STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	03/15/2018

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SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/13/18 through 03/15/18. No complaint(s) were investigated during the survey. Significant Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 98 bed facility was 82 during the survey. An unannounced Medicare/Medicaid standard survey was conducted 3/13/18 through 3/15/18. Corrections are required for compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The Life Safety Code survey/report will follow. The census in this 98 certified bed facility was 82 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 2 closed record reviews.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004		4/26/18

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

Electronically Signed | 04/08/2018

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E 004	Continued From page 1 The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, it was determined the facility staff failed to develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth by the Medicare and Medicaid Programs; "Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers" Findings: On 3/15/18 at 10:45 AM, the surveyor reviewed the emergency preparedness process with the facility administrator. The administrator reviewed her disaster plan book, kept at the nursing station for staff members. The administrator provided the surveyor with a survey taken with the fire marshall to identify the different disasters that may happen within the facility. There was no documentation presented about risk assessment and associated strategies.	E 004	1. All residents have a potential to be affected. Our facility had developed a team that included Owner, Administrator, Maintenance Director, and Director of Nurses that reviewed extensively all systems that affect facility operations and how any system failure would affect the facility and what measures were to be taken. This team also discussed any possible disaster that could potentially affect our facility for appropriate responses and actions. Our entire disaster plan book was reviewed in February of 2017 to review and update all emergency preparedness policies and procedures. In-servicing was provided to all staff at this time. The facility also has participated in a table top exercise and a Community based Full Scale exercise coordinated by Near Southwest Preparedness Alliance. Our facility had also registered with VHASS platform. In addition to the above mentioned, the	

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E 004	Continued From page 2 When the surveyor asked the administrator to provide the actual emergency preparedness policy and documentation linking all her submissions, she said she didn't know she needed to have one. She stated, "This was all done over a year ago with the Near Southwest Preparedness Alliance. I didn't realize I was going to have to have policies to document that we discussed what happened when the phones went down and we had decided to use walkie-talkies." The administrator said it hadn't occurred to her to fill up a huge binder with policies and plans no one would ever have time to read anyway. No additional information was provided prior to the survey team exit.	E 004	facility will develop a separate emergency preparedness manual to outline the facility emergency preparedness program. 2. All residents have the potential to be affected. 3. An Emergency Preparedness manual will be put together to outline the facility Emergency Preparedness program. It will include all the policies and procedures that have been reviewed/revised/created in our current disaster book. The manual will include our facility risk assessment, participation in collaborative community planning, identify emergency supply policies and procedures, evacuation plan and community contracts, emergency contacts, and documentation of our facility involvement with an integrated emergency system. 4. The Emergency Preparedness Plan will be reviewed at the next QA meeting April 26, 2018. The EP Plan will be reviewed annually at the QA committee meeting. The EP Plan will be reviewed and updated as necessary any time system changes occur at the facility by the EP team. 5. Corrective Action will be complete by April 26, 2018.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		4/26/18

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results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 4 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to inform the resident representative of a change of condition for 1 of 20 residents (Resident #4). The findings included: The facility staff failed to inform the resident representative of a bruise found on 1/5/18 on Resident #4. Resident #4 was admitted to the facility 9/11/15 and readmitted 10/5/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, protein calorie malnutrition, non-ST elevation myocardial infarction, chest pain, Vitamin B12 deficiency, anemia, bilateral hearing loss, chronic pain, constipation, hypothyroidism, depressive disorder, hypertension, gastroesophageal reflux disease, and atherosclerotic heart disease. Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/11/17 assessed the resident with a BIMS summary score of 6/15. The surveyor reviewed Resident #4's clinical record 3/13/18 through 3/15/18. A progress note dated 1/5/18 read in part "Resident has been sleeping all night so staff let her sleep per her request and woke her to check for incontinence at this time-before touching her, other than to	F 580	1. The responsible party of resident #4 was notified of the bruise found on 1/5/18 during the survey process between 3/13-15/18. 2. All investigation sheets from March 1-April 13th will be reviewed by DON or designee for appropriate notification to MD and Responsible Party to address any other residents found to have been affected. 3. The current Bruise/Skin Tear/Abrasion Investigation form will be revised to include a notification confirmation of both MD and RP for identified incident on the investigation form. The current Policy and Procedures for MD/RP notification will be reviewed and revised as needed. 4. All nurses will be in-serviced on changes to the Investigation form. The DON/designee will audit all Investigation Forms for proper notification for three months. The changes to Investigation Form will be communicated at the Quarterly QA meeting. 5. The Investigation Form will be revised and in-serviced to all nursing staff by 4/13/18. Implementation of the revised Investigation Form will be in effect by 4/13/18. Form revision will be communicated at Quarterly QA meeting 4/26/18. Corrective action will be completed by 4/26/18.	

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awaken her, noted bruise on top of right hand, dark purple, approx. (approximately) 5 x 7 cm (centimeters) with a line from it approx. 3 cm long to knuckle (from bruise)-asked how it happened-said "it happened a week ago-they were rough when they put me on the shower chair & I hit my hand on the arm."

The surveyor was unable to locate physician notification and resident representative notification of the bruise in the clinical record. The surveyor informed the administrator, former administrator and facility owner, and the director of nursing of the above concern on 3/14/18 at 3:43 p.m.

On 3/15/18 at 9:03 a.m., the director of nursing informed the surveyor Resident #4's niece had not been informed of the bruise found 1/5/18 on the right hand. The DON stated the bruise happened on a weekend and she did not get the incident form until Monday. The DON stated the medical doctor was informed but not the niece. The DON stated the facility would need to revamp their investigation form. The surveyor requested the facility policy on notification.

The facility policy titled "MD/RP Notification" was reviewed 3/15/18.The policy read in part "This facility will inform the resident and/or RP, and consult the resident's MD when:
" There is an incident/accident involving the resident which results in significant injury and has potential for requiring immediate MD intervention.
" A significant change in resident's physical, mental, or psychosocial status.
" A need to alter treatment significantly because of adverse consequences
PROCEDURE:

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F 580	Continued From page 6 1. The nurse will notify MD by phone or fax for changes not requiring immediate attention of the MD. RP will be notified as soon as possible within 24 hours of change in resident condition or treatment." The surveyor informed the administrator and the director of nursing of the above concern during the end of the day meeting on 3/15/18 at 12:32 p.m. No further information was provided prior to the exit conference on 3/15/18.	F 580		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to meet professional standards of quality for 2 of 20 residents in the final survey sample, Resident # 56 and Resident # 63. The findings included The facility staff failed to document blood sugar results for Resident # 56 and failed to follow the facility policy for blood sugar monitoring and treatment for Resident # 63. 1. Resident #56 is a 75-year-old female who was admitted to the facility on 11/6/17. Diagnoses	F 658	1. MD and RP were notified of accu-checks missing for identified dates for resident #56. MD and RP were notified of policy and procedure not being followed for resident #63 related to the hypoglycemic episodes. No negative clinical outcomes were experienced by resident #56 or #63. 2. All residents with accu-check orders from 3/1/18-4/13/18 will have documentation audited to identify any other residents affected by the deficient practice. 3. Beginning 4/12/18, between each shift change the on-coming charge nurse will	4/13/18

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F 658	Continued From page 7 included but were not limited to: type 2 diabetes mellitus, hemiplegia and hemiparesis, cerebrovascular accident affecting the left dominant side, and hypertension. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/9/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #56 had a BIMS (brief interview for mental status) score of 13/15, which indicated that Resident #56 is cognitively intact. On 3/15/18 at 9:02 am, the surveyor reviewed the clinical record for Resident # 56. The most recent plan of care for Resident #56 was reviewed and revised on 2/27/18. In the focus area of nutrition, interventions include but are not limited to: "Obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated." Resident # 56 has current orders that were signed by the physician on 3/5/18 for "Accuchecks before meals and at bedtime using (facility name withheld) sliding scale chart on Accucheck sheet." On 11/10/17 there were blood sugar results documented for 11:30 am, 4:00pm, and 8:00pm only. On 11/17/17 there were blood sugar results documented for 6:00 am, 11:30 am, and 4:00 pm only. On 11/18/17 there were blood sugar results documented for 11:30 am, 4:30 pm, and 9:00 pm only.	F 658	audit the off-going charge nurse for accurate documentation of accu-checks as well as adherence to proper blood sugar monitoring. The nightly MAR check performed by 11-7 charge nurse will have a monitor for appropriate documentation of all accu-check orders added. This audit will include proper documentation of accu-checks as well as adherence to the policy and procedure for blood sugar monitoring. All nurses will be in-serviced on the blood sugar monitoring and blood sugar documentation policies. 4. The audit between on-coming charge nurse and off-going charge nurse will be done between each shift for 30 days. The DON/designee will review the audit between on-coming and off-going charge nurses weekly X 4 weeks. The DON/designee will audit the nightly MAR check sheets weekly x 3 months to ensure appropriate documentation. The nightly MAR check sheets and weekly audits reviewed by DON/designee will be communicated at the quarterly QA meeting. 5. In-servicing to all nursing staff will be complete by 4/13/2018. Changes to nightly MAR check will begin by 4/10/18 and continue on-going. Corrective action will be complete by 4/13/18.	

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F 658	Continued From page 8 On 11/23/17 there were blood sugar results documented for 11:30 am, 4:00 pm, and 8:00 pm only. On 11/27/17, there were blood sugar results for 6:00 am, 11:15 am, and 4:00 pm only. On 12/7/17 there were blood sugar results documented for 11:30 am, 4:30 pm, and 8:30 pm only. On 12/9/17 there were blood sugar results documented for 11:30 am, 4:30pm, and 9:00 pm only. On 12/14/17 there were blood sugar results documented for 6:00 am, 11:30 am, and 4:00 pm only. On 12/23/17 there were blood sugar results documented for 11:30 am, 4:30 pm, and 9:00pm only. On 12/24/17 there were blood sugar results documented for 6:00 am, 11:30 am, and 4:30 pm only. On 12/25/17 there were blood sugar results documented for 11:30 am, 4:15 pm, and 8:30 pm only. On 12/26/17 there were blood sugar results documented for 11:30 am, 4:35 pm, and 8:50 pm only. On 12/29/17 there were blood sugar results documented for 11:30 am, 4:30 pm, and 8:30 pm only. On 12/31/17 there were blood sugar results documented for 11:30 am and 4:30 pm only. On 1/7/18 there were blood sugar results documented for 5:50 am, 4:00pm, and 8:30 pm only. On 1/11/18 there were blood sugar results documented for 6:00 am, 11:30 am, and 4:30 pm only. On 1/17/18 there were blood sugar results documented for 6:00 am, 11:30 am, and 4:00 pm	F 658		

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F 658	Continued From page 9	F 658		

only.
On 1/19/18 there were blood sugar results documented for 11:10 am, 4:30 pm, and 8:30 pm only.
On 1/20/18 there were blood sugar results documented for 6:00 am, 11:30 am, and 4:00 pm only.
On 1/21/18 there were blood sugar results documented for 6:00 am, 11:30 am, and 9:00 pm only.
On 1/23/18 there were blood sugar results documented for 11:30 am, 4:30 pm, and 9:00 pm only.
On 2/3/18 there were blood sugar results documented for 6:00 am, and 11:30 am only.
On 2/6/18 there were blood sugar results documented for 6:00 am, 4:30 pm, and 8:30 pm only.
On 2/8/18 there were blood sugar results documented for 6:00 am, and 11:00 am only.

On 3/15/18 at 9:45 am, the surveyor spoke with the director of nursing about the findings as stated above and requested the facility policy for blood sugar documentation. According to the facility policy for "Blood Sugar Documentation," the procedure includes but is not limited to:
"1. Once a blood sugar is obtained, it is checked off on the MAR. (medication administration record) The accucheck flow sheet is where the accucheck and insulin coverage is documented."

On 3/15/18 at 11:30 am, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 3/15/18.

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2. Resident #63 is a 79-year-old female who was admitted to the facility on 1/18/18. Diagnoses included but were not limited to: diabetes with hyperglycemia, hypertension, atrial fibrillation, and intracerebral hemorrhage.

The most recent comprehensive MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 1/25/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff coded Resident # 63 as 3 which indicated that Resident # 63's cognitive skills for daily decision making was severely impaired-never/rarely made decisions.

The current plan of care for Resident # 63 was reviewed and revised on 2/6/18. In the focus area "The resident has diabetes mellitus," interventions included but were not limited to: " Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of hypoglycemia: Sweating, Tremor, Increased heart rate (tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait."

On 3/15/18 at 8:45 am, the surveyor reviewed the clinical record for Resident # 63. Resident #63 had current physician's orders that were signed on 3/1/18 for "Accuchecks before meals and at bedtime. Follow (physician's name withheld) sliding scale."

On 2/24/18 at 6:00 am, Resident # 63 had a blood sugar reading of 66. The nurse documented "snack given." The next blood glucose check was done on 2/24/18 at 11:30 am.

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On 2/25/18 at 6:00 am, Resident # 63 had a blood sugar reading of 66. The nurse documented "snack given." The next blood glucose check was done on 2/25/18 at 11:30 am.

On 2/27/18 at 6:00 am, Resident # 63 had a blood sugar reading of 60. The nurse documented "snack with medpass." The next blood glucose check was done on 2/27/18 at 11:30 am.

On 3/1/18 at 6:00 am, Resident # 63 had a blood sugar reading of 64. The nurse documented "pudding given." The next documented blood glucose check was on 3/1/18 at 4:30 pm.

On 3/2/18 at 6:00 am, Resident # 63 had a blood sugar reading of 68. The nurse documented "snack given" The next documented blood glucose check was on 3/3/18 at 11:30 am.

On 3/3/18 at 6:00 am, Resident # 63 had a blood sugar reading of 69. The nurse documented "medpass." The next documented blood glucose check was on 3/3/18 at 11:30 am.

On 3/6/18 at 6:00 am, Resident # 63 had a blood sugar reading of 62. There were no documented interventions. The next documented blood glucose check was 3/6/18 at 11:15 am.

On 3/11/18 at 5:45 am, Resident #63 had a blood sugar reading of 56. The nurse documented "8 oz (ounces) medpass." The next documented blood glucose check was 3/11/18 at 11:30 am.

On 3/15/18 at 9:33 am, the surveyor made the director of nursing aware of the findings and requested the facility policy on blood sugar

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SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

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F 658	Continued From page 12 monitoring. On 3/15/18 at 9:57 the director of nursing provided the surveyor with the facility policy on "Blood Sugar Monitoring/Treatment," the procedure/requirements include but are not limited to: "4. The blood glucose will be obtained as ordered by the physician or PRN when the resident demonstrates symptoms of hypo or hyperglycemia or as follow-up of previous abnormal BS (blood sugar). 5. Findings of the blood glucose readings will be recorded in the clinical record. 8. Hypoglycemia-Unless a physician has ordered specific parameters for monitoring, treating, and notifying the physician of blood sugar levels, the facility routine standing orders will be used. For blood sugars between 50-70, A) Give the resident a carbohydrate snack which may include: 1) Peanut butter cracker 2) Cheese cracker 3) Fruit juices (4-6 oz.) 4) Soft drink -non-diet drink (4-6 oz.) 5) Milk (4-6 oz.) or House Supplement (2-4 oz.) B) Monitor for signs/symptoms of insulin shock. C) Recheck BS in 15-30 minutes." On 3/15/18 at 11:30 am, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 3/15/18.	F 658		
F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		4/26/18

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F 755 SS=D	Continued From page 13 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure physician ordered medications were available for administration to 1 of 20	F 755	1. MD and RP were notified of medications not administered on 3/7/18 and 3/10/18 to resident #59. 2. All resident MAR's from 3/1/18-4/13/18	

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F 755	Continued From page 14 residents (Resident #59). The findings included: The facility staff failed to ensure Resident #59's physician ordered medications were available for administration. The clinical record of Resident #59 was reviewed 3/13/18 through 3/15/18. Resident #59 was admitted to the facility 11/13/15 and readmitted 3/7/18. Diagnoses included but were not limited to spinal stenosis, lumbosacral region, atherosclerosis of aorta, low back pain, wedge compression fracture of second lumbar vertebra, insomnia, pain in joints of left hand, constipation, breast cancer, hyperlipidemia, atrial fibrillation, hypertension, cerebral infarction, polyarthritis, and osteoporosis. Resident #59's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/14/18 assessed the resident with a BIMS summary score of 9/15. (a) Resident #59's post hospital orders dated 3/7/18 were reviewed and included the following: Lovenox 70 mg (milligrams) subcutaneous twice daily x 5 days LD (last day)=3/12/18 to prevent blood clots and Robaxin 750 mg by mouth three times a day x 14 days LD=3/21/18 (muscle relaxer). The surveyor reviewed the March 2018 medication administration records (MARs). The entry for Lovenox read as ordered. The box for 3/7/18 at 10:00 p.m. was circled and initialed and on the reverse side of the MAR was written "Not available from pharmacy." The entry for Robaxin	F 755	will be audited by DON/designee for medications unavailable to identify patterns with specific medications, residents, and/or administration times. 3. Individual counseling has been provided to nurse responsible for failing to follow facility policy. A meeting has been set up with Pharmacy management to discuss the deficiency and barriers to obtaining narcotics given changes in regulations for ordering. The nightly MAR review performed by 11-7 charge nurse will have monitoring of any medications unavailable, the reason, and proper adherence to policy and procedure added. A thorough review of medications available in the medication dispense system will be done by Medical Director, Pharmacy, DON, and Administrator with any identified changes to be discussed and made as appropriate. Current policies and procedures on medication administration guidelines and medication shortages/unavailable medications will be in-serviced to all nurses. 4. Counseling completed 4/6/18. The nightly MAR review performed by 11-7 charge nurse will be reviewed by DON/designee weekly x 3 months, then monthly ongoing. Any identified changes needed in the medication dispense will be discussed at the quarterly QA meeting and more often as needed. 5. The meeting with Pharmacy management is scheduled for April 12th. The nightly MAR review will be updated by 4/10/18. Medications identified in med dispense will be reviewed and changes if identified will be complete by 4/26/18.	

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F 755	Continued From page 15 read as ordered. The box for 3/7/18 at 10:00 p.m. was circled and initialed and on the reverse side of the MAR was written "Not available from pharmacy." (b) The physician order dated 3/9/18 read "Oxycontin 10 mg (milligrams) po (by mouth) bid (twice a day) 2° (secondary) to pain." The March 2018 mediation administration record was reviewed. The entry for Oxycontin was entered on the March MAR as ordered. The 3/10/18 9:00 a.m. entry was circled and initialed. On the reverse side of the MAR was written "Oxycontin not in from pharmacy." The progress note written 3/10/18 at 8:15 p.m. read "MD (name omitted) in, brought enough pain med scheduled and prn (whenever needed) to last resident through weekend. He had ordered a STAT dose through CVS then delivered it to resident here at SRNH (South Roanoke Nursing Home)." The surveyor informed the director of nursing of post hospital medications not available for Resident #59 on 3/14/18 at 2:50 p.m. The DON stated the nurses need to check the medication dispense cabinet/Pixus, call the contract pharmacy and then the contract pharmacy calls the two back-ups (CVS and Walgreen). If the medication is still not available, the nurses need to send a note to the MD. The surveyor requested the facility policy on the procedure for obtaining medications from the contracting pharmacy and a list of the medications in the medication dispense system. The surveyor reviewed the list of medications	F 755	Policies and procedures will be in-serviced to all nurses by 4/13/18. Corrective action will be complete by 4/26/18.	

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F 755	Continued From page 16	F 755		

from the medication dispense system on 3/14/18. Lovenox, Oxycontin or Robaxin were not on the list of medications from the medication dispense system.

The surveyor reviewed the facility policy on obtaining medications from the contracting pharmacy titled "Medication Storage/Unavailable Medications" on 3/14/18. The policy read in part: "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, the nurse will notify the DON or designee and initiate action to obtain the medication from the pharmacy.
2. If a medication shortage is discovered during normal pharmacy hours: a. Nurse will call pharmacy to determine status of the order. If the medication has not been ordered, the nurse should place the order or reorder for the next scheduled delivery. b. If the next available delivery would cause a delay or a missed dose in the resident's medication schedule, the nurse will obtain the medication from the pharmacy STAT box/med dispense. c. If the medication is not available in the STAT box, the nurse will notify pharmacy and arrange for an emergency delivery or use of an emergency (back-up) third party pharmacy.
6. When a missed dose is unavoidable, nurse will notify the physician and responsible party and document notification in the nurse's note."

The surveyor informed the administrator, the former administrator/owner, and the director of nursing of the above issue with medications not available for Resident #59 in the end of the day meeting on 3/14/18 at 3:43 p.m.

No further information was provided prior to the

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F 755	Continued From page 17 exit conference on 3/15/18.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician ordered parameters for blood sugar monitoring and sliding scale insulin administration for 1 of 20 residents (Resident #65). The findings included: The facility staff failed to follow the physician ordered blood sugar parameters for the	F 757	1. MD and RP were notified of sliding scale insulin not being administered to resident #65 on 3/6/18. No negative clinical outcomes were experienced by resident #65. 2. All residents with sliding scale insulin coverage ordered from 3/1/18-4/13/18 will have documentation audited to identify any other residents affected by the deficient practice.	4/13/18

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F 757	Continued From page 18 administration of sliding scale insulin for Resident #65. The clinical record of Resident #65 was reviewed 3/13/18 through 3/15/18. Resident #65 was admitted to the facility 3/7/15 and readmitted 9/29/15 with diagnoses that included but not limited to Type 2 diabetes mellitus, dementia with behavioral disturbances, urinary tract infection, osteoarthritis right hand, obsessive compulsive disorder, hypercholesterolemia, and cerebral infarction without residual deficits. Resident #65's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/12/18 assessed the resident with short-term memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making. Current person centered care plan initiated 3/20/15 and revised 2/22/18 read in part "Resident #65 has Diabetes Mellitus Insulin dep (dependent)-Receives a therapeutic diet. Weight is stable. Interventions: Diabetes medication as ordered by doctor. Insulin per MD (medical doctor)." Resident #65's March 2018 physician's orders read in part "Accucheck blood sugar before meals and at bedtime with sliding scale prn (whenever needed). Novolog Flexpen 3ml (milliliter) syr (syringe) Inject per sliding scale: < (less than) 200=0; 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; > (greater than) 500 call MD unless otherwise ordered." The surveyor reviewed the March 2018 blood	F 757	3. Beginning 4/12/18, between each shift change the on-coming charge nurse will audit the off-going charge nurse for accurate documentation of sliding scale insulin coverage. The nightly MAR check performed by 11-7 charge nurse will have a monitor for appropriate documentation and coverage of all accu-check orders requiring sliding scale insulin coverage added. All nurses will be in-serviced on the blood sugar monitoring and blood sugar documentation policies. 4. The audit between on-coming charge nurse and off-going charge nurse will be done between each shift for 30 days. The DON/designee will review the audit of on-coming and off-going charge nurses weekly X 4wks. The DON/designee will review the nightly MAR check sheets weekly x 3 months. The nightly MAR check sheets and weekly audits performed by DON/designee will be communicated at quarterly QA meeting. 5. In-servicing to all nursing staff will be complete by 4/13/2018. Changes to nightly MAR check will begin by 4/10/18 and continue on-going. Corrective action will be complete by 4/13/18.	

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F 757	Continued From page 19 sugar log. The blood sugar obtained 3/6/18 at 9P was 219 and no sliding scale insulin was administered. Based on the physician orders, Resident #65 should have received 2 units of Novolog insulin. The surveyor interviewed licensed practical nurse #1 on 3/14/18 at 3:20 p.m. L.P.N. #1 reviewed the blood sugar log and stated she knew what she had done wrong. L.P.N. #1 stated she gave the resident 2 units of insulin but stated she documented zero. L.P.N. #1 stated "Resident #65 was a fragile diabetic." The surveyor informed the administrator, the administrator/owner, and the director of nursing of the above concern on 3/14/18 at 3:43 p.m. No further information was provided prior to the exit conference on 3/15/18.	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 20 residents was free of a significant medication error (Resident #59). The findings included: The facility staff failed to ensure Resident #59's admission medications were available and administered as ordered (Lovenox and Robaxin)	F 760	1. MD and RP were notified of medications not administered on 3/7/18 and 3/10/18 to resident #59. After being notified the oxycontin was not available, the residents physician went to back-up pharmacy and picked up enough medication for resident until narcotic was available and delivered to the facility by contracted pharmacy. 2. All resident MAR's from 3/1/18-4/13/18	4/26/18

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F 760	Continued From page 20 and failed to ensure Resident #59's physician ordered pain medication was available and administered as ordered (Oxycontin). The clinical record of Resident #59 was reviewed 3/13/18 through 3/15/18. Resident #59 was admitted to the facility 11/13/15 and readmitted 3/7/18. Diagnoses included but were not limited to spinal stenosis, lumbosacral region, atherosclerosis of aorta, low back pain, wedge compression fracture of second lumbar vertebra, insomnia, pain in joints of left hand, constipation, breast cancer, hyperlipidemia, atrial fibrillation, hypertension, cerebral infarction, polyarthritis, and osteoporosis. Resident #59's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/14/18 assessed the resident with a BIMS summary score of 9/15. (a) Resident #59's post hospital orders dated 3/7/18 were reviewed and included the following: Lovenox 70 mg (milligrams) subcutaneous twice daily x 5 days LD (last day)=3/12/18 to prevent blood clots and Robaxin 750 mg by mouth three times a day x 14 days LD=3/21/18 (muscle relaxer). The surveyor reviewed the March 2018 medication administration records (MARs). The entry for Lovenox read as ordered. The box for 3/7/18 at 10:00 p.m. was circled and initialed and on the reverse side of the MAR was written "Not available from pharmacy." The entry for Robaxin read as ordered. The box for 3/7/18 at 10:00 p.m. was circled and initialed and on the reverse side of the MAR was written "Not available from pharmacy."	F 760	will be audited by DON/designee for medications unavailable to identify patterns with specific medications, residents, and/or administration times. 3. A meeting has been set up with Pharmacy management to discuss the deficiency and barriers to obtaining narcotics given changes in regulations for ordering. The nightly MAR review performed by 11-7 charge nurse will have monitoring of any medications unavailable, the reason, and proper adherence to policy and procedure added. A thorough review of medications available in the medication dispense system will be done by Medical Director, Pharmacy, DON, and Administrator with any identified changes to be discussed and made as appropriate. Current policies and procedures on medication administration guidelines and medication shortages/unavailable medications will be in-serviced to all nurses. 4. The nightly MAR review performed by 11-7 charge nurse will be reviewed by DON/designee weekly x 3 months, then monthly ongoing. Any identified changes needed in the medication dispense will be discussed at quarterly QA meeting and more often as needed. 5. A meeting with Pharmacy management is scheduled for April 12th. The nightly MAR review will be updated by 4/10/18. Medications identified in med dispense will be reviewed and changes if identified will be complete by 4/26/18. Policies and procedures will be in-serviced to all nurses by 4/13/18. Corrective action will be complete by	

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F 760	Continued From page 21 LOVENOX access at www.lovenox.com is a low molecular weight heparin [LMWH] indicated for1: Prophylaxis of deep vein thrombosis (DVT) in abdominal surgery, hip replacement surgery, knee replacement surgery, or medical patients with severely restricted mobility during acute illness; Inpatient treatment of acute DVT with or without pulmonary embolism; Outpatient treatment of acute DVT without pulmonary embolism; Prophylaxis of ischemic complications of unstable angina and non-Q-wave myocardial infarction [MI]; Treatment of acute ST-segment elevation myocardial infarction [STEMI] managed medically or with subsequent percutaneous coronary intervention [PCI]. Robaxin (methocarbamol) accessed at www.robaxin.com is a muscle relaxant. It works by blocking nerve impulses (or pain sensations) that are sent to your brain. Robaxin is used together with rest and physical therapy to treat skeletal muscle conditions such as pain or injury. Robaxin may also be used for purposes not listed in this medication guide. The 3/8/18 3:15 p.m. admission progress note read in part "We were unable to get weight secondary she is exhausted and back hurting 10/10. We will get her weight when her medication comes in and we can get her pan controlled." The facility staff failed to ensure the anticoagulant Lovenox was administered on 3/7/18 at 10:00 p.m. as well as the muscle relaxer Robaxin. (b). The facility staff also failed to ensure Resident #59's medication for pain was	F 760	4/26/18.	

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administered as ordered (Oxycontin).
The physician order dated 3/9/18 read "Oxycontin 10 mg (milligrams) po (by mouth) bid (twice a day) 2° (secondary) to pain."

The March 2018 mediation administration record was reviewed. The entry for Oxycontin was entered on the March MAR as ordered. The 3/10/18 9:00 a.m. entry was circled and initialed. On the reverse side of the MAR was written "Oxycontin not in from pharmacy."

Oxycontin accessed at www.drugs.com read "OxyContin (oxycodone) is an opioid pain medication, sometimes called a narcotic. OxyContin is used to treat moderate to severe pain. OxyContin extended-release tablets are used for around-the-clock treatment of pain. They are not for use on an as-needed basis for pain."

The progress note dated 3/10/18 at 6:20 p.m. read "Oxycodone 7.5 mg (milligrams)/325 mg acetaminophen prn (as needed) back pain 8 on a scale of 10."

The progress note written 3/10/18 at 8:15 p.m. read "MD (name omitted) in, brought enough pain med scheduled and prn (whenever needed) to last resident through weekend. He had ordered a STAT dose through CVS then delivered it to resident here at SRNH (South Roanoke Nursing Home)."

The surveyor informed the director of nursing of post hospital medications not available for Resident #59 on 3/14/18 at 2:50 p.m. The DON stated the nurses need to check the medication dispense cabinet/Pixus, call the contract pharmacy and then the contract pharmacy calls

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F 760	Continued From page 23	F 760		

the two back-ups (CVS and Walgreen). If the medication is still not available, the nurses need to send a note to the MD.

The surveyor requested the facility policy on the procedure for obtaining medications from the contracting pharmacy and a list of the medications in the medication dispense system.

The surveyor reviewed the list of medications from the medication dispense system on 3/14/18. Lovenox, Oxycontin or Robaxin were not on the list of medications from the medication dispense system.

The surveyor reviewed the facility policy on obtaining medications from the contracting pharmacy titled "Medication Storage/Unavailable Medications" on 3/14/18. The policy read in part: "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, the nurse will notify the DON or designee and initiate action to obtain the medication from the pharmacy.
2. If a medication shortage is discovered during normal pharmacy hours: a. Nurse will call pharmacy to determine status of the order. If the medication has not been ordered, the nurse should place the order or reorder for the next scheduled delivery. b. If the next available delivery would cause a delay or a missed dose in the resident's medication schedule, the nurse will obtain the medication from the pharmacy STAT box/med dispense. c. If the medication is not available in the STAT box, the nurse will notify pharmacy and arrange for an emergency delivery or use of an emergency (back-up) third party pharmacy.
6. When a missed dose is unavoidable, nurse will

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F 760	Continued From page 24 notify the physician and responsible party and document notification in the nurse's note." The surveyor informed the administrator, the former administrator/owner, and the director of nursing of the above issue with medications not available for Resident #59 in the end of the day meeting on 3/14/18 at 3:43 p.m. The former administrator/owner stated the physician was not happy that the medications ordered were not available for Resident #59. No further information was provided prior to the exit conference on 3/15/18.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		4/26/18

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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.

§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;

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F 842	Continued From page 26 (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 observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure an accurately documented clinical record for 1 of 20 residents in the final survey sample, Resident # 34. The findings included The facility staff failed to ensure that the clinical record for Resident #34 contained accurate documentation. Resident #34 is a 91-year-old female who was admitted to the facility on 9/16/16. Diagnoses included but were not limited to: hypertension, atrial fibrillation, abdominal pain, muscle weakness, and history of breast cancer. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/17/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #34 had a BIMS (brief interview for mental status) score of 15/15, which indicated that Resident #34 was cognitively intact. Section K of the MDS assesses swallowing and nutritional status. In section K0200, the facility staff documented Resident #34's weight as 89 pounds. The clinical record for Resident # 34 was reviewed on 3/13/18 at 2:50 pm. The current plan	F 842	1. Nursing documentation that was inaccurate in the recording of the house supplement med pass provided to resident #34 on 3/14/18 had a nurses note made to correct accuracy of the amount of house supplement med pass that was consumed. No weight loss was experienced by resident #34 after not consuming 100% of her dose of house supplement. 2. All residents with orders to receive house supplement med pass will be randomly audited for proper documentation from 4/9/18-4/20/18 by DON/designees to help identify any residents that may be affected by the deficient practice. 3. Given this resident stated to LPN #1 on 3/14/18 that she "did not need it", the Dietitian was consulted to discuss supplement and interventions with resident. All residents with orders for supplements will continue to be reviewed for acceptance and effectiveness by the RD PRN. LPN #1 will receive individual counseling on the policy and procedures for medication administration and house supplement administration. Residents with house supplement med pass orders will be randomly audited at time of administration for accurate documentation by the DON/designee. All nurses will be in-serviced on the proper administration	

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F 842	Continued From page 27 of care for Resident #34 was reviewed and revised on 2/6/18. In the focus area of "Nutritional Status" the facility staff documented interventions that included but were not limited to: "provide and serve supplements as ordered." On 3/8/18 an intervention was documented "weekly weight x 4 then d/c (discontinue) for weight loss trend." A "Comprehensive Nutrition Assessment" that was completed on 1/23/18 has documentation that states that Resident # 34 has an "unplanned weight loss." "Weight loss shows a loss of 12.2% x 60 days (12 lbs)." Resident #34 has orders for "Med pass 2 cal supplement give 120 ml by mouth twice a day for supplement" On 3/14/18 at 9:06 am, the surveyor observed 150 ml (milliliters) of Medpass 2.0 supplemental shake on over bed table in front of Resident #34. The surveyor asked Resident #34 if she knew what was in the cup in front of her and Resident #34 stated that she did not know. On 3/14/18 at 9:30 am, the surveyor observed the cup with 150 ml of Medpass 2.0 still on the over bed table in front of Resident #34. On 3/14/18 at 9:49 am, the surveyor approached LPN (licensed practical nurse) #1 and requested to see the MAR (medication administration record) for Resident #34. The surveyor observed documentation on the MAR that indicated that Resident # 34 had consumed 100% of the Medpass supplement for the 10 am medication pass. The surveyor spoke with LPN # 1 and asked why there was documentation that stated	F 842	and documentation procedures for house supplement med pass. 4. The DON/designee will randomly audit residents with house supplement med pass orders 2X/wk x 1 month, then 1X/wk x 2 months to monitor nursing education of house supplement med pass administration is being sustained. Results of the audit will be communicated at Quarterly QA meeting on 4/26/18. 5. Corrective action will be complete by 4/26/18.	

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F 842	Continued From page 28 that Resident #34 had consumed 100% of the Medpass supplement when the supplement was still sitting in front of Resident #34 on the over bed table. LPN #1 stated, "I wrote a note on it that she would not give it back to me." LPN #1 then stated that she was going to write a nurses note as well. On 3/14/18 at 9:57 am, LPN #1 went in and talked to Resident #34. Resident #34 was then observed by the surveyor taking a few sips of the Medpass supplement, put the cup back on the table, and stated, "I don't need it." LPN #1 poured the remaining Medpass supplement in the sink. According to the facility policy for "Medication Pass Supplementation Program" The procedure includes but is not limited to "2. Transfer the physicians order onto the resident's medication record. The medication record should denote the amount accepted at each offering." On 3/14/18 at 3:45 pm, the administrator and director of nursing was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 3/15/18.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/26/18

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F 880	Continued From page 29 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 30 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review it was determined the facility failed to implement infection control procedures for 1 of 20 residents. (Resident # 130.) Findings: The facility staff failed to implement infection control procedures for Resident # 130. Resident # 130's clinical record review was conducted on 3/14/18 at 8:00 AM. The resident was admitted on 3/2/18. Her diagnoses included: Shingles & she was on contact precautions for same. The staff had not completed the resident's comprehensive MDS (minimum data set) at this	F 880	1. All scheduled staff were in-serviced immediately during survey on 3/13/18 and 3/14/18 for the diagnosis and reason for isolation of resident #130 and appropriate measures to be taken per the policy on contact precautions. 2. No other residents had isolation precaution orders at the time of survey to present time. 3. The Standard precautions and Contact precautions policies will be re-educated to all staff by 4/13/18. Nursing staff will be educated by 4/13/18 as to their responsibility to notify other nurses and C.N.A.'s of any isolation orders on their unit. A notification sheet will be developed to be used as a quick reference for all staff to know the resident under isolation, what time of precautions are to be	

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F 880	Continued From page 31 juncture. Resident # 130's CCP (comprehensive care plan) included the resident was placed on contact precautions on 3/13/18 due to shingles. The documentation included an order for an antiviral medication to treat the shingles. Telephone orders from the physician on 3/13/18 included the following: 1. Valtrex 1000 mg po (oral) TID (three times a day) x 7 days. 2. Contact isolation. 03/14/18 at 12:29 PM, Resident #130 was observed in a room with signage "Please See nurse before entering room". There was a PPE (personal protective equipment) cart outside the door with gloves & gowns. Red bags were also in this cart. No masks were observed in the cart. Two large bags were on a hanger in the room, red for infection control trash and yellow for linens only. CNA I was in the room assisting the resident to set up her tray. During this process she was seen to handle several personal items, cups, kleenex boxes and books that were on the table. She cut the meat up and took the lids off drinks. CNA I did NOT have a gown or gloves on. She told the surveyor she did not know what the resident had and she should have put on a gown, gloves and mask on before entering room. CNA I stated she wasn't her resident and thought it was ok to serve her food without the benefit of PPE. I would normally do that if I was taking someone to the bathroom--but just setting up a	F 880	followed, any personal protective equipment that is required, and the date isolation begins. This notification will be kept at nurses station so that all appropriate employees have access to review. 4. As of 4/8/18 there are no current residents with isolation precautions to monitor performance. However, the notification sheet will be developed and reviewed/approved at QA on 4/26/18 and put in place for the next resident with isolation orders. 5. Corrective action will be complete by 4/26/18.	

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tray? CNA said "I probably should have talked to the nurse first, to see if it was ok. Then CNA I exited the room without washing her hands or using an antibacterial solution.

03/14/18 at 12:36 PM, CNA II said she had been caring for this resident and had been using PPE when providing care. "I use everything in the cart--gloves, gown and masks" She did not know what type precautions the resident was on. (No masks were in cart at this time--however two drawers full of gowns and whole box of gloves just placed there since this surveyor visited her yesterday--and there was no signage on door then.)

On 3/14/18 at 12:55 PM Resident # 130's call light came on. The SW (social worker) entered the room and then asked the resident what she wanted. The resident asked her to take her tray out, because she's through with lunch.

The SW then came out of room and started to gown and don gloves. CNA III came in to get the tray, taking the gown and gloves from the SW.

CNA III picked up the tray, handed it off to another CNA (outside room) and got her to untie her gown, removed gloves, washed her hands and then began to rearrange the resident's overbed table with all her personal items: juice glass, box tissues, other food snacks, resident's personal items--bare-handed after she discarded her gloves. Then she exited the room without washing her hands or using the antibacterial at the door--after touching the resident's items, drink cup, tissue box food items, etc.

When asked about the precautions and PPE

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usage she told the surveyor, "If it's in your urine like hers, it's ok--but if it was in her saliva, The meal would come in on paper and we would dispose it all in a bag."

On 03/14/18 12:50 PM, RN I said the resident had shingles (but doesn't know where) and is taking Valtrex TID beginning 3/14/18. The MAR (medication adminstration record) was documented with one administration that morning.
.
03/14/18 12:58 PM CNA III came back to the surveyor and told her she checked with the nurse and the resident is being "TESTED" for shingles--and that they're using the PPE as a precaution.

On 3/14/18 at 2:00 PM, the surveyor told the DON of her findings. The DON provided the facility policy on contact precautions. The policy included: "".....In addition to wearing gloves according to standard precautions, wear gloves and wash hands when providing direct care or handling items potentially contaminated.....After glove removal and handwashing, ensure that your hands do not touch potentially contaminated environmental surfaces or items in the resident's room...."

The DON told the surveyor they did not have to gown unless they were changing the dressing covering the area and there was a possibility the staff could get the virus on their clothing. She did agree they she be wearing gloves during each visit and washing their hands prior to leaving the room if they had handled anything that might be contaminated.

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F 880	Continued From page 34 No additional information was provided prior to the survey team exit.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review. The facility staff failed to establish an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. The findings included The facility staff failed to establish an antibiotic stewardship program. On 3/15/18 at 11:34 am, the surveyor spoke with the director of nursing about the facility antibiotic stewardship program. The director of nursing informed the surveyor that an antibiotic stewardship program is something that the facility is actively working on however; the facility has not yet implemented a program. The director of nursing provided the surveyor with handouts from webinars that the facility attended, one of which was dated 8/9/2017, and discussed having a family night to discuss with families about	F 881	1. All residents have the potential to be affected. 2. All residents have the potential to be affected. 3. The facility currently monitors infections and antibiotic use as infections are identified and discuss these weekly at the clinical at risk meeting, this will continue. All nursing staff will be in-serviced on the need for antibiotic monitoring by 4/13/18. All nursing staff will be in-serviced on all policies and protocols developed by 4/26/18. A meeting with Pharmacy has been scheduled for 4/12/18 to further discuss our antibiotic stewardship program. An RP/Resident communication education tool will be developed by DON, Medical Director, Pharmacist, and Administrator to be used for education of antibiotic use and alternate interventions. 4. Antibiotic use policies and protocols	4/26/18

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F 881	Continued From page 35 antibiotic stewardship. On 3/15/18 at 12:20 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 3/15/18.	F 881	will be developed by 4/26/18. Antibiotic use and monitoring will be reviewed weekly at clinical at risk meeting and will continue on-going. In the event the clinical at risk meeting does not take place, the DON/designee will review the antibiotic tracking sheets. The Antibiotic stewardship program will be discussed at the Quarterly QA meeting 4/26/18. 5. Antibiotic Stewardship Program will continue ongoing. Corrective action will be complete by 4/26/18.	