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	495396	A. BUILDING _____ B. WING _____	C 07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HILL HEALTH AND REHAB CENTER	**6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407**

(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 7/17/18 through 7/19/18. The facility was in substantial complaince with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One (1) complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/17/18 through 7/19/18. Complaints were investigated during the survey. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 132 at the time of the survey. The survey sample consisted of 32 current Resident reviews and closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		8/22/18

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

Electronically Signed | 08/13/2018

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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§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview and staff interview, the facility staff failed to provide privacy in a manner that maintained or enhanced the dignity of the residents during a group meeting of the resident council.

The findings included:

During a group interview held on 7/18/18 at approximately 10:00 a.m., the facility staff failed to respect the resident's dignity, privacy, and individuality. The facility staff entered the area

On 7/25/2018 the Administrator attended Resident Council and apologized for the interruptions and for the staff's failure to provide privacy during their recent group meeting with the survey team.

Any Resident who attended the group meeting has the potential to be affected by the staff's failure to provide privacy. No other incidents of staff interrupting or failing to provide privacy while residents were in group meetings have been

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F 550	Continued From page 2 that the group meeting was held five times disturbing the group meeting. The group meeting was held in the dining area in the facility. This meeting was attended by seven (7) residents of the facility. During this meeting, there were five (5) different staff members entering the facility dining room to bring individual resident trays in to the kitchen and one (1) staff member brought a large tray cart into the dining room and went into the kitchen with these. At the start of the meeting, the social worker informed the surveyor that a sign had been placed on the dining room door stating there was a resident council meeting. The social worker also informed the surveyor that she would be standing outside of the door and directing staff not to enter while this meeting was ongoing. The surveyor notified the administrator of the above documented observations made while the resident council meeting was in progress on 7/18/18 at 11:30 am. The administrator stated, "I had the staff put up signs on the door so that the staff would know that there was a meeting in progress. I also told staff not to be entering the dining room while this meeting was ongoing." The survey team met with the administrator, the director of nursing and the corporate registered nurse on 7/18/18 at 4:18 p.m. During this meeting, the administrative staff was notified of the above. No further information was provided prior to the exit conference on 7/19/18.	F 550	reported by residents. Staff members will be provided in-service education on Resident Rights including but not limited to the importance of providing privacy in a manner that maintains or enhances the dignity of the residents during a group meeting of the resident council. The Administrator or designee will monitor Resident Council to validate that signs are posted to prevent interruptions and remain in the area to ensure privacy is provided to the group (monthly times three months). Results will be reported in the monthly Quality Assurance meeting (times three months) for further discussion and recommendations.	

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F 641	Continued From page 3	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		8/22/18

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 3 of 26 Residents in the survey sample, Resident #116, Resident #12 and Resident #133.

The Findings Included:

1. For Resident #116 the facility staff failed to ensure a complete and accurate Admission Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) of 7/4/18. The facility staff inaccurately coded Section J. Health Conditions J. 1800 Falls Since Admission.

Resident #116 was an 83 year old male who was admitted on 6/27/18. Admitting diagnoses included, but were not limited to the following: hypertension, cerebro-vascular accident (stroke) with hemiplegia, muscle weakness, dysphasia, Cancer of the Prostate and cognitive communication deficit.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Admission MDS assessment with an Assessment Reference Date (ARD) of 7/4/18. The facility staff coded that Resident #116 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #116 required extensive assistance

Resident #116's MDS ARD 7/4/18 was corrected/modified accurately coded for the 6/27/18 fall. Resident #12's Quarterly MDS ARD 3/21/18 corrected/modified to accurately code for use of alarms. Resident #133's Discharge MDS ARD 4/25/18 has been corrected/modified for accurate coding of a discharge home.

Any resident has the potential to be affected if MDS is not coded to accurately reflect resident's status. An audit of current residents' MDS assessments will be completed for accuracy of falls and alarms coding (Sections J and P). An audit of all discharged residents in the past fourteen days will be completed for coding accuracy for discharge destination (Section A).

The Regional RAI Coordinator will provide in-service education on coding accuracy to the MDS Coordinators including but not limited to the coding of falls, alarms and discharge destinations.

Peer to peer audits of the MDS assessments will be completed by the MDS Coordinators on a weekly basis (times twelve weeks) for coding accuracy in Sections J, P and A.

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F 641	Continued From page 4 (3/3) with Activities of Daily Living (ADL's). In Section J. Health Conditions J. 1800 Falls Since Admission the facility staff coded that Resident #116 had not had any falls since his admission into the facility. On July 17, 2018 at 2:46 p.m., the surveyor reviewed Resident #116's clinical record. Review of the clinical record revealed the Comprehensive Care Plan (CCP). The CCP identified that Resident #116 had had a fall since his admission into the facility. Continued review of the clinical record produced nursing progress notes that documented that Resident #116 fell on 6/28/18. The nursing progress notes documented that Resident #116 was found in the floor near the bottom of his bed at 1:15 a.m. On July 17, 2018 at 3:56 p.m., the surveyor spoke to the MDS Coordinator, who was a Registered Nurse (RN). The surveyor notified the MDS Coordinator that Resident #116's Admission MDS with the ARD of 7/4/18 was inaccurate. The surveyor reviewed the clinical record with the MDS Coordinator. The surveyor specifically reviewed the nursing progress note dated 6/28/18 that documented that Resident #116 had a fall out of bed. The surveyor then reviewed the Admission MDS with the ARD of 7/4/18 with the MDS Coordinator. The surveyor specifically pointed out that Section J. Health Conditions J. 1800 Falls Since Admission not code/capture Resident #116's fall on 6/28/18. On July 18, 2018 at 4:15 p.m., the survey team met with the Administrator (ADM), Director of Nursing (DON) and Corporate Compliance Nurse	F 641	Results will be reported in the monthly Quality Assurance meeting (times three months) for further discussion and recommendations.	

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F 641	Continued From page 5	F 641		

(CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate MDS assessment for Resident #116. The surveyor notified the AT that Resident #116 fell in the facility on 6/28/18. The surveyor notified the AT that Resident #116's Admission MDS assessment with the ARD of 7/4/18 did not code/capture the fall on 6/28/18.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #116.

2. The facility staff failed to code Resident #12's alarms on the quarterly minimum data set (MDS) assessment with an assessment reference date of 3/21/18.

The clinical record of Resident #12 was reviewed 7/17/18 through 7/19/18. Resident #12 was admitted to the facility 6/1/17 with diagnoses that included but not limited to Alzheimer's disease, dementia with behavioral disturbances, history of falls, hypertensive heart disease, and mood disorder.

Resident #12's annual MDS with an assessment reference date (ARD) of 6/4/18 coded the resident with a BIMS (brief interview for mental status) Summary Score of 4/15.

Resident #12's current comprehensive care plan initiated 6/22/17 and revised 6/13/18 identified falls as a focus area. Interventions/tasks: Bed alarm, chair alarm, concave mattress, dycem to seat of wheelchair, fall mats to side of bed when resident in bed, low bed, and non-skid strips in bathroom in front of toilet.

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The surveyor observed Resident #12 on 7/17/18 at 1:03 p.m. sitting at a table in the dining room having lunch. Resident #12 was sitting in a wheelchair. A chair alarm was observed attached to the wheelchair.

The surveyor observed Resident #12 again on 7/18/18 at 3:08 p.m. in the day room sitting in a wheelchair. A chair alarm was attached to wheelchair.

The surveyor reviewed Resident #12's clinical record. A physician order dated 7/14/17 read "Chair alarm check placement and function q (every) shift." A second physician order dated 7/14/17 read, "Bed alarm-check placement and function qshift."

The annual MDS with an ARD of 6/4/18 was coded for alarms (chair and bed); however, the quarterly MDS with an ARD of 3/21/18 did not have alarms coded (Section P0200).

The surveyor interviewed the MDS LPN #1 on 7/18/18 at 4:06 p.m. After reviewing the quarterly MDS, LPN #1 stated Section P of the MDS would be corrected.

The surveyor informed the administrative staff of the above concern on 7/18/18 at 4:18 p.m.

No further information was provided prior to the exit conference on 7/19/18.

3. The facility staff failed to have a complete and accurate MDS (Minimum Data Set) for Resident #133.

Resident #133 was admitted to the facility on 3/28/18 with the following diagnoses of, but not

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F 641	Continued From page 7 limited to anemia, diabetes, high blood pressure and depression. On the admission MDS with an ARD (Assessment Reference Date) of 4/11/18, the resident was coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. During the review of Resident #133's clinical record on 7/19/18, the surveyor noted that the discharge MDS with ARD of 4/25/18 under Section A2100, the MDS was coded with a "3" for discharge to "acute hospital". The surveyor also reviewed the nurses' notes and physician's orders for this resident. There was a physician order dated for 4/23/18, which stated, "Pt. (patient) scheduled to discharge home on Wednesday, 4/25/18 ..." The surveyor also reviewed the discharge instructions and under Section E, "Destination/Living Arrangements" read in part " ...Home with family ..." The surveyor notified MDS nurse #1 and DON (director of nursing) on 7/19/18 at approximately 1:15 pm of the above documented finding. MDS nurse #1 stated, "I will go and make that correction now." No further information was provided to the surveyor prior to the exit conference on 7/19/18.	F 641		
F 689 SS=D	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	F 689		8/22/18

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F 689	Continued From page 8 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to ensure an environment free of accident hazards for 1 of 26 Residents in the sample survey, Resident #116. The Findings Included: For Resident #116 the facility staff failed to implement physician ordered fall interventions. The facility staff failed to provide the physician ordered bed and a wheelchair personal alarm(s). Resident #116 was an 83 year old male who was admitted on 6/27/18. Admitting diagnoses included, but were not limited to the following: hypertension, cerebro-vascular accident (stroke) with hemiplegia, muscle weakness, dysphasia, Cancer of the Prostate and cognitive communication deficit. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Admission MDS assessment with an Assessment Reference Date (ARD) of 7/4/18. The facility staff coded that Resident #116 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #116 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On July 17, 2018 at 10:55 a.m., the surveyor observed Resident #116 sitting up in his wheelchair dressed in street clothes. The surveyor did not observed a wheelchair alarm.	F 689	Resident #116 has been re-assessed for appropriateness of bed/chair alarms and observed to be in place per physician orders. Any resident has the potential to be affected if staff fail to follow physician's orders. An audit of physicians' orders for bed and chair alarms has been completed for placement and functionality. Licensed Nursing staff will be in-serviced on ensuring physician ordered bed and chair alarms are in place. Audits of physician ordered bed and chair alarms to ensure placement will be conducted by the Unit Manager or designee (weekly times twelve weeks). Results will be reported in the monthly Quality Assurance meeting (times three months) for further discussion and recommendations.	

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F 689	Continued From page 9	F 689		

On July 17, 2018 at 12:32 p.m., the surveyor observed Resident #116 sitting in his wheelchair in the therapy gym. The surveyor did not observe a wheelchair alarm.

On July 17, 2018 at 12:41 p.m., the surveyor observed Resident #116 sitting in his wheelchair in his room. Resident #116 was feeding himself. The surveyor did not observe a wheelchair alarm.

On July 17, 2018 at 2:46 p.m., the surveyor reviewed Resident #116's clinical record. Review of the clinical record produced signed physician order sheets dated 6/28/18. Signed physician orders included, but were not limited to: "Bed Alarm-Check function and placement q (every) shift every shift for Safety Awareness. Chair Alarm-Check function and placement q shift every shift for Safety Awareness." (sic)

Continued review of the clinical record revealed the Comprehensive Care Plan (CCP). The CCP identified that Resident #116 had had one fall since his admission into the facility.

Further review of the clinical record produced nursing progress notes that documented that Resident #116 fell on 6/28/18. The nursing progress notes documented that Resident #116 was found in the floor sitting near the bottom of the bed at 1:15 a.m.

On July 17, 2018 at 02:50 p.m., the surveyor observed Resident #116 lying in bed and asleep. Once again the surveyor did not observed a bed alarm.

On July 17, 2018 at 3:56 p.m., the surveyor spoke to the MDS Coordinator, who was a

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Registered Nurse (RN). The surveyor notified the MDS Coordinator that Resident #116 had a history of falls and that the physician ordered safety/fall interventions. The surveyor notified the MDS Coordinator that the surveyor had observed Resident #116 on multiple occasions and that the surveyor had not observed a bed or a wheelchair alarm. The surveyor reviewed the signed physician orders with the MDS Coordinator and specifically pointed out the physician orders for a bed and a wheelchair alarm. The surveyor asked for the MDS Coordinator to accompany the surveyor down to Resident #116's room. The surveyor and MDS Coordinator walked down the hallway and entered Resident #116's room. Resident #116 was lying in his bed asleep. The MDS Coordinator searched Resident #116 and Resident #116's bed and was unable to locate a bed alarm. The MDS Coordinator stated she would locate Resident #116's Certified Nursing Assistant (C.N.A.) and see if additional information could be provided. The surveyor and MDS Coordinator stepped into the hallway and walked towards the nurses station.

Within a few moments the MDS Coordinator and Resident #116's Medication Nurse, who was an RN, stepped into the hallway and towards the surveyor. Resident #116's Medication Nurse pulled a personal alarm from her pocket and stated that earlier in the day someone had placed a broken personal alarm on her medication cart. The Medication Nurse stated that she was not notified who's personal alarm was broken and/or placed on her medication cart. The Medication Nurse started to walk down to Resident #116's room. The surveyor notified the Medication Nurse that Resident #116 had a history of falls. The surveyor also notified the Medication Nurse

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F 689	Continued From page 11 that the surveyor had made multiple observations of Resident #116 and that the wheelchair and bed alarm had not been in place. The Medication Nurse stated that the personal alarms are transferred from the bed to wheelchair or visa versa with each transfer of the resident. On July 18, 2018 at 4:15 p.m., the survey team met with the Administrator (ADM), Director of Nursing (DON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to implement physician ordered fall/safety interventions. The surveyor notified the AT that the physician ordered a bed and a wheelchair alarm for Resident #116 and that neither of the alarms had been in place during multiple observations of Resident #116. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure an environment free of accident hazards for Resident #116.	F 689		
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	F 757		8/22/18

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CARRIAGE HILL HEALTH AND REHAB CENTER	6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407

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F 757	Continued From page 12 §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, it was determined that the facility staff failed to ensure that 3 of 26 Residents in the sample survey was free from unnecessary medications, Resident #96, Resident #17 and Resident #38. The Findings Included: 1. For Resident #96 the facility staff failed to follow physician ordered blood pressure parameters in the administration of Midodrine 10mg and Midodrine 5 mg. Midodrine is a medication treats postural hypotension. Resident #96 was a 73 year old male who was originally admitted on 6/15/18 and readmitted on 7/2/18. Admitting diagnoses included, but were not limited to: Parkinson's disease, epilepsy, dysphagia, hypertension, depression, cognitive communicative deficit, osteoarthritis, dementia and orthostatic hypotension. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 5 Day Medicare and Admission MDS assessment with and Assessment Reference Date (ARD) of	F 757	Resident #96 received no negative outcome relating to the staff not following physician ordered blood pressure parameters in the administration of Midodrine. On 7\21\2018 a medication error report was completed for Resident #96 and the attending physician was notified accordingly. Resident #38 received no negative outcome relating to the staff not obtaining blood pressures as ordered by the physician. A review of Resident #38's medical record revealed there were no instances of blood pressure medication administration on dates with missing physician ordered blood pressures. Resident #17 received no negative outcome relating to the staff not obtaining a physician ordered accucheck. On 7/25/2018 a medication error report was completed for Resident #17 and the attending physician was notified accordingly. Any resident has the potential to be affected if staff fail to follow physician's orders for monitoring vital signs and blood sugars as ordered. An audit of resident	

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6/22/18. The facility staff coded that Resident #96 had a Cognitive Summary Score of 5. The facility staff also coded that Resident #96 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On July 18, 2018 at 8:06 a.m. the surveyor reviewed Resident #96's clinical record. Review of the clinical record produced physician orders dated 7/2/18. Signed physician orders included, but were not limited to: "Midodrine HCl Tablet 10 MG Give 1 tablet by mouth three times a day for Hypotension HOLD for SBP (systolic blood pressure) greater than 140. Midodrine HCl Tablet 5 MG Give 1 Tablet three times a day for Hypotension HOLD for SBP greater than 140." (sic)

Further review of the clinical record produced the July 2018 Medication Administration Records (MAR's). Review of the July 2018 July MAR's documented that Resident #96's systolic blood pressure was greater than 140 on multiple occasions. The July 2018 MAR's also documented that the physician ordered Midodrine systolic blood pressure parameters had not been followed, as the Midodrine had not been held.

The July 2018 MAR's documented the following:
7/3/18 at 4 p.m. blood pressure 156/83 Midodrine 5 mg was administered.
7/3/18 at 6 p.m. blood pressure 156/83 Midodrine 10 mg was administered.
7/6/18 at 6 a.m. blood pressure 166/95 Midodrine 10 mg was administered.
7/7/18 at 4 p.m. blood pressure 144/94 Midodrine 5 mg was administered.
7/8/18 at 9 a.m. blood pressure 141/68 Midodrine 5 mg was administered.

Medication Administration Records in the past 30 days was completed for validation that physician ordered blood pressure parameters relating to the administration of blood pressure medication was followed.
An audit of all resident Medication Administration Records in the past 30 days was completed for validation that physician ordered blood pressures were obtained and recorded prior to the administration of a blood pressure medication. An audit of all resident Medication Administration Records in the past 30 days was completed for validation that physician ordered accuchecks were completed and recorded.

In-service education will be provided to licensed nurses following physician ordered parameters for administration of medications, obtaining and recording physician ordered blood pressures prior to the administration of a blood pressure medication and obtaining and recording physician ordered accuchecks.

Unit Managers and/or designees will conduct a review of Medication Administration Records for validation that physician ordered blood pressure parameters are adhered to, physician ordered blood pressures are obtained and recorded and physician ordered accuchecks are obtained and recorded. These audits will be completed weekly for twelve weeks and any variances will be reported to the attending physician and the responsible nurse will receive

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F 757	Continued From page 14 7/14/18 at 12 noon blood pressure 141/76 Midodrine 10 mg was administered. On July 18, 2018 at 8:45 a.m., the surveyor observed the Director of Nursing (DON) walking towards the surveyor. The surveyor requested to speak with the DON. The surveyor informed the DON that Resident #96 had physician ordered blood pressure parameters related to the administration of Midodrine 10 and 5 mg, each ordered to be administered three times a day. The surveyor reviewed the July 2018 MAR's with the DON and specifically pointed out the dates that Resident #96's systolic blood pressure was greater than 140 and that the staff administered the Midodrine. The DON looked at the surveyor and said, "I see that." On July 18, 2018 at 4:15 p.m., the survey team met with the Administrator (ADM), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to follow physician ordered blood pressure parameters related to the administration of the Midodrine. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #96 was free from unnecessary medications. The facility staff failed to follow the physician ordered blood pressure parameters for the Midodrine. 2. The facility staff failed to obtain blood pressures as ordered by the physician when administering a blood pressure medication for Resident #38. Resident #38 was readmitted to the facility on 5/19/16 with the following diagnoses of, but not	F 757	associate education. Results will be reported in the monthly Quality Assurance meeting (times three months) for further discussion and recommendations.	

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limited to anemia, high blood pressure, diabetes and respiratory failure. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/3/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #38 was also coded as requiring extensive assistance of 2 staff members for dressing and extensive assistance of 1 staff member for personal hygiene. The resident was totally dependent on 1 staff member for bathing.

On 7/18 and 7/19/18, the surveyor performed a review of Resident #38's clinical record. It was noted by the surveyor that the physician had ordered the following for Resident #38: "check BP TID three times a day ...give Clonidine 0.1 mg (milligram) po (by mouth)for SBP (systolic blood pressure) >160 or DBP (diastolic blood pressure) >90." The surveyor also reviewed the MAR (Medication Administration Record) for Resident #38. The following dates and times were left blank on the MAR: "5/3 at 1400 (2 pm), 5/9 at 0600 (6 am), 5/14 at 1400 (2 pm), 5/16 at 1400 (2 pm), 5/26 at 2100 (9 pm), 5/27 at 2100 (9 pm), 5/29 at 1400 (2 pm), 6/1 at 0600 (6 am), 6/19 at 2100 (9 pm), 6/21 at 2100 (9 pm), 6/28 at 0600 (6 am) and 7/17 at 0600 (6 am)."

The surveyor notified the administrative team of the above documented findings on 7/18/18 at 4:18 pm in the conference room.

On 7/19/18 at approximately 1 pm, the director of nursing stated, "I have reviewed the clinical record and could not find any more blood pressures for the dates that were missing."

No further information was provided to the

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surveyor prior to the exit conference on 7/19/18.
3. The facility staff failed to obtain a physician ordered accucheck for Resident #17.

The clinical record of Resident #17 was reviewed 7/17/18 through 7/19/18. Resident #17 was admitted to the facility 4/11/14 and readmitted 8/17/16 with diagnoses that included but not limited to Type 2 diabetes mellitus, Parkinson's disease, dementia with behavioral disturbances, hypertension, depressive diosrder, mood disorder, chronic embolism and thrombosis, fall history, hypercholesterolemia, wandering, hypothyroidism, and presence of intraocular lens.

Resident #17's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/5/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score of 2/15. Section C Delirium assessed the resident with disorganized thinking, no evidence of psychosis and rejection of care occuring every 1 -3 days.

Resident #17's current comprehensive careplan initiated 4/21/14 and revised 4/13/18 identified that the resident was at risk for alterations in endocrine status r/t (related to) her diet controlled diabetes mellitus with potential for fluctuating blood sugar levels and hypothyroidism that may impact health status and day to day function. Interventions/tasks: Medication per MD (medical doctor) order. Observe for effectiveness and side effects. See MAR (medication administration record).

The July 2018 physician orders were reviewed. Resident #17 had the following order: Novolog Solution 100 unit/ml (milliliter) (Insulin Aspart)

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F 757	Continued From page 17 Inject as per sliding scale: if 150-200=2; 201-250=4; 251-300-6; 301-350=8; 351-400=10; 401-450=15, subcutaneously before meals and at bedtime for DM (diabetes mellitus) Type II Hold if BS (blood sugar) is less than 60 or greater than 450; notify MD. The surveyor reviewed the July 2018 electronic medication administration record (eMAR). The box for documentation of the blood sugar results for 7/1/18 at 2000 (8:00 p.m.) was blank. There were no recorded initials or results. The progress notes for 7/1/18 and 7/2/18 were reviewed. There was no documentation that the 7/1/18 8:00 p.m. blood sugar had been obtained or refused. The surveyor requested the assistance of the unit manager registered nurse #1 on 7/18/18 at 2:12 p.m. The unit manager after reviewing the eMAR stated "I'm not seeing a note for 7/1/18 at 2000 (8:00 p.m.)." The unit manager stated Resident #17 often refused care but that should have been documented as well. The surveyor informed the administrative staff of the above concern on 7/18/18 at 4:18 p.m. No further information was provided prior to the exit conference on 7/19/18.	F 757		
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	F 880		8/22/18

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diseases and infections.

§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

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F 880	Continued From page 19 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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, facility policy review and clinical record review the facility staff failed to follow professional standards of practice regarding infection control for 1 of 26 residents on reverse isolation precautions (Resident #125). Findings: The facility staff failed to follow professional standards of practice for reverse isolation control for Resident #125. The resident's clinical record was reviewed on 7/18/18 at 8:59 AM. The resident was admitted on 5/28/18. Her current diagnoses included pneumonia, neutropenia, chronic obstructive pulmonary disorder, diabetes, urinary tract infection, asthma,	F 880	Infection control concerns identified during survey rounds are duly noted and Resident #125 received no negative outcome relating to the staff not following professional standards of practice for reverse isolation precautions. Resident #125 has been discharged home with family. Any resident residing in the center is potentially at risk if staff fails to practice professional standards for isolation precautions. A review of current resident records revealed there were no other residents with physician orders for reverse isolation precautions. In-service education will be provided to	

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F 880	Continued From page 20 fibromyalgia and depression. The latest MDS (minimum data set) assessment dated 5/28/18 coded the resident with slightly impaired cognitive ability. She required nursing staff assistance for all the ADLs (activities of daily living. The resident's active physician's orders signed and dated 6/29/18, included, "Reverse isolation precautions every shift." (This was documented due to the resident's neutropenia.) On 7/17/18 at 9:14 AM Resident #125's CCP (comprehensive care plan) was reviewed. The document was reviewed and revised on 7/2/18. This documented the resident with anemia with neutropenia and thrombocytopenia. The interventions for nursing staff were: "Reverse isolation as per MD orders". 07/17/18 at 12:40 PM CNA I brought the resident back to room and wheeled her in. She then went back outside and brought in her lunch tray and set it up. She did not wear a mask during this process. Resident #125 had on mask in the hallway and in the room during this observation. The sign on Resident #125's door stated, "Reverse precautions (in addition to standard precautions) Perform hand hygiene when in room; follow standard precautions; Hand hygiene (foam/soap and water); Wear mask; Wear eye protection if splash/spray to eyes likely." On 07/18/18 at 09:48 AM CNA II entered the room and removed the resident's tray from her room without donning a mask. The resident is observed to be seated in her room in a w/c at this	F 880	staff members on adhering to professional standards for isolation precautions. Unit Managers and/or designees will conduct random rounds three times per week for twelve weeks to ensure isolation precautions are adhered to accordingly. Results will be reported in the monthly Quality Assurance meeting (times three months) for further discussion and recommendations.	

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F 880	Continued From page 21 time. She did not have on a mask. This information was shared with the facility administrator and the DON on 7/18/18 at 4:15 PM. The DON said they tried to follow the latest CDC (Centers for Disease Control) guidelines, but did not have a policy for reverse isolation precautions. She acknowledged the physician's order to implement same. No additional information was provided prior to the survey team exit.	F 880		