoring:** The Director of Nursing (DON) or designee shall audit medical records of residents with intravenous lines to ensure staff compliance with physician order for flushing of the line. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 694	Continued From page 39 flushed the line in the past. She stated, "Yes, but I won't do it today because I don't see an order...I just know we flush ports, but I don't see anything on here about it." Medications were administered to Resident #28. While in the room, LPN #4 showed the line to this surveyor. The insertion site was at Resident #28's upper chest, one lumen was visible to this surveyor. LPN #4 stated, "It's a double lumen, the other one is over here." The clinical record was reviewed at approximately 9:15 a.m., to reconcile the medications administered to Resident #28. There were no orders observed to flush Resident #28's PICC line. The care plan was reviewed. A focus area "LTC [long term care] Communication was observed with the following intervention: "flush with 10 cc ns q shift [normal saline every shift] if no int [interventions] used." The unit manager, RN (registered nurse) #3 was interviewed at approximately 9:30 a.m. She was asked if there were standing orders for the care of PICC lines. She stated, "We don't use standing orders." She was then asked if there were orders to flush Resident #28's PICC line. She looked at the electronic record and stated, "I don't see an order and we don't put that on the MAR [Medication administration record]...it looks like we care planned it under communications. RN #3 was asked what that meant. She stated, "That tells the nurses what needs to be done." RN #3 was asked if all the nurse's knew that. She stated, "Yes, they should." RN #3 was asked if there needed to be an order for PICC line flushes. She stated, "We use a protocol..I'll get you a copy."	F 694		

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F 694	Continued From page 40 At approximately 10:30 a.m., RN #3 presented the following: "Peripherally inserted central catheter (PICC) flushing and locking." She stated, "We use Lippincott [clinical reference book] for our procedures...we follow what they recommend and we add Critical Notes that personalize it to us." The policy was reviewed. Under the "Critical Notes" section was the following information: "Flush with 20 cc NS after all medications, blood draws every 8 hours not in use." After reviewing the policy this surveyor spoke with RN #3. She stated, "We should have an order, we think we have figured out a way to get it on the MAR so the nurse's can see it." The difference in the procedure provided and the care plan documentation for the amount of NS to be used for flushes was discussed. She stated, "It should be 10 cc." The above information was discussed during a meeting with the DON (director of nursing) and the administrator on 05/10/2018 at approximately 2:30 p.m. No further information was provided prior to the exit conference on 05/10/2018.	F 694		
F 697 SS=G	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.	F 697	**F 697 Pain Management** **Corrective Measure for Residents Affected** Resident # 5 is currently receiving effective pain management. Pain assessment is being conducted every shift and documented. Appropriate interventions for pain is being provided. **Identification of Other Residents with Potential To Be Affected** A list of all residents who are receiving pain medications will be reviewed to determine residents at risk. Their pain management will be reviewed for effectiveness and adjusted if indicated.	

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F 697	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure effective pain management was provided, and failed to determine the cause of pain, for one of 23 residents in the survey sample: Resident # 5. Resident # 5 sustained a fall on 11/30/18. From 12/1/18 through 12/8/18, the facility staff failed to evaluate and manage a complaint of leg pain, not relieved by a current as needed order for Tylenol already in place for back pain. On 12/8/18 the resident was sent out for x-rays which determined a fracture of the hip. Findings include: Resident # 5 was admitted to the facility 8/24/17 with diagnoses to include, but were not limited to: dementia, anxiety, depression, GERD, and high blood pressure. The most recent MDS (minimum data set) was a quarterly review dated 1/29/18 and had Resident # 5 assessed with severe impairment in cognition with a total summary score of 03 out of 15. The electronic medical record (EMR) was reviewed on 5/9/18 at 7:45 a.m. Nursing narrative notes were as follows: (It should be noted here there was no times given for the events; just a time stamp for when the documentation was entered in the computer system): 12/1/17: "While receiving her nightly bath Res (resident) complained of pain in her right leg. CNA (certified nursing assistant) tried putting lotion on her feet, Res cried out in loud pain.	F 697	**Measures to Prevent Recurrence** A policy and procedure that includes pain assessment in the 72-hour post fall monitoring will be implemented. In-service to nursing staff on this policy and on pain management in general will be conducted. One- on-one in-services and /or counseling will be given to Staffs who failed to appropriately address Resident # 5's pain. **Monitoring:** The Director of Nursing (DON) or designee shall audit medical records of residents with physician order for pain medications to ensure they are receiving effective pain management. The QA/Risk Nurse will conduct audits of post-fall pain assessments to ensure they are being completed per policy. Interviews of a random sample of residents will also be conducted to determine if the resident's pain is being managed effectively. The resident's	

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F 697	Continued From page 42 Writer gave Res 650 mg of Tylenol. Res continued to complain of pain the rest of the night." 12/4/17: "While res was receiving her bed [sic], she complained of pain in her left leg. CNA tried rubbing lotion on the same leg and the res cried out in pain. Writer gave res 650 mg of Tylenol, but res continued to complain of pain. Writer passed along information to dayshift on 12/5/17." 12/8/17: "Resident complains by hollering out when any care is provided and staff touches left side of body." 12/8/17: "Staff reports resident complains of pain to left hip, leg, arm and shoulder when giving care, ADL's (activities of daily living), applying lotions, turning and repositioning. Assessed resident: confusion related to dementia, left hip and leg pain when rolled side to side to change resident, complains of left shoulder pain, laying supine (on her back) holding onto arm...Informed unit manager to inform MD and request xrays be done..." 12/8/17: "New order to obtain xray of left hip and left shoulder due to extreme pain/ hollering out..." 12/8/17: Informed MD of pain/hollering out, obtained new order for xrays, created orders, and put in transportation slip. Awaiting update from MD to see if they are to be sent via 911 today or wait until Monday since radiology doubts they can fit her in today." On 5/9/18 at 11:00 a.m. RN (registered nurse) # 1 was asked about the documentation of Resident # 5's pain, and what had happened. RN	F 697	cognitive level will be considered in deciding whether monitoring will be thru interviews or observations. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 697	Continued From page 43 # 1 stated the resident had fallen on 11/30/17 out of her wheelchair, but did not appear at the time to have incurred any injury. This surveyor asked where the documentation about the fall was located in the nurses' notes. RN # 1 stated "Well, we have been told not to document any notes in the computer as the new program is not set up for that type of documentation. We have forms that are checked off and entered; there are some notes but those are usually if there's a significant event...we do documentation by exception, so unless there's something out of the ordinary we are told not to make daily notes." RN # 1 was then asked about the notes entered about the resident's pain. RN # 1 was also asked for pain assessments done for Resident # 5 after the fall, and any other notes about the resident's pain that were done. A copy of of the care plan in place at the time of the fall was also requested. RN # 1 stated "She really didn't complain of that much pain after she fell until much later..." RN # 1 was referred to the above notes which were written the day after Resident # 5 fell, noting it was documented the resident was in pain. RN # 1 did not comment. RN # 1 stated she would get the pain assessments copied, and the care plan. On 5/9/18 at 2:45 p.m. RN # 1 provided a copy of pain assessments, notes, and the care plan in place at the time of the fall. The pain assessments were not complete. The care plan, dated as implemented 9/5/17 was reviewed. Under "Problems" was documented "Risk for injury: bruises, skin tears, scratches, falls...related to dementia..." Under "Goals" was documented "No fall related injuries..." "Interventions" included: "If (name of resident) has a fall assess each shift for 72 hours for pain,	F 697		

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F 697	Continued From page 44 injury..." Per a fall incident report, the resident was noted to have fallen at 4:43 p.m. on 11/30/17. Pain assessment sheets revealed from 5:00 p.m. on 11/30/17 through 12/4/17 the resident was assessed as having pain; a pain scale of 0-10 was used, but no documentation was located noting the resident's pain level. The assessment form also included an area where the pain was to be described for onset, duration, region, quality, when occurs, what makes pain worse, what makes pain better and comments. All the area's were blank. There was one pain assessment dated 12/2/17 which was partially completed and documented the resident had pain in the leg which was brought on by movement. A "Resident Pain Perception Note" dated 12/8/17 documented "Ability to rate pain: Making self understood: Usually understood. Pain interview to be conducted: Yes." Under "Resident Pain Perception" was documented: "How often pain or hurting was present in past 5 days: Frequently...Verbal rating of pain over past 5 days: Very severe, horrible." An xray report from the hospital dated 12/8/17 documented "Clinical History: Pain after fall." Findings: ...Proximal left femur is suspicious for a minimally impacted subcapital fracture..." The ER (emergency room) physician notes attached to the xray report documented "History of Present illness: Pt. unable to provide much history. Onset 5 days ago. The course/duration of symptoms is constant. Type of injury"fall. Location: left hip/shoulder. The character of symptoms is pain..." "Diagnosis: Hip fracture."	F 697		

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F 697	Continued From page 45 On 5/10/18 at 2:00 p.m. RN # 1 was asked about the documentation on the pain assessment sheets. RN # 1 stated "Well, it's not filled out or documented, I can say that." The administrator, DON (director of nursing), and several nursing staff were made aware of the above findings during a meeting with facility staff 5/10/18 beginning at 2:30 p.m. It was discussed at that time of the potential for harm associated with the deficiency, and if there were any questions or additional information they could provide. The administrator stated "No, I don't think so." No further information was provided prior to the exit conference.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700	**F 700 Bed Rails** **Corrective Measure for Residents Affected** The use of bilateral ½ side rails at the bottom half of Resident # 34's bed has been discontinued. Entrapment assessment was conducted and there were no issues identified. **Identification of Other Residents with Potential To Be Affected** Residents with physician orders for bed rail use during care have the potential to be affected as well as those who have bed rails attached to their beds.	

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F 700	Continued From page 46 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess one of 23 residents for the use of full bilateral padded side rails, Resident #34. Resident #34 was observed with full bilateral padded side rails in the upright position throughout the survey. There was no assessment or order for the use or safety of the side rails. Findings were: Resident #34 was originally admitted to the facility on 01/30/1996 and readmitted on 05/17/2017. Her diagnoses included but were not limited to: Spastic Quadriplegia, Cerebral vascular accident,contractures, dysphagia and seizures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/09/2018. Section B - Hearing, Speech, and Vision assessed Resident #34 as being "Comatose Persistent vegetative state/no discernible consciousness"; therefore, no cognitive status was assessed. On 05/08/2018 during initial tour of the facility Resident #34 was observed lying on an air mattress; bilateral full padded side rail were in the up position on her bed. Bilateral fall mats were inplace beside her bed.	F 700	They will be identified through review of physician orders and actual inspection of beds. Issues identified will be addressed. **Measures to Prevent Recurrence** In-service to nursing staff will be conducted to reiterate the policy and procedure for complying with physician orders for the use of side rails. Policy and procedure for assessing beds for entrapment will be reviewed with the nursing staff and implemented. All beds will be inspected and measured for risk of entrapment and issues identified corrected. **Monitoring:** The Director of Nursing (DON) or designee shall audit medical records of residents with physician order for side rails to ensure staff compliance. Random observations of staff will be made to determine if side rails are being used properly.	

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F 700	Continued From page 47 On 05/09/2018 at approximately 10:00 a.m. the clinical record was reviewed. The physician order sheet contained the following order dated 11/14/17: "2 1/2 side rails at head of bed to promote safety while resident is receiving care in bed". The care plan was reviewed. The focus area "LTC ADL [long term care activities of daily living] Function Rehab" had the following intervention: "1/2 rail both sides of bed to promote safety while receiving care." A side rail assessment was requested from the unit manager, RN (registered nurse) #3. Presented was a "Side Rail & Entrapment Risk Evaluation" last competed on 2/15/2018. No dimensions or distances of various parts of the bed or specialty mattress, or Resident #34's size and weight were included in the evaluation. Attached to the evaluation was a consent attached, dated 12/15/2017. The consent contained the following information: "...The physician has recommended: 1/2 side rail on both sides Benefit: The side rail[s] is/are being used to: Promote safety while resident is receiving care in bed. Risks: ...Entrapment, injury such as skin tears, abrasions, bruises, etc..." The assessment was shown to RN #3. She was asked why Resident #34 had full bilateral padded side rails. She stated, "She's had them forever." RN #3 was asked if measurements regarding the safety of the full side rails being used had been done. She stated, "I don't know....I'll see what I can find out." At approximately 4:00 p.m., the administrator provided a spread sheet regarding maintenance	F 700	Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 700	Continued From page 48 of beds at the facility. She stated, "I have someone from biomed coming to speak with you about the beds...they did all of our measuring...our rule is if we move a resident from room to room we move bed and all now to make sure it is appropriate...if we change mattresses the nurses are going to start doing the measurements...the tool we use is out for calibration and [name of bio med manager] said it is easy to do and he has a video to train the nurses...we will do that when the tool gets back..." On 05/09/2018 at approximately 5:00 p.m., during a meeting with the DON (director of nursing), the administrator and other facility staff, the Facility Biomed Maintenance Manager, OS (other staff) #2, came to speak with this surveyor. He stated, "That spread sheet was done in 2017...it is per bed. We look at the mattress to make sure it is the correct one for the bed. We are not responsible for the measurements...I can measure right now and make sure everything is okay and in two hours they can move somebody or add an air mattress and my measurements aren't valid...I told the administrator that...I gave her a brand new tool to use and told her there was a video the nurse's could watch...nursing is responsible for the measurements." He was asked when the decision was made for nursing to do the measurements. He stated, "February 2017 when the repairs listed on that spreadsheet were completed." He was asked if that meant no bed measurements had been done since then. He stated, "Not by us [biomed]. The administrator was asked if she was aware of the information being provided by the Biomedical manager. She stated, "Yes...blame it on my short term memory loss." This surveyor asked who measured the air mattresses with side rails observed on the unit.	F 700		

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F 700	Continued From page 49 OS #2 stated, "Nursing is responsible for that." On 05/10/2018 the DON came to the conference room and spoke with this surveyor. She stated, "We are only using the top rails now...we reassessed her and got a consent from the family to use them." The DON was asked if the measurements for entrapment had been done. She stated, "I don't think so." No further information was obtained prior to the exit conference on 05/10/2018.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725	**F 725 Sufficient Nursing Staff** **Corrective Measure for Residents Affected** Resident # 73 was the only resident identified in the 2567 report under this citation. A reassessment of her needs and functional level were conducted and the plan of care updated based on this assessment. The clinical coordinator of the Unit where she resides will ensure staff compliance with interventions implemented.	

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F 725	Continued From page 50 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on individual resident interviews and a Group Interview, the facility staff failed to ensure sufficient staffing to provide care and services to maintain the residents' highest practical physical, mental, and psychosocial well-being. The individual residents and group complained of insufficient staff, as well as the staff's slow response to call bells. The findings were: During the Group Interview at 3:00 p.m. on 5/8/18, the nine residents present all agreed that call bell response was a problem. Several of the residents cited waits of 15 to 20 minutes for staff to respond to call bells. One male resident cited and instance in which he rang his call bell but got no response for about 15 to 20 minutes. "I got in my wheelchair and rolled down to the Nurses Station," he said. There were four nurses just sitting there talking and call bells were going off (ringing). I asked them what they were doing, and one of the nurses said 'If you ask nicely you will get help.' " The nine residents also complained of short staffing. "A CNA (Certified Nursing Assistant) will call in or not show up for work and they will work short handed. Sometimes on weekends it's one CNA for 20 residents," one of the residents said.	F 725	**Identification of Other Residents with Potential To Be Affected** All residents who are dependent or needing assistance with ADL's have the potential to be affected. They will be identified through review of their ADL status per their most current MDS. Staff assignments and work flows will be redesigned to maximize staff coverage and meet resident needs in a timely manner. **Measures to Prevent Recurrence** A thorough analysis was completed of our resident population, acuity needs and the staffing ratios of our closest competitors. The data utilized in the analysis was obtained from CMS Five Star Staffing Data (Payroll Based Journal) Report. The analysis verified that our staffing ratios are more than adequate to meet the needs of our resident population and we have significantly higher direct licensed nurse staffing than our closest competitor and the acuity-adjusted expected hours per patient day.	

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F 725	Continued From page 51 In an individual resident interview, conducted at 4:10 p.m. on 5/8/18, Resident # 73 spoke about call bell response and sufficient staffing. The resident said she frequently experienced slow call bell response. According to the resident, when she is up in the recliner (chair) and her hip starts to hurt, she has to wait 30 minutes to an hour to be put back in her bed. Resident # 73 went on to say that, "I don't ring the call bell unless I have to." The resident said she frequently had long wait times and she doesn't believe there are enough aides (CNA's) in the facility. In another individual interview conducted at 3:50 p.m. on 5/8/18, the resident reported there was limited staff on the second shift "...especially during the weekends. Sometimes it takes 30 to 45 minutes for them (CNA's) to answer a call bell." Another resident, interviewed at 10:00 a.m. on 5/9/18, said there was not enough staffing. "Sometimes it is only one person on third shift. I've waited sometimes an hour for someone to come help me to the bathroom or answer my call bell." During the Initial Tour of the facility at 11:30 a.m. on 5/8/18, residents on the second floor reported that there was not enough staff, especially on weekends. According to the residents, the nurses were adequate, but there were not enough CNA's on most shifts. One resident said, "On weekends, and sometimes during the week, there is one CNA on the entire hall. I don't need a lot of help, so it really doesn't affect me, but I am sure it impacts some of the other people up here."	F 725	On April 25, 2018 the organization implemented an "Incentivized Shift" program that allows additional premium pay on hours worked over and above the staff's regularly scheduled shift to encourage staff to pick up additional hours to cover emergency staffing issues. Additional measures: Staff will be re-in-serviced on the "No Pass Zone" program The DON and clinical coordinators will review with staff: job requirements, duties and responsibilities, and workflows that maximize efficient use of time. Management staff will round throughout the day to ensure call lights are answered promptly, staffs are on their assigned halls and breaks are staggered to provide sufficient coverage on the units.	

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F 725	Continued From page 52 Also on the Initial Tour, another resident was asked about call bell response time. "Well, I can tell you," the resident said, "I make them stay right beside the bathroom door now. I don't need a great amount of help, but I do need a little help getting on and off the toilet. The first time they helped me in the bathroom, I sat there for about 40 minutes after ringing the call bell for someone to come and help me get off the commode. That's why I don't let them leave me now. I don't take that long, so when they put me on the toilet I tell them to wait right there, I'll be done in just a minute." On 5/10/18, at the beginning of the evening shift (3:00 p.m.), a CNA at the second floor nurses station was heard to say, "The state must be leaving. It's just me tonight from there to there (pointing from one end of the hall to the other, a total of 20 rooms). Last night we had plenty of help because they were here." The findings were discussed during an end of day meeting on 5/9/18, and again prior to the exit conference on 5/10/18, that included the facility administrative staff and the survey team.	F 725	**Monitoring:** The Director of Nursing (DON) or designee will review daily staffing sheets to assess adequacy of staff on each shift. Actual staff worked hours from the previous 24 hours will be provided to the DON daily by the staffing coordinator. Call light response audits and interviews with residents will be conducted by designated staff. Variances identified during audits will be corrected. Non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted daily X 14 days then weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		

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F 756	Continued From page 53 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff failed to provide a timely response to a pharmacy recommendation for two of 23 residents in the survey sample, Residents #46 and #43. 1. Resident #46's physician failed to respond to a pharmacy recommendation dated 02/27/18 regarding the discontinuation of Lorazepam	F 756	**F 756 Drug Regimen Review** **Corrective Measure for Residents Affected** The order for prn Lorazepam for Resident # 46 has been changed so that it stops after 14 days. A new order will be obtained if indicated. The attending physician does not want dose reduction for Resident # 43's Effexor at this time. **Identification of Other Residents with Potential To Be Affected** Other residents with potential to be affected will be identified through review of physician orders for prn psychoactive medications. Corrections will be made as appropriate, based on the facility's revised policy and procedure for the use of prn psychoactive medications. Pharmacy recommendations will be reviewed to identify residents who may	

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F 756	Continued From page 54 (Ativan). 2. Resident #43 had a pharmacy recommendation to determine if a GDR (gradual dose reduction) for Effexor XR would be acceptable on 3/20/2018; the facility failed to act upon this in a timely manner. Findings included: 1. Resident #46 was admitted to the facility on 12/21/17 with diagnoses including, but not limited to: Diabetes, Alzheimer's, BPH (benign prostatic hypertrophy), Glaucoma, Diverticulitis, and Mild Intellectual Disability. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/26/18. Resident #46 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #46's clinical record was reviewed on 05/09/18 at 12:25 p.m. A "30 Day Medication Regimen Review Note" dated 02/27/18 and signed by the pharmacist included the following documentation: "...Lorazepam 0.5 MG TAB, PO every 6 hours, PRN: Anxiety...Recommendations to Physician: Other: Please consider discontinuation due to lack of use (11 doses in past 60 days)..." No physician response was located in the clinical record. Included in this resident's physician order sheet dated May 2018 was an order that stated, "...Start Date: 12/28/17... Lorazepam 0.5 mg [milligrams], HIGH ALERT med [medication], Tab [tablet], PO [by mouth], every 6 hours, PRN [as needed] Anxiety, initial therapy, X [times] 120 Doses	F 756	be affected by the lack of physician response to pharmacy consultant recommendations. Corrections will be made pursuant to the facility's revised policy and procedure for Monthly Medication Regimen Review. **Measures to Prevent Recurrence** A memorandum and a copy of the regulations and revised policy and procedure addressing prn psychoactive medications and monthly medication regimen review will be sent again to practitioners serving the facility's residents/patients. The Director of Nursing and licensed nursing staff will be in-serviced on these changes. **Monitoring:** The Director of Nursing (DON) or designee shall audit medical records of residents with orders for prn	

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F 756	Continued From page 55 (Times), Give first dose: Routine, Start: 12/26/17..." RN #3 (registered nurse) was interviewed on 05/10/18 at 10:40 a.m. re: pharmacy recommendations to the physician. RN #3 stated, "The DON [director of nursing] gets all those recommendations. She then may ask us to get in touch with the doctor." LPN #2 (licensed practical nurse) was interviewed on 05/10/18 at 10:50 a.m. re: pharmacy recommendations. LPN #2 stated, "That was taken from the charge nurses and given back to the DON in September 2017." During a meeting with the survey team on 05/10/18 at 2:45 p.m., the DON stated, "Pharmacy Recommendations are put into [Name of Computer System] and the recommendations go to me, physician and the medical director. I check to see if the recommendations have been addressed. The doctor will either write on the recommendation or write an order in [Name of Computer System]. If I don't see anything in either place, then we call the physician's office. This one must have slipped through." No further information was received by the survey team prior to the exit conference on 05/10/18. 2. Resident #43 was admitted to the facility 6/30/14, with a readmission on 4/26/16 with diagnoses that included dementia, depression, hematuria, hypocholesteremia, mental retardation, osteoporosis, seizure disorder, congestive heart failure, constipation and hypertension. The minimum data set (MDS) dated 3/22/18 assessed Resident #43 as moderately impaired for daily decision making.	F 756	psychoactive medications. Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. The Director of Nursing (DON) or designee shall audit pharmacy recommendations for practitioner response. Audits will be conducted monthly for 3 months. Variances identified during audits will be corrected and names of non-compliant providers will be provided to the VP of Patient Services and/or Medical Quality Committee. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 756	Continued From page 56 Review of the Physician' Order Form dated 5/10/2018 revealed the following medication order, dated 12/13/2017, and carried forward monthly: Venlafaxine (generic form of Effexor XR 150 mg) 150 mg, Cap-SR, to be given by mouth daily for depression. During the resident's clinical record review, the resident's pharmacy recommendations were reviewed. A pharmacy recommendation dated 3/20/2018 documented, "Effexor XR 150 mg, daily for depression. Review behaviors, consider dosage adjustment. Please review resident's condition to determine if a GDR (Effexor XR 75 mg daily for depression) would be acceptable at this time." The physician saw the resident on 3/28/2018 and 5/2/2018 and there was no mention of a GDR for the Effexor XR documented in the progress notes for these visits. On 5/10/2018 at 2:15 p.m., the director of nursing (DON) was interviewed regarding how the physician was notified about the pharmacy recommendations during Medication Regimen Reviews. The DON stated the pharmacy recommendations were noted in the facility's electronic medical record. The medication regimen review report is sent to the physician and the DON after the review is complete. The administrator was made aware of the above information and was asked for the Medication Regimen Review policy. A facility policy titled Medication Regimen Review (revised/reviewed 3/15/2018) documented "the	F 756		

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F 756	Continued From page 57 attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If the attending physician does not want to act upon the identified irregularity(s), the attending physician shall document his/her rationale in the resident's medical record. This documentation must be performed within 15 days of receipt of the pharmacist's report. The Director of Nursing shall track physician response to the pharmacy reports. A follow-up phone call shall be made to the physician's office if there is no physician response within 15 days of the report. The director of nursing shall notify the VP of Patient Services if physician does not respond within 7 days of the follow-up phone call. No further information and/or documentation was presented prior to the exit conference on 5/10/18 at approximately 4:00 p.m.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--	F 758	**F 758 Free From Unnecessary PRN Psychotropic Drugs** **Corrective Measure for Residents Affected** The order for prn Lorazepam for Resident # 46 has been changed so that it stops after 14 days. A new order will be obtained if indicated. **Identification of Other Residents with Potential To Be Affected** Other residents with potential to be affected will be identified through	

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F 758	Continued From page 58 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, facility staff failed to discontinue an order for prn (as needed) Lorazepam (Ativan) greater than 14 days for one of 23 residents in the survey sample, Resident #46.	F 758	review of physician orders for prn psychoactive medications. Corrections will be made as appropriate, pursuant to the facility's revised policy and procedure for the use of prn psychoactive medications. **Measures to Prevent Recurrence** The administrator and DON were both aware of the new regulation limiting the use of prn psychoactive medications to fourteen days. This knowledge was shared with the pharmacy consultant and practitioners serving facility residents in November, 2017. The facility's policy for the use of prn psychoactive medications has been revised to include built in automatic stop order, weekly review by pharmacy consultant, and steps to be taken when practitioners are non-compliant. Practitioners, pharmacy consultant and Licensed nursing staff will be made aware of these changes.	

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F 758	Continued From page 59 Resident #46 has had a continuous physician order for prn Ativan since December 28, 2017 to present. Findings Included: Resident #46 was admitted to the facility on 12/21/17 with diagnoses including, but not limited to: Diabetes, Alzheimer's, BPH (benign prostatic hypertrophy), Glaucoma, Diverticulitis, and Mild Intellectual Disability. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/26/18. Resident #46 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #46's clinical record was reviewed on 05/09/18 at 12:25 p.m. Included in this resident's physician order sheet dated May 2018 was an order that stated, "...Start Date: 12/28/17... Lorazepam 0.5 mg [milligrams], HIGH ALERT med [medication], Tab [tablet], PO [by mouth], every 6 hours, PRN [as needed] Anxiety, initial therapy, X [times] 120 Doses (Times), Give first dose: Routine, Start: 12/28/17..." The Administrator and DON (director of nursing) were informed of the above order on 05/10/18 during a meeting with the survey team at approximately 2:30 p.m. They were asked during this meeting if they were aware of the new regulation that this medication can only have an order for fourteen days and both stated, "No." No further information was received by the survey team prior to the exit conference on 05/10/18.	F 758	**Monitoring:** The Director of Nursing (DON) or designee shall audit medical records of residents with orders for prn psychoactive medications. Variances identified during audits will be corrected and name of non-compliant providers will be submitted to the VP of Patient Services and/or Medical Quality Committee for further actions. Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, one of 23 residents, did not have an order for a specific therapeutic diet, Resident #67. Resident #67 did not have orders for a puree diet. Findings were: Resident #67 was admitted to the facility on 03/27/2018. Her diagnoses included but were not limited to: Stage IV pressure ulcer of the sacrum, sepsis, dementia, and body mass index 19.9 or less (adult). The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 04/03/2018. Resident #67 was assessed as being impaired with both long and short term memory, and severely impaired with daily decision making skills. During the initial tour of the facility on 05/08/2018 at approximately 11:45 a.m., Resident #67 was observed lying in her bed. CNA (certified nursing	F 808	**F 808 Therapeutic Prescribed by Physician** **Corrective Measure for Residents Affected** A physician order for the puree diet for Resident # 67 has been obtained. **Identification of Other Residents with Potential To Be Affected** Other residents who had changes and or additions to their diet have the potential to be affected. Variances Identified will be corrected. **Measures to Prevent Recurrence** The policy and process for communicating dietary changes to Dietary have been revised to ensure Dietary is aware of the changes. The revised policy also reflects that dietary recommendations by Speech Therapist or other staff will take effect only after a physician order for the change has been obtained. In-services to speech therapist and nursing and dietary staffs	

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F 808	Continued From page 61 assistant) # 4 was sitting beside the bed feeding Resident #67 a puree diet for lunch. A tube feeding pump was observed beside the bed. The pump was attached to a pole and not turned on; a container of Jevity 1.2 was hanging above the pump. The tubing from the pump was capped and secured to the pole. At approximately 1:00 p.m., CNA #4 was in the hallway. This surveyor asked her how much lunch Resident #67 had consumed. She stated, about 25 %. CNA #4 was asked if Resident #67 could feed herself at all. She stated, "No, we feed her at every meal." The clinical record was reviewed at approximately 2:30 p.m. Observed on the physician orders was an order dated 04/13/2018: "Modified diet Textured Restricted (must add a modifier), Nectar thick liquid, Start: 04/13/18...Nursing Instructions: pleasure tray." On 05/09/2018 at approximately 9:00 a.m., the unit manager, RN [registered nurse] #3 was interviewed regarding the diet order for Resident #67. She was asked what a textured restricted diet meant. She stated, "She is on nectar thick liquids." RN #3 was asked to clarify what type of "textured restricted diet" did the physician want since there was no modifier added to the order, did that mean mechanical soft, ground meat, puree, etc. She stated, "Oh, I see...that wasn't added...I'll see what she is getting." RN #3 was informed that this surveyor had observed a puree diet being served at two different meal observations. RN #3 stated, "I'll check on that." The above information was discussed during an end of the day meeting on 05/09/2018 at	F 808	on the policy and process changes will be conducted. **Monitoring:** Food and Nutrition Service director or designee shall audit dietary orders and tray tickets. Variances identified during audits will be corrected and non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted weekly times 8 weeks. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 808	Continued From page 62 approximately 4:40 p.m. with the facility administrative team. On 05/10/2018 at approximately 11:00 a.m., RN #3 came to speak with this surveyor. She stated, "When she came back after having her feeding tube put in, the order was put into the system. We didn't add the modifier so dietary resumed what she was on previously which was the puree...here is a note from the speech therapist." RN #3 presented a "...Therapy Data Collection Form" date "3/28, 3/29/18" that contained the following comments: "Total A [assist]...puree/nectar thick...nonverbal..." A "Sticky note" from the therapist was attached, which contained the following: "This is the screen I found by the prior SLP [speech language pathologist]. Looks like she came here on puree/NTL [nectar thick liquids] and was considered to be appropriate on those consistencies, given total feed A [assistance]." RN #3 stated, "We didn't add the modifier to the order, but it was the right diet...we will add that now." RN #3 was asked if dietary should have clarified the diet order prior to resuming the previously ordered puree diet. She stated, "Yes, they should have." No further information was obtained prior to the exit conference on 05/10/2018.	F 808		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842	**F 842 Resident Records** **Corrective Measure for Residents Affected** There was no specific resident cited in the 2567 report as having been directly affected by this citation.	

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F 842	Continued From page 63 accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842	**Identification of Other Residents with Potential To Be Affected** All residents have the potential to be affected. Enhancements to the electronic medical record system (EMR) have been made to ensure information is readily accessible, care plan application has more flexibility for individualization and documentation in the EMR, including treatments and interventions, is readily accessible. **Measures to Prevent Recurrence** Each surveyor was provided with a folder with step by step instructions on how to access each section of the EMR. These instructions will be revised to reflect the changes/enhancements that have been made. Selected staff will also be trained to access and use surveyor view so that they can be more effective In assisting the surveyors navigate the EMR. Certain sections of the medical record can only be printed by the medical records staff and any request for printing will be accomplished in a	

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F 842	Continued From page 64 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure resident medical records were complete, accurate and readily accessible during the current survey. The survey team had difficulty locating information within the computerized medical record system for 26 of 26 records reviewed. The computerized records had conflicting resident health information for resident weights. Surveyors were unable to locate information within the record without assistance from staff. The findings include: During the entrance conference on 5/8/18 at 11:15 a.m., the administrator stated the facility transitioned to a new health record software in	F 842	timely manner. This information will be included in the instructions and surveyors will also be informed of this during entrance conference. Appropriate nursing and dietary staff will be re-educated in the policy for weights – that weights obtained at the hospital are not to be used. Weights are to be obtained by assigned staff pursuant to facility policy and recorded in Cerner on the correct encounter. **Monitoring:** The Director of Nursing or designated staff shall review surveyor instructions every three months for accuracy and test surveyor view to ensure data and information from all sections of the EMR are easily accessible. Variances identified will be corrected. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date: 6/24/2018**	

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F 842	Continued From page 65 November 2017. The administrator stated the software was hospital based and identical to the system used by their partnered hospital. The administrator stated there had been challenges with transitioning to the system and assistance would be provided as needed for the survey process. After sign on names and passwords were provided to the survey team, all surveyors had difficulty locating nursing notes, physician progress notes, care plans, physician orders and medication/treatment records in the facility's computerized health records. Assistance was requested from facility administration concerning locating the records. On 5/9/18 at 8:15 a.m., the facility's information technology (IT) manager attempted to provide help in locating physician progress notes in a health record. The IT manager stated she was not familiar with the screen view that was provided for the surveyors. The IT manager stated she did not see any physician progress notes in the record reviewed and stated, "I'm not abreast of that view [computer screen view]." On 5/9/18 at 10:45 a.m., the IT manager stated the only other access available allowed the ability to write and enter data into the software. The IT manager stated the screen views provided to the surveyors were not the same as the working software used by the nurses. The survey team had difficulty locating nursing notes and treatment records. On 05/08/2018 at approximately 1:30 p.m., the registered nurse unit manager (RN #3) was in the conference room assisting the survey team with the electronic	F 842		

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F 842	Continued From page 66 record. She was asked where the nurses' notes/progress notes were located. RN #3 stated, "There are no progress notes. We would love to show them to you but the nurses have been instructed not to do notes in this system ...there are forms that we complete for most things ...there are a few exceptions and if there isn't a form then you can write a clinical note ....believe me we would love to show you notes." On 05/09/2018 at 1:35 p.m., RN #3 was asked where treatment administration records (TAR) were located in the clinical record. She stated, "We don't have a TAR ...we have communications." RN #3 was asked to explain. RN #3 stated, "It comes up on the screen as something the nurse needs to do, but there is no check off for it." She was asked how they tracked whether or not items such as prevalon boots, alarms, etc. were in place on a daily basis. RN #3 stated, "The nurses check them but it isn't tracked on a TAR. I can't show you that because we don't do it." The body weights displayed and tracked in the resident health records were not accurate. A surveyor requested to talk with the facility's registered dietitian (RD) after reviewing a resident's weight history on the computerized health record. On 5/9/18 at 2:36 p.m., the RD stated the weights in the computerized health record were not the same as those entered into the Care Tracker system. The RD stated the health record weights were "calculated" for dosage use by the pharmacy and were not actual body weights. The RD stated she used weights entered into the Care Tracker system because they were actual measured weights entered by the aides. The RD stated she was told the weights in the health record system were not	F 842		

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F 842	Continued From page 67 actual but estimated for pharmacy dosage purposes only. The survey team had not been informed regarding the displayed calculated weights or the location of actual weights until this interview with the RD. The survey team was not able to get printouts of records as requested. On 5/9/18 at 2:45 p.m. the DON (director of nursing) and RN (registered nurse) # 1 were asked for a copy of a resident's medication administration record (MAR). A few moments later, LPN # 5 came to the conference room and informed the surveyor, "We aren't able to print out the MAR's (medication adminstration record); the computer software we are using now doesn't allow us to print that." On 5/10/18 at 11:15 a.m., a surveyor asked the DON for clarification of a physician's order. The DON looked at the order and stated, "I'm not sure why that order was put in that way; when we went to this new computer program nurses from the OB [obstetric] unit at the hospital came over and helped put in a lot of the orders and forms since the system was new to us." Several nurses and unit managers attempted to assist surveyors with locating information throughout the survey. The nurses had difficulty locating the information in the health record because they were not familiar with the screen views provided to the surveyors. The nurses stated the view provided to the surveyors did not match what they used on the floor. The facility was requested to print any information needed by surveyors for review due to the inability of the survey team to locate needed items in the computer system even after	F 842		

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F 842	Continued From page 68 assistance from facility staff members. The survey proceeded with staff printing documents as requested from the computerized system.	F 842		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinic record review and complaint investigation, the facility staff failed to ensure proper functioning of the Wanderguard door locking system on one of five alarmed doors in the facility. Resident #187, with a wander prevention device in place, fell after exiting his living unit through the South stairwell door due to a malfunctioning locking system. After exiting his living unit into the first floor stairwell, Resident #187 was found at the bottom of the steps on the ground floor landing. The resident was diagnosed with a fractured left upper arm, left elbow laceration and an abdominal contusion as a result of the fall. The findings include: Resident #187 was admitted to the facility on 4/20/17, was re-admitted on 3/13/18 and died in the facility on 4/15/18. Diagnoses for Resident #187 included renal cancer, atrial fibrillation, heart failure and chronic obstructive pulmonary disease. The minimum data set (MDS) dated 3/20/18 assessed Resident #187 with moderately impaired cognitive skills.	F 908	Past noncompliance: no plan of correction required.	

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F 908	Continued From page 69 Resident #187's clinical record documented a nursing note dated 6/7/17 at 1:30 p.m. stating, "I was alerted by another employee that the resident had fallen down South hall stairs. When I arrived to the scene his wheelchair was at the top of the stairs, wandergaurd [Wanderguard] was still in place on his chair, and so was his sensory pad. He was lying with his arm hanging off the step...took his vital signs and placed him on a stretcher to be transported to the ER [emergency room]...." A note dated 6/7/17 at 11:30 p.m. stated, "Report was called from the E.R...was told that the resident had an abrasion to his lt [left] elbow, non displaced fracture of the left humerus, contusion of abd. [abdominal] wall..." The emergency room report dated 6/7/17 documented, "...was rolling down the hallway in his wheelchair like he normally does, and he opened the door to the stairwell and fell down two flights of stairs...Assessment....approximately 7 cm [centimeter] skin tear noted to L [left] elbow...Abrasion of elbow - Left, Nondisplaced fracture (avulsion) of lateral epicondyle of left humerus - Suspected, Contusion of abdominal wall..." The facility's investigation report to the state agency dated 6/8/17 documented, "Resident found at Ground Level Landing having exited from first Floor Door (south exit). Transferred to ED [emergency department] for evaluation and returned to facility. Finding of nonDisplaced fracture of left humerus." The facility's investigation stated on 6/7/17 at 1:30 p.m., dietary staff heard the resident hollering for help and found the resident on the ground at the stairwell on the ground level landing. This report	F 908		

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F 908	Continued From page 70 documented, "Investigation revealed that the resident left the first floor unit and went out of the south stairwell exit door. He then got up from his wheelchair and by using the handrail, went down the steps. He got to the ground floor landing and slipped or fell...His wheelchair was found on the first floor landing...The resident's Wander guard bracelet activated the alarm system but the door did not lock upon activation...Nurse assigned to the resident stated that she had heard the alarm on the south stairwell door go off about 20 minutes before the incident. She checked the stairwell and did not find anything amiss...South door Wander guard system's automatic locking mechanism was not functioning properly..." On 5/9/18 at 2:00 p.m., the administrator was interviewed about Resident #187's elopement and fall in the stairwell. The administrator stated the resident had a pressure seat alarm and Wanderguard as interventions prior to the elopement/fall on 6/7/17. The administrator stated the Wanderguard bracelet was supposed to activate the door alarm and the door lock to prevent the resident from going into the stairwell. The administrator stated the alarm sounded but the door did not lock. The administrator stated maintenance checked the door after the incident and found a defective part. On 5/9/19 at 5:10 p.m., the maintenance director was interviewed about the South hall door lock malfunction found when Resident #187 fell on 6/7/17. The maintenance director stated the door was inspected after the incident and found with a power supply failure. The maintenance director stated the alarm sounded at the nursing station but the magnet door lock did not activate allowing the resident to get into the stairwell. The	F 908		

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F 908	Continued From page 71 maintenance director stated prior to Resident #187's elopement/fall the door locks were checked for proper function every 6 months. The maintenance director stated the door locks were lasted checked on 5/15/17 prior to the fall. The facility implemented a plan of correction regarding the malfunctioning door lock system on 6/7/17. The plan of correction included the following: South hall door identified with malfunction was repaired on 6/9/17. All doors and elevators with Wanderguard alarm system were checked for proper function and those found with sporadic issues were repaired. All residents with a Wanderguard bracelet were checked for proper function of the bracelet. In-service education was provided to all staff regarding Wanderguard system, alarms and locks. The frequency of checking the function of the door locks was changed to daily. The corrective actions listed were completed on 7/27/17. During the current survey, the daily checks of the Wanderguard doors and alarms were ongoing and completed daily as indicated. Any defective issues with the Wanderguard door locks and alarms had been repaired when found. There had been no further elopement issues in the facility since 7/27/17. This deficiency was cited as a past non-compliance.	F 908		
F 909 SS=F	This was a complaint deficiency. Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all	F 909	**F 909 Resident Beds** **Corrective Measure for Residents Affected** There was no specific resident cited in the 2567 report as having been affected by this citation. **Identification of Other Residents with Potential To Be Affected** All residents have the potential to be affected. Engineering staff will inspect all beds to ensure all bed frames, mattresses and bed rails are compatible and areas of possible entrapment are identified and corrected.	

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F 909	Continued From page 72 bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to conduct regular inspection of facility beds for potential entrapment in the facility. Findings were: On 05/09/2018 at approximately 4:00 p.m., the administrator provided a spread sheet regarding maintenance of beds at the facility. She stated, "I have someone from biomed coming to speak with you about the beds...they did all of our measuring...our rule is if we move a resident from room to room we move bed and all now to make sure it is appropriate...if we change mattresses the nurses are going to start doing the measurements...the tool we use is out for calibration and [name of bio med manager] said it is easy to do and he has a video to train the nurses...we will do that when the tool gets back." On 05/09/2018 at approximately 5:00 p.m., during a meeting with the DON (director of nursing), the administrator and other facility staff, the Facility Biomed Maintenance Manager, OS (other staff) #2, came to speak with this surveyor. He stated, "That spread sheet was done in 2017...it is per bed. We look at the mattress to make sure it is the correct one for the bed." The spreadsheet was reviewed. It contained room numbers, bed	F 909	**Measures to Prevent Recurrence** The policy and procedure for regular inspection of all beds and subsequent inspections when necessary have been revised to provide clear delineation of responsibility between Engineering and Nursing staff. In-service to Engineering and Nursing staffs on this revised policy and procedure will be conducted. **Monitoring:** The QA/Risk Management Nurse or designee shall inspect a set number of beds weekly to determine compliance with the policy. Variances identified during inspections will be corrected immediately. Non-compliant staff will be re-in-serviced, counseled or disciplined. Audits will be conducted weekly times 8 weeks then per schedule. Findings will be reported to the QAPI Committee for further discussion or recommendations. **Correction Date:** 6/24/2018	

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F 909	Continued From page 73 numbers, maintenance issues, and electrical safety. OS #2 was asked if measurements had been done specific to resident's height/weight to ensure the bed/mattress used was appropriate or if the side rails on the beds were correct. He stated, "We are not responsible for the measurements...I can measure right now and make sure everything is okay and in two hours they can move somebody or add an air mattress and my measurements aren't valid...I told the administrator that...I gave her a brand new tool to use and told her there was a video the nurse's could watch...nursing is responsible for the measurements." He was asked when the decision was made for nursing to do the measurements. He stated, "February 2017 when the repairs listed on that spreadsheet were completed." He was asked if that meant no bed measurements had been done since then. He stated, "Not by us [biomed]...we are not going to be responsible for that...it is up to nursing." The administrator was asked if she was aware of the information being provided by the Biomedical manager. She stated, "Yes...blame it on my short term memory loss." OS #2 stated, "I sent [name of DON] an email with all my work order history that was done in January of this year." This surveyor asked who measured the air mattresses with side rails observed on the unit. OS #2 stated, "Nursing is responsible for that." On 05/10/2018 at approximately 8:00 a.m., the DON presented a stack of work orders (over 300 pages) from OS #2. The "work orders" were inspections conducted regarding the functioning of the beds and any problems discovered were corrected. At approximately 10:00 a.m., OS #2 was asked	F 909		

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F 909	Continued From page 74 about the information on the work orders. He stated that a checklist was used to inspect the beds annually but it did not include measurements. He was asked for a copy of the checklist. He presented the checklist at approximately 11:15 a.m. He stated, "The first things on there aren't used over here...they are at the hospital." The checklist contained the following, but not limited to: "Verify mattress (foam or air) is appropriate for the bed installed. Verify no excessive gaps are noted between the framing of the bed and mattress" OS #2 was asked how that would be determined if he was not doing measurements. He stated, "What we do here is we look at the mattress to make sure it fits the bed...an 84 inch bed needs an 84 inch mattress...that's what we are doing, making sure the right mattress is on the bed." He was asked what difference if made it the mattress was incorrect. He stated, "It can be an entrapment risk... but we (biomed/maintenance) are not going to be responsible for the measurements. That is up to nursing." No further information was obtained prior to the exit conference on 05/10/2018.	F 909		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495177	A. BUILDING _____ B. WING _____	05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Initial Comments An unannounced biennial State Licensure Inspection survey was conducted 5/8/18 through 5/10/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this 140 bed facility was ninety-four at the time of the survey. The survey sample consisted of twenty-one current resident reviews and two closed record reviews.	F 000	**This Plan of Correction (POC) for the Virginia Rules and Regulations cited during the Licensure Survey conducted on 5/8/18 through 5/10/18 is respectfully submitted as evidence of compliance.**	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC-371-250(C) and (F). Please cross reference to F657 12VAC-371-220(A). Please cross reference to F689. 12VAC-371-220(C,3). Please cross reference to F690. 12VAC-371-220(C) and (D). Please cross reference F691. 12VAC-371-220(D). Please cross reference to F694. 12VAC-371-220(A). Please cross reference F700.	F 001	**12-VAC-371-250(C) and (F)** Please cross reference to POC for F657 **12-VAC-371-220(A)** Please cross reference to POC for F689. **12-VAC-371-220(C,3)** Please cross reference to POC for F690 **12-VAC-371-220(C) and (D)** Please cross reference to POC for F691 **12-VAC-371-220(D)** Please cross reference to POC for F694 **12-VAC-371-220(A)** Please cross reference to POC for F700.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alyssa Williams | TITLE: Administrator | (X6) DATE: 5/31/18

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495177	A. BUILDING _____ B. WING _____	05/10/2018

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F 001	Continued From Page 1 12VAC-371-210(B). Please cross reference to F725. 12VAC-371-300(H). Please cross reference to F756. 12VAC-371-300(B). Please cross reference to F758. 12VAC-371-340(J). Please cross reference to F808. 12VAC-371-360(A) and (E). Please cross reference to F842. 12VAC-371-370 (A) and (B). Please cross reference to F908. 12VAC-371-370(A) and (B). Please cross reference to F909.	F 001	**12-VAC-371-210(B)** Please cross reference to POC for F725 **12-VAC-371-300(H)** Please cross reference to POC for F756 **12-VAC-371-300(B)** Please cross reference to POC for F758 **12-VAC-371-340(J)** Please cross reference to POC for F808 **12-VAC-371-360(A) and (E)** Please cross reference to POC for F842 **12-VAC-370(A) and (B)** Please cross reference to POC for F908 **12-VAC-371-370(A) and (B)** Please cross reference to POC for F909	