| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495153 | A. BUILDING _____ B. WING _____ | C 06/21/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDARS HEALTHCARE CENTER | 1242 CEDARS CT CHARLOTTESVILLE, VA 22903 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 6/19/18 through 6/21/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. Eight complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 6/19/18 through 6/21/18. Eight complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 143 certified bed facility was 131 at the time of the survey. The survey sample consisted of 26 current Resident reviews and five closed record reviews. | F 000 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br><br>To remain in compliance with all Federal and State regulations, the facility has taken or will take the action set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason J. Williams | TITLE: Administrator | (X6) DATE: 7/9/18

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

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| | 495163 | A. BUILDING _____ B. WING _____ | C 06/21/2018 |

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| F 550 | Continued From page 1<br>§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.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, family interview, and group interview, the facility staff failed to treat residents with dignity and respect. The facility staff also failed to ensure one of 31 resident's personal items were not moved and left the way the resident preferred.<br><br>1. The facility staff failed to treat residents with dignity and respect during care.<br><br>2. Resident #141 was upset after facility staff moved personal items in his room without his permission. | F 550 | F 550 Resident Rights/Exercise of Rights: Dignity and Respect<br><br>1. Resident #141 personal items were located and reviewed with the resident and care plan has been updated to include preferences.<br>2. Unit Managers reviewed current residents to ensure that they felt respected by staff, treated with dignity and personal preferences were being followed.<br>3. DON/Designee will in-serviced staff on treating residents with dignity and respect, not using cell phones at bedside while feeding or providing care, not moving residents belonging without their consent. Staff will be educated on following the resident's plan of care.<br>4. DON/Designee will interview 10 resident per week x4 and monthly x 2 to ensure they are being treated with dignity and respect, preferences are being followed and cell are not in use during care. Findings will be reported to QAPI committee monthly for 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 550 | Continued From page 2<br><br>Findings include:<br><br>1. During the initial tour 6/19/18 beginning at 10:30 a.m. a family interview was conducted. The family stated "When two CNA's come in to provide care for my mother, they talk over the bed to each other; they do not include her in any way, even to ask how she is doing."<br><br>On 06/20/18 at 08:42 a.m. a resident informed a surveyor CNA's will feed her and text on their phones in between bites. The resident stated that she has to tell them, "I'm ready for my next bite."<br><br>A group interview was conducted in the facility 6/20/18 beginning at 10:45 a.m. with eight cognitive residents in attendance. The resident group was unanimous that CNA's have earbuds in and plugged into their cell phones either listening to music, or talking to someone when they come in to provide care, make up a bed, or assist them to the bathroom. The group identified this was predominately on the 3-11 shift. The group further stated less cognitive residents think the CNA is talking to them, and will attempt to talk back but are ignored. One resident in the group stated "I bet they are not supposed to be on their cell phones at work."<br><br>On 6/21/18 at 3:00 p.m. the administrator and DON (director of nursing) were informed of the above findings. The administrator stated "Yes, we do have a policy about cell phone usage; it is not to be done."<br><br>No further information was provided prior to the exit conference. | F 550 | | |

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| F 550 | Continued From page 3<br><br>THIS IS A COMPLAINT DEFICIENCY.<br>2. Resident #141 was admitted to the facility on 1/27/18 with a re-admission on 5/31/18. Diagnoses for Resident #141 included neurogenic bladder, diabetes, high blood pressure, neuralgia, gout and hyperlipidemia. The minimum data set (MDS) dated 6/7/18 assessed Resident #141 as cognitively intact.<br><br>On 6/19/18 at 11:30 a.m., Resident #141 was interviewed about quality of life in the facility. Resident #141 stated he was upset because staff members had moved his clothes during the night without his permission. Resident #141 stated he placed clothes beside his bed last evening (6/18/18) so they would be ready for him to put on this morning. Resident #141 stated while he was asleep someone moved the clothes. Resident #141 stated when the aide came in this morning to help him dress, she could not find the clothes. Resident #141 stated the CNA (certified nurses' aide) eventually found the clothes in the dirty hamper. Resident #141 stated staff moving his personal items was "most irritating" to him. Resident #141 stated, "I don't want my things moved unless I oversee it and ok it so I know where things are." Resident #141 stated he has had similar issues in the past and reported his concerns to multiple nurses and aides. Resident #141 stated staff members "treat me like a child" and gave him a "patronizing" response when he complained about moved items. Resident #141 stated he sometimes was out of the facility during the day and when he returned found personal items moved without his permission.<br><br>Resident #141's clinical record documented a nursing note dated 6/19/18 at 10:33 a.m. stating | F 550 | | |

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| F 550 | Continued From page 4<br>the resident was "yelling and cursing" about his missing clothes. The note documented, "Resident yelling 'the clothes were on my tub last night and people can't keep their hands off my stuff'."<br><br>On 6/21/18 at 9:45 a.m., CNA #1 caring for Resident #141 was interviewed about the moved clothing. CNA #1 stated the resident likes to put out what he wants to wear for the next day. CNA #1 stated she had no problems with Resident #141 getting upset because she lets him direct what he wants to do with his items. CNA #1 stated it was known that Resident #141 was sensitive about clothing and items moved in his room without his approval. CNA #1 stated, "He [Resident #141] wants to control his clothes and things." CNA #1 stated the resident was upset on the morning of 6/19/18 because the clothes he put out had been moved while he was asleep.<br><br>On 6/21/18 at 9:52 a.m., the licensed practical nurse (LPN #3) caring for Resident #141 was interviewed about the resident getting upset over moved clothing. LPN #3 stated on Tuesday (6/19/18) the aide moved his clothing during the 11:00 p.m. to 7:00 a.m. shift. LPN #3 stated Resident #141 "got very upset" when he saw the clothing was not there. LPN #3 stated the resident was sensitive about his personal items and got upset when they were moved without his permission. When asked what interventions were implemented to respect the resident's requests about his items, LPN #3 stated they tried to avoid moving his personal items/clothing without his permission. LPN #3 stated issues with Resident #141 "depended on the aide, whether they know him or not." | F 550 | | |

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| F 550 | Continued From page 5<br>On 6/21/18 at 10:23 a.m., the unit manager (LPN #4) was interviewed about staff members moving Resident #141's personal items without permission. LPN #4 stated it was known that Resident #141 did not want staff moving his items without permission. LPN #4 stated they recently hired some new staff members on the 11:00 p.m. to 7:00 a.m. shift. LPN #4 stated the aide caring for Resident #141 on the early morning of 6/19/18 was not aware of his requests and put the clothes away without his permission.<br><br>Resident #141's plan of care (revised 6/6/18) documented the resident gets upset and yells when personal items were moved in his room. The care plan stated, "Resident prefers his personal items close and within reach and not moved around." Interventions to minimize behaviors included, "Anticipate and meet resident's needs. Offer me assistance with decluttering my room...Intervene as necessary to protect the rights and safety of others...Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations..."<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/21/18 at 3:00 p.m. | F 550 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. | F 561 | | |

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| F 561 | Continued From page 6<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview and staff interview, the facility staff failed to honor preferences for two of 31 residents, Resident #103 and Resident #48.<br><br>1. Resident #103 stated that she was unable to get coffee in the mornings before breakfast.<br><br>2. The facility staff failed to honor Resident # 48's preference for a cup of coffee and a sandwich before bed.<br><br>Findings were:<br><br>1. Resident #103 was admitted to the facility on 01/02/2018. Her diagnoses included but were not | F 561 | F 561: Self determination<br><br>1. Resident #103 has coffee delivered daily prior to breakfast. Resident #48 has coffee and a sandwich delivered prior to bed.<br>2. Unit managers/dietary manager/designee conducted an audit of current residents to obtain food preferences.<br>3. DON/Designee will educate staff on completing resident's preference timely.<br>4. DON/Designee will interview 10 residents per week x4 weeks and monthly x2 to ensure their dietary preferences are being followed. Findings will be reported to QAPI committee monthly for 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 561 | Continued From page 7<br>limited to: Major depressive disorder, Atrial flutter, hypothyroidism, end stage renal disease with dialysis, hypertension, and cerebrovascular disease.<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/18/2018. Resident #103 was assessed as being cognitively intact with a summary score of "15".<br><br>On 06/20/18 at approximately 2:17 PM Resident #103 was observed in the dining room waiting to play bingo. Resident #103 was asked how things were going. She stated that she had repeatedly asked to have her coffee first thing in the morning. She stated she had been told that she had to wait for the breakfast trays to be delivered.<br><br>At approximately 4:00 p.m., Resident #103 was interviewed in her room. She repeated her concerns over her morning coffee. She stated, "I use to be able to go out and get my own but they stopped letting us do that a couple of months ago. Since then I have to wait for them to bring it to me...I like to drink my coffee and then eat my breakfast...When I ask the CNAs [certified nursing assistants] to get me a cup in the morning, they tell me to wait a minute, the trays are coming...I keep telling them I want my coffee before my tray comes but that doesn't help....the hall I live on is the last to get trays so my breakfast isn't up here until 8:30 or later. If I drink my coffee off of my tray and then eat, my food is cold."<br><br>A meeting was held with the administrator and the DON (Director of Nursing) on 06/21/2018 at | F 561 | | |

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| F 561 | Continued From page 8<br>approximately 8:15 a.m. The above information was discussed regarding Resident #103's request for morning coffee. The administrator stated the facility no longer has a hot fluid hospitality station due to company policy. The DON stated that they can put in a request for dietary to send coffee up to her first thing in the morning prior to breakfast tray coming.<br><br>No further information was obtained prior to the exit conference on 06/21/2018.<br>2. A group interview was conducted in the facility 6/20/18 beginning at 10:45 a.m. with eight cognitive residents in attendance. Resident # 48 was present and stated "I don't understand why I can't get a cup of coffee before I go to bed. I used to be able to go in the dining room and get one, but they changed things and now I have to ask for it. I've asked for some now, and have yet to get my coffee. They will tell me "I'll go get it" but I never get it. I also have asked for a peanut butter and jelly sandwich at bedtime, not every night, but sometimes. I have yet to get that either." Resident # 48 further stated coffee helped him relax prior to going to bed.<br><br>On 6/21/18 at 3:00 p.m. the administrator and DON (director of nursing) were informed of the above findings. The DON stated "That is not an unreasonable request; I didn't know he wanted coffee and a sandwich. I will make sure that happens."<br><br>No further information was provided prior to the exit conference. | F 561 | | |
| F 567 SS=C | Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) | F 567 | | |

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| F 567 | Continued From page 9<br>§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.<br>(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.<br>(ii) Deposit of Funds.<br>(A) In general: Except as set out in paragraph (f)( l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br>(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. | F 567 | F567: Protection/Management of Personal Funds<br>1. Resident #31 now has access to personal funds during weekend hours.<br>2. ED reviewed banking hours to ensure proper posting and staff availability to provide access to funds after hours.<br>3. BOM/Designee will educate staff that residents funds are available 24 hours a day.<br>4. BOM/Designee will interview 5 residents a week x 4 and monthly x2 to ensure that they have access to their funds when needed. Findings will be reported to QAPI committee monthly for 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 567 | Continued From page 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident interview and staff interview the facility failed to ensure money was available to resident's during the weekend.<br><br>Resident's are unable to get petty cash (money less than $100.00) during the weekend.<br><br>The findings Include:<br><br>Resident #31 was admitted to the facility on 09/6/13 with a readmission on 3/20/18. Diagnoses for Resident # 31 included: Respiratory infection, and cerebrovascular accident.<br><br>The most current MDS (minimum data set)with a cognitive status was a 5 day assessment with an ARD (assessment reference date) of 3/27/18. Resident #31 was assessed with a cognitive score of 13, indicating cognitively intact.<br><br>On 06/20/18 at 08:57 AM, Resident #31 was interviewed. When asked about being able to get money from the facility during the weekend, Resident #31 verbalized that money isn't available on weekends.<br><br>On 06/20/18 at 09:55 AM, the business manager (other staff, OS #1) was interviewed concerning money availability on weekends. OS #1 verbalized banking hours are from 10:00 AM to 2:00 PM Monday through Friday and they don't have banking hours on weekends. OS #1 verbalized that resident's can get petty cash during weekends via the receptionist. OS #1 went on to verbalize that the receptionist would have to call her (business manager) and she | F 567 | | |

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| F 567 | Continued From page 11<br>would come in and give the resident the money. When asked if the receptionist is here all the time including evenings, OS #1 verbalized that the receptionist was here during the day. This surveyor asked if a resident wanted to order a pizza on a Saturday evening and needed money, would the resident have access to money. OS #1 verbalized that there would be no money available for resident.<br><br>On 6/20/18 at 10:45 AM a group interview was conducted consisting of 7 cognitively intact residents. The group was asked about availability of money on weekends. The group indicated that there was no petty cash available on weekends.<br><br>On 6/21/18 at 8:30 AM the above finding was brought to the attention of the administrator and director of nursing (DON). The DON nodded her head.<br><br>No other information was provided prior to exit conference on 6/21/18. | F 567 | | |
| F 584 SS=B | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can | F 584 | | |

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| F 584 | Continued From page 12<br>receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to ensure a wheelchair was in good repair for one of 31 residents in the survey sample.<br><br>The covering on both arm cushions of Resident #3's wheelchair was cracked with exposed foam.<br><br>The findings include: | F 584 | F 584<br>Safe/Clean/Comfortable/Homelike Environment<br><br>1. Resident # 3 Wheelchair was replaced on 6/20/18<br>2. Maintenance Director/Designee will audit current resident wheelchairs to ensure all wheelchair arm are in good repair.<br>3. DON/Designee will provide educate to all staff on the procedure for requesting maintenance services and identifying wheelchair maintenance needs.<br>4. Maintenance Director/Designee will audit 10% of facility wheelchairs weekly x 4 weeks and monthly x2 to ensure all wheelchairs arms are in good condition. Findings will be reported to QAPI monthly x 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 584 | Continued From page 13<br>Resident #3 was admitted to the facility on 03/20/17 with a readmission on 10/09/17. Diagnoses for Resident #3 included: cerebral palsy, muscle weakness, hyperlipidemia, seizure disorder, anxiety disorder, depression, dysphasia, moderate intellectual disability, constipation, pain, tracheostomy, and gastro-esophageal reflux disease (GERD). The minimum data set (MDS) dated 06/06/18 assessed Resident #3 as severely cognitively impaired.<br><br>On 06/20/18 at 1:34 p.m., Resident #3's wheelchair was observed. The covering on both arm cushions were cracked along the outer edges with yellow foam visible. The left arm cushion had a tear approximately an inch long with yellow foam visible.<br><br>On 06/20/18 at 3:46 p.m., accompanied with the maintenance director, Resident #3's wheelchair was observed with the cracked armrest cushions. The maintenance director stated nursing was responsible for entering work orders for any equipment items needing repair. The maintenance director stated he was not aware the wheelchair was in disrepair.<br><br>On 06/20/18 at 4:00 p.m., the licensed practical nurse (LPN #2) caring for Resident #3 was interviewed about the wheelchair in disrepair. LPN #2 stated she did not realize the armrests were in disrepair. LPN #2 stated nurses were responsible for sending work orders to maintenance when repairs were needed.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 06/21/18 at 8:17 | F 584 | | |

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| F 636 | Continued From page 14 | F 636 | | |
| F 636 | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in | F 636 | F 636 Comprehensive Assessments and timing<br><br>1. Resident #19's cognitive status, mood and pain were evaluated. Resident #31's cognitive status and pain were evaluated. Resident #90's cognitive status and mood were evaluated. Any identified changes were evaluated and plan of care was reviewed and revised accordingly.<br>2. MDS/Designee reviewed current resident assessments in the last 30 days. If any resident's assessments were identified with dashes in sections C, D, or J, resident's cognitive patterns, pain and mood were evaluated and any identified changes were addressed as indicated. | |

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| F 636 | Continued From page 15<br>assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to complete a comprehensive assessment for three of 31 residents in the survey sample, Resident #'s 19, 31, and 90.<br><br>1. Resident #19 did not have sections C, D, and J completed on a quarterly comprehensive assessment.<br><br>2. Resident #31 did not have sections C and J completed on a significant change assessment.<br><br>3. Resident #90 did not have sections C and D completed on a annual assessment. | F 636 | 3. Regional MDS coordinator/ Designee will provided education to the IDT team on the timing required for the completion of section C, D, and J of the MDS in accordance with the RAI guidelines. MDS interviews for section C, D and J that are not completed on or before the assessment reference date will be coded with dash indicating that the interview was not completed during the lookback period in accordance with the RAI guidelines. The quarterly assessment, Significant change assessment and annual assessment requirements will be fulfilled by completing interviews during the completion period and documenting resident responses in the PCC user defined assessments<br>4. MDS Coordinator/designee will review all completed resident assessments section C for 30 days and then 10% monthly x 2. Findings will be reported to QAPI for review monthly for 3 months.<br>5. Date of compliance: July 20th, 2018 | |

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| F 636 | Continued From page 16<br>The findings Include:<br><br>1. Resident #19 was admitted to the facility on 01/9/15. Diagnoses for Resident # 19 included: Alzheimer's, anxiety, and depression.<br><br>The current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/23/18. Resident #19 was not assessed with a cognitive score.<br><br>On 6/19/18 Resident #19's record was reviewed. The current MDS dated 3/27/18 documented section C, D, and J as not assessed.<br><br>On 06/19/18 04:51 PM registered nurse, MDS coordinator (RN #1) was interviewed regarding missing sections on Resident #19's MDS. RN #1 verbalized that all sections of the MDS should be completed prior to the ARD date or the system would not allow the coordinator to enter the information.<br><br>RN #1 reviewed Resident #19's MDS and verbalized that assessments were not being done timely, because the facility had gotten behind due to only having one MDS coordinator for a period of time; the coordinator was responsible for section J. RN #1 also verbalized section C and D was done by SW and the facility did not have a social worker for a period of time.<br><br>On 6/21/18 at 8:30 AM the above information was presented to the director of nursing (DON) and administrator during a meeting.<br><br>On 6/21/18 at 11:30 AM the DON presented assessments that were done after the ARD of Resident #19. This surveyor verbalized | F 636 | | |

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| F 636 | Continued From page 17<br>understanding that the facility had identified an issue with missing sections on MDS's, and had done paper assessments for residents, but the issue was not submitting a complete assessment to CMS (Center for Medicaid and Medicare Services).<br><br>No other information was presented prior to exit conference on 6/21/18.<br><br>2. Resident #31 was admitted to the facility on 09/6/13. Diagnoses for Resident # 31 included: Chronic obstructive pulmonary disease, sepsis,and major depressive disorder.<br><br>The current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 4/3/18. Resident #31 was not assessed with a cognitive score.<br><br>On 6/20/18 Resident #31's record was reviewed. The current MDS dated 4/3/18 documented section C, and J as not assessed.<br><br>On 06/20/18 at 08:45 AM registered nurse, MDS coordinator (RN #1) was interviewed regarding missing sections on Resident #31's MDS. RN #1 reviewed Resident #31's MDS and verbalized that section "J" should have been completed by the MDS coordinator and it was either late or missed, and section "C" should have been done by the social worker and the social worker was hired in April and it was missed.<br><br>On 6/21/18 at 8:30 AM the above information was presented to the director of nursing (DON) and administrator during a meeting.<br><br>On 6/21/18 at 11:30 AM the DON presented | F 636 | | |

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| F 636 | Continued From page 18<br>assessments that were done after the ARD of Resident #19. This surveyor verbalized understanding that the facility had identified an issue with missing sections on MDS's, and had done paper assessments for residents, but the issue was not submitting a complete assessment to CMS (Center for Medicaid and Medicare Services).<br><br>No other information was presented prior to exit conference on 6/21/18.<br>3. Resident # 90 was admitted to the facility on 05/31/16 with diagnoses including, but not limited to: dementia, anxiety disorder, depression, and borderline personality disorder.<br><br>The most recent MDS was an annual assessment dated 06/04/18. This MDS did not assess the resident's cognitive status and/or memory. Section C. Cognitive Status of the MDS was 'not assessed.' Section D. MOOD was 'not assessed.'<br><br>On 06/20/18 at 11:00 AM, the DON was interviewed regarding MDS coding for Resident # 90. The DON stated that the MDS coordinator handles that.<br><br>On 06/20/18 at 11:02 AM, the MDS coordinator was interviewed regarding the areas on Resident # 90's MDS that were not assessed. The MDS coordinator stated that it was 'either missed, or it didn't get done." The MDS coordinator stated that the Social Services department (SW) is responsible for those sections.<br><br>On 06/21/18 at 10:23 AM, the SW was interviewed regarding Resident # 90's MDS. The SW stated that she started working here on April | F 636 | | |

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| F 636 | Continued From page 19<br>9th, 2018 and further stated, "I did not get to it in that time frame, I am the only SW."<br><br>The DON and administrator were made aware of the above findings in a meeting with the survey team on 06/21/18 at approximately 5:30 p.m.<br><br>No further information and/or documentation was presented prior to the exit conference on 06/21/18. | F 636 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility staff failed for one of 31 residents in the survey sample (Resident # 76) to ensure a complete and accurate Minimum Data Set.<br><br>Resident # 76 had an Annual Minimum Data Set with an incorrect entry at Section G (Functional Status).<br><br>The findings were:<br><br>Resident # 76 was admitted to the facility on 5/30/17, and most recently readmitted on 3/17/18, with diagnoses that included hypertension, diabetes mellitus, seizure disorder, depression, encephalopathy, generalized muscle weakness, and Muscular Dystrophy.<br><br>According to the most recent Minimum Data Set | F 641 | F 641: Accuracy of Assessments<br><br>1. Resident #76 continues to reside at the facility. Resident #76 MDS was corrected to show current level of function.<br>2. RNAC/Designee will audit current residents assessments that were completed in the last 30 days, if any inaccuracies in section G are identified a MDS correction will be completed.<br>3. DON/Designee will in-services the IDT RNAC on coding ADLS accurately per the RAI guidelines.<br>4. RNAC/Designee will audit 10% of section G submitted monthly to ensure accuracy of ADL coding. All findings will be reported to QAPI monthly for 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 641 | Continued From page 20<br>(MDS), an Annual with an Assessment Reference Date of 5/5/18, the resident was assessed under Section G (Functional Status), at Item G0110.H (Activities of Daily Living Assistance - Eating) as an 8/8, indicating the activity (eating) did not occur. The resident was receiving nutrition by means of Peg (Percutaneous endoscopic gastrostomy) Tube.<br><br>According to CMS's RAI Manual, the resident should have been assessed as totally dependent with one person physical assist (4/2) for eating. (Ref. CMS's RAI Version 3.0 Manual, Chapter 3, page G-18, September 2010)<br><br>At 8:30 a.m. on 6/20/18, RN # 1 (Registered Nurse), the MDS Coordinator, was interviewed regarding the assessment of Resident # 76's eating skills. After reviewing the documentation regarding the resident's eating skills, RN # 1 indicated that the assessment of 8/8 (the activity did not occur) was incorrect.<br><br>The finding was brought to the attention of the Director of Nursing and the Administrator during a meeting with the survey team at 8:15 a.m. on 6/21/18. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial | F 656 | | |

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| F 656 | Continued From page 21<br>needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, and clinical record review, the facility staff failed to develop a care plan for one of 31 residents , Resident #21.<br><br>Resident #21 did not have a care plan to address | F 656 | F656: Develop/Implement Comprehensive Care Plan<br><br>1. Resident #21 no longer resides at the facility.<br>2. Audit was conducted on current residents with diagnosis of depression to assess for suicide ideation. Resident with suicidal ideations identified and care plan was reviewed and revised.<br>3. DON/Designee educated license staff on updating resident's comprehensive plan of care to reflect mood/suicidal ideations.<br>4. DON/Designee will review daily clinical meeting 3 times a week for 4 weeks and weekly x 2 months for residents with suicidal ideations and ensure care plan is reviewed and revised. Findings will be reported to QAPI monthly for 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 656 | Continued From page 22<br>suicidal ideation's.<br><br>The Findings Include:<br><br>Resident #21 was admitted to the facility on 10/6/17. Diagnoses for Resident #21 included: Hemiplegia, muscle weakness, and cerebral infarction.<br><br>The most current MDS (minimum data set) was a quarterly with an ARD (assessment reference date) of 3/24/18. Resident #21 was assessed with a cognitive score of 15, indicating cognitively intact.<br><br>On 6/20/18 Resident #21's record was reviewed. A nursing note dated 4/17/18 documented that Resident #21 was overheard talking to a suicidal hotline. Subsequently Resident #21 was transferred to the emergency department and later discharged back to the facility with a suicidal behavior contract.<br><br>Resident #21's care plan was then reviewed and did not indicate a care plan was developed for suicidal ideation's.<br><br>On 6/21/18 at 8:30 AM, the above information was presented to the director of nursing (DON) and administrator. The DON verbalized that the nurses knew about the suicidal contract and were paying attention to Resident #21's mood and actions and documenting in the nurses notes.<br><br>On 06/21/18 at 10:26 AM, the social worker was interviewed concerning the above finding. The social worker reviewed the hospitals suicide contract and verbalized a care plan should have been developed for suicidal precautions so that | F 656 | | |

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| F 656 | Continued From page 23<br>all nursing staff were aware of the concern.<br><br>No other information was provided prior to exit conference on 6/21/18. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed review and | F 657 | F 657: Care Plan Timing and revision<br>1. Resident #41 continues to reside at the facility. Resident #41 is now being assist by staff with meals and care plan has been reviewed and revised to include weight loss interventions. Resident #140 continues to reside at the facility. Resident #140 care plan was reviewed and revised to include correct code status.<br>2. RD/Designee will review all current residents with significant weight loss to ensure care plan is updated to reflect current status and weight loss interventions. SSD/Designee conducted an audit on all current residents' code status to ensure care plan is accurate.<br>3. DON/Designee will educate the IDT team and licensed staff on the process of updating and revising comprehensive care plans timely and accurately. | |

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| F 657 | Continued From page 24<br>revise the CCP (comprehensive care plan) for two of 31 residents in the survey sample, Resident # 41 and Resident # 140.<br><br>1. The facility staff failed to review and revise the CCP for Resident # 41 for weight loss prevention. Resident # 41 had total weight loss of over 25 lbs (pounds) from January 2018 to present (June 2018) with no new and or revised interventions.<br><br>2. The facility staff failed to review and revise the CCP code status for Resident #140.<br><br>Findings include:<br><br>1. Resident # 41 was admitted to the facility on 12/14/17. Diagnoses for Resident # 41 included, but was not limited to: Alzheimer's disease, dysphagia, osteoarthritis, and osteoporosis.<br><br>The most current MDS (minimum data set) was a quarterly assessment dated 04/17/18. This MDS assessed the resident with a cognitive score of 5, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from staff for most ADL's (activities of daily living) and assessed as set up with limited assistance for nutritional intake.<br><br>On 06/19/18 at 1:15 PM, Resident # 41 was sitting in his wheelchair with his bedside table in front of him. The resident's meal tray was delivered, opened and set up by aides. The aides then left the room. Resident # 41's tray had pasta, garlic bread, mixed vegetables, a power shake (sysco strawberry/banana) in a small carton, and a mixed fruit bowl. Resident # 41 picked up the bowl of fruit and asked to 'open' it, no staff | F 657 | 4. DON/Designee will review new admission care plans for accurate code status for 3 months. DON/Designee will review all residents with significant weight loss to ensure interventions are care planned timely and accurately. Findings will be reported to QAPI monthly for 3 months to review compliance.<br><br>Date of compliance: July 20th, 2018 | |

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| F 657 | Continued From page 25<br>members were present. The resident then picked up his shake and put finger down in the opening. The resident then picked up the bread and took a bite. The resident continued to handle the shake, pulling on the carton opening (it was already opened) and then picked up his fork and stuck the fork in the shake carton. No staff members were present or available to assist the resident. Resident # 41 was having difficulty feeding himself.<br><br>Resident # 41's current POS (physician's order set) was reviewed and documented that the resident was to have a NAS (no added salt) mechanical soft texture with thin consistency.<br><br>The resident's current CCP (comprehensive care plan) documented, "...potential nutritional problem...monitor/document/report...dysphagia, pocketing, choking, coughing...several attempts to swallow...appears concerned during meals...monitor/record/report...signs/ symptoms of malnutrition...significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months...weigh per orders...consult with dietitian and change if chewing/swallowing problems are noted..."<br><br>Resident 41 was observed on 06/20/18 at approximately 9:00 a.m. The resident's tray was in front of him with approximately 30-50% of the meal eaten, and 100% of the milk consumed. The resident was asked if he wanted more to eat and the resident stated that he didn't want anymore. The resident had scrambled eggs, oatmeal, 2% milk, coffee and juice. No assistance was observed with the resident's meal consumption. | F 657 | | |

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| F 657 | Continued From page 26<br>On 06/21/18 at approximately 8:55 a.m., the resident was observed in bed with his bedside table in front of him with his breakfast tray. The resident had scrambled eggs, 2 pancakes, ground sausage and oatmeal. The resident's tray had 4 opened packets of sugar on it, along with one opened syrup pack (observed on the pancakes), and one unopened butter packet. The resident had one carton of 2% milk. The resident was feeding himself with little difficulty. The resident stated, "Can you cut that [pancakes] my mouth ain't that big." The resident drank all of his milk and ate approximately 50% of the meal. The resident did not eat any of the oatmeal. No assistance was observed with meal consumption.<br><br>On 06/21/18 at approximately 9:15 a.m., the DON and administrator were made aware of the above information regarding Resident # 41 and was asked for an interview with the registered dietitian (RD). Information regarding fortified foods was also requested at this time.<br><br>A RD note dated 02/04/18 documented a weight of "171.8 returning the resident to previous baseline" and identifying the resident as "remains at high risk for unintentional weight loss related to diagnoses and age."<br><br>The resident lost a total of 18.3 lbs in approximately 1 month, from 03/09/18 to 04/06/18. A total loss to date was 24.9 lbs in less than 3 months; the resident's weight records revealed that the resident had been weighed on a weekly basis, but did not get weighed at all for nearly a month during which time he experienced a significant weight loss.<br><br>An RD noted dated 04/23/18 documented, | F 657 | | |

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| F 657 | Continued From page 27<br>"...Weight Warning: Value: 147.4...may be 'down' and that may be impacting his appetite...has refused dinner trays at times..fortified foods, 120 cc med pass every day...weekly weights..."<br><br>An RD note dated 06/11/18 documented, "...146.4...fortified foods began on 04/23, 120 cc med pass began on 04/24 related to history of weight loss...continues with confusion...continue POC..."<br><br>On 06/21/18 at approximately 11:00 a.m., the RD was interviewed. The RD was made aware of concerns regarding Resident # 41's significant weight loss. The RD was asked about fortified foods. The RD presented a list of items and stated, "It's basically added fats and calories" and went on to explain that it would consist of food items, such as oatmeal, mashed potatoes, and whole milk.<br><br>The list was reviewed and documented, "fortified cereal, hot of choice portion size 3/4 cup, oatmeal, cream of wheat, and rice" and "fortified potatoes, mashed portion size 1/2 cup."<br><br>The RD was asked how is it ensured that a resident gets fortified foods. The RD couldn't answer the question. The RD was informed of Resident # 41's 7.6 lb weight loss in a month. The RD stated, "We couldn't verify a cause of the weight loss, he was eating the same amounts." The RD was again asked how to ensure fortified foods are given to resident's who need them. The RD stated that there is really no way of knowing.<br><br>The RD was made aware that the resident's CCP | F 657 | | |

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| F 657 | Continued From page 28<br>did not have information regarding the residents interventions for fortified foods and/or the med pass supplementation, no information regarding cueing the resident or assisting as needed with meal consumption as documented by the RD in the nutritional assessment and nutritional review.<br><br>The RD was given Resident # 41's meal ticket for 06/21/18 breakfast. The ticket documented, NAS mechanical soft FORTIFIED FOODS Pancakes 2, margarine 1, syrup 1, ground sausage patty 2 ounces, cream gravy 2 ounces, oatmeal 3/4 cup, and milk 8 ounces. The RD was made aware that the resident's milk was 2% that morning, not whole and the meal ticket did not specify whole milk, the resident's margarine was not opened and the resident did not get the gravy. The resident did not eat the oatmeal.<br><br>The RD stated that he understood, but could not explain how a resident with fortified foods is tracked to ensure they are getting the foods.<br><br>The RD was then asked about the resident's weight record and the RD stated that the resident was on weekly weights. The RD was made aware that the resident did not get weighed for one month and lost about 18 lbs during that month. The RD stated that he did not know why the resident was not weighed, as there was nothing to indicate that the weights be stopped.<br>2. Resident #140 was admitted to the facility on 05/08/18 with diagnoses that included diabetes, depression, legal blindness (right eye), hypokalemia, repeated falls, muscle weakness, difficulty walking, cognitive communication deficient, and bilateral glaucoma. The minimum data set dated 06/05/18 assessed Resident #140 as cognitively intact. | F 657 | | |

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| F 657 | Continued From page 29<br><br>The clinical record was reviewed on 06/20/18 at 1:45 p.m. Observed on the physician orders were orders for Do Not Resuscitate, dated 05/08/18. Observed on the medication review report was an order for Do Not Resuscitate, dated 05/08/18.<br><br>Resident #140's CCP was reviewed on 06/20/18 at 2:02 p.m. A focus area for "Code Status" was observed. The code status was shown as Full Code. The date initiated was listed 5/10/18. The revision date was listed as 5/10/18.<br><br>On 06/20/18 at 4:06 p.m., the social services director (SSD) was interviewed regarding the code status care plan. The SSD stated she updates care plans as soon as she is notified of any changes. She stated this one was overlooked.<br><br>These findings were reviewed with the administrator and director of nursing on 06/21/18 at 8:17 a.m. | F 657 | | |
| F 658 SS=G | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to follow professional standards of care for one of 31 | F 658 | Past noncompliance: no plan of correction required. | |

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| F 658 | Continued From page 30<br>residents in the survey sample.<br><br>Resident #135's daily dosage of the anti-seizure medication Dilantin (Phenytoin) was increased in error when it should have been decreased. Nursing failed to clarify or question the erroneous dosage prior to administering the medication. The increased dosage caused Resident #135's Dilantin level to exceed therapeutic levels resulting in slurred speech, headache, chest pain and a decline in muscle coordination. The resident was diagnosed with Dilantin toxicity due to the increased dosage and was hospitalized for four days for treatment of the non-therapeutic levels.<br><br>The findings include:<br><br>Resident #135 was admitted to the facility on 3/25/16 with a re-admission on 4/20/17. Diagnoses for Resident #135 included convulsions, high blood pressure, neurogenic bladder, paraplegia, lymphedema and osteoporosis. The minimum data set (MDS) dated 4/27/18 assessed Resident #135 as cognitively intact.<br><br>Resident #135's clinical record documented a physician's order dated 3/7/17 for Dilantin 400 mg (milligrams) once per day for treatment of seizures. The resident's medication administration record (MAR) documented the Dilantin was administered as ordered.<br><br>A lab test report dated 4/3/17 documented the resident's Dilantin level was high with a reading of 22.8 ug/mL (micrograms per milliliter) with a reference range of 10.0 to 20.0 ug/mL. The nurse practitioner (NP) was notified and entered | F 658 | | |

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| F 658 | Continued From page 31<br>an order on 4/4/17 to change the resident's Dilantin dosage from 400 mg per day to 350 mg twice per day with a repeat Dilantin level check in four weeks.<br><br>The clinical record documented the order was entered as written with the resident administered 350 mg of Dilantin twice per day starting on 4/4/17. The record documented no questioning or clarification of the order that actually increased the resident's daily Dilantin dose instead of decreasing the dose.<br><br>Following the Dilantin dose change on 4/4/17, nursing notes documented the resident was assessed with chest pain and inability to assist with transfers starting on 4/12/17. The record documented the NP was notified and entered an order on 4/12/17 to send the resident to emergency room for evaluation. A note dated 4/12/17 at 12:31 p.m. documented the resident stated she was not short of breath, only felt weak and did not want to go the to the emergency room. The NP ordered additional lab work, a chest x-ray and an EKG. The NP evaluated Resident #135 on 4/13/18, assessed the resident with cough and nasal congestion and ordered Claritin, azithromycin (antibiotic) and Mucinex for treatment of an upper respiratory infection. There was no re-check of the resident's Dilantin level.<br><br>A nursing note dated 4/14/17 documented the resident complained of feeling lethargic and was unable to hold her eating utensils during dinner. A note dated 4/15/17 documented, "Resident presents with slurred speech, lethargy and severe throbbing headache." A physician's order was entered on 4/15/17 to send the resident to the emergency room for evaluation and treatment. | F 658 | | |

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| F 658 | Continued From page 32<br><br>The emergency room report dated 4/15/17 documented, "Phenytoin [Dilantin] toxicity: Presented with slurred speech, AMS [altered mental status], nystagmus [involuntary eye movement]...in the setting of increasing in dilantin dose at her SNF [skilled nursing facility] (increased from 400 mg daily to 350 mg BID [twice per day] in setting of already elevated level for unclear reasons). Also has been on azithromycin since 4/14 [2017] which could increase serum dilantin level. Dilantin level was high at 54.2." (sic) The resident was hospitalized for four days with the Dilantin held until the level returned to a therapeutic range. The resident was re-admitted to the facility on 4/20/17.<br><br>A facility reported incident form to the state agency dated 4/17/17 documented Resident #135 was diagnosed with Dilantin toxicity due to a medication error. The facility's investigation documented the resident had a slightly elevated Dilantin level of 22.8 (normal range of 10 to 20 ug/ml) on 4/4/17. The nurse practitioner (NP) was notified and entered a physician's order changing the resident's Dilantin dose from 400 mg once per day to 350 mg twice per day. The investigation stated, "The NP thought that she was decreasing the dose but mistakenly increased the dose to twice a day." The facility investigation stated, "...The MD [physician] wrote order to change Dilantin dose to 350 mg BID [twice per day]. The original order was for 400 mg QD [each day] so medication was increased as opposed to decreased...At hospital was noted with a Dilantin level of 54.8..."<br><br>On 6/20/18 at 11:09 a.m., the director of nursing (DON) was interviewed about the Dilantin error | F 658 | | |

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| F 658 | Continued From page 33<br>with Resident #135 resulting in toxicity. The DON stated the resident's routine Dilantin level checked on 4/3/17 indicated the level was high and above the therapeutic range. The DON stated the NP wrote the order wrong and increased the resident's dose instead of lowering the dose. The DON stated the nurses entered the order as written and administered the Dilantin as ordered. The DON stated nursing did not question why the dosage was increased even though the resident's Dilantin level was already high. The DON stated their investigation did not reveal a transcription error but that the NP ordered the wrong dosage and the dosage error was not caught or questioned until after the resident had symptoms and went to the emergency room.<br><br>The NP that wrote the order for the increased Dilantin dosage was not available for interview, as she no longer worked at the facility.<br><br>The Nursing 2017 Drug Handbook on page 1171 describes Dilantin (phenytoin) as an anticonvulsant used to control seizures. Page 1174 of this reference lists signs and symptoms of overdose as decreased muscle coordination, nystagmus, lethargy and slurred speech. Nursing considerations listed on page 1174 include, "Monitor drug level. Therapeutic level of total phenytoin is 10 to 20 mcg/mL [micrograms/milliliter]..." (1)<br><br>The facility's policy titled Medication Ordering & Prescribing: New Orders (2017) stated, "Nurse will review medication order for completeness as to: name of the medication, strength, dose, route of administration, frequency, stop date if applicable, and indication for use if ordered | F 658 | | |

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| (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 |
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| F 658 | Continued From page 34<br>"PRN" or "as needed" and diagnosis."<br><br>The Lippincott Manual of Nursing Practice 10th edition states on pages 16 and 17 concerning standards of care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to...follow appropriate nursing measures, communicate information about the patient...follow physician's orders that should have been questioned or not followed, such as orders containing medication dosage errors..." (2)<br><br>The DON presented a plan of correction to address the Dilantin medication error that was implemented with a correction date of 5/19/17. The corrective plan included the following:<br>1. Resident #135 was sent to the emergency room, Dilantin was held until the level returned to therapeutic range, dose adjusted to maintain therapeutic level.<br>2. Audit of 100% of all residents in the facility on anti-seizure medications, labs were obtained with therapeutic levels and dosages verified.<br>3. Education to 100% of licensed nurses regarding medication orders, dosages and therapeutic lab levels. Education provided to nurses on 4/17/17 included steps to take when lab results were received related to seizure medications. This education documented, "...review with MD [physician] - ensure the correct, current dose of med [medication] is given to MD. After new orders are obtained, [check] the new orders & compare to previous orders. Enter order correctly into [computer] and d/c [discontinue] all other/previous orders."<br>4. Audit of all new seizure medication orders, order changes and lab testing three times per week for 4 weeks and then monthly for 3 months. | F 658 | | |

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| F 658 | Continued From page 35<br><br>During the current survey, a list of any medication errors since 5/19/17 was requested. There were no further medication errors on record in the facility since the incident with Resident #135 in April 2017. There were no significant medication errors cited during the current survey.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 6/21/18 at 8:15 a.m.<br><br>This deficiency was cited as past non-compliance.<br><br>This was a complaint deficiency.<br><br>(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.<br><br>(2) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. | F 658 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to ensure nail care was provided to one of 31 residents in the survey sample, Resident # 41. | F 677 | | |

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| F 677 | Continued From page 36<br>The facility staff failed to ensure Resident # 41, a dependent resident, was provided nail care. The resident's nails were observed with dirt/dark debris under the nails on both hands.<br><br>Findings include:<br><br>Resident # 41 was admitted to the facility on 12/14/17. Diagnoses for Resident # 41 included, but was not limited to: Alzheimer's disease, dysphagia, osteoarthritis, and osteoporosis.<br><br>The most current MDS (minimum data set) was a quarterly assessment dated 04/17/18. This MDS assessed the resident with a cognitive score of 5, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from staff for most all ADL's (activities of daily living).<br><br>Resident # 41 was observed multiple times throughout the survey process from 06/19/18 through 06/21/18. The resident was unkempt and had visibly soiled nails on bilateral hands with accumulated dirt/dark debris under the fingernails.<br><br>On 06/21/18 at approximately 8:45 a.m., Resident # 41 was interviewed. The resident was asked if he had, had a bath. The resident stated, "No, why?." The resident was asked about his fingernails. The resident stated, "I think they cleaned them, when I was laying dead in the hospital."<br><br>At approximately 9:00 a.m. LPN (Licensed Practical Nurse) # 1 was interviewed regarding nail care and who is responsible. The LPN | F 677 | F677: ADL Care Provided for Dependent Residents<br><br>1. Resident #41 currently resides at the facility. Resident #41 nails have been cleaned and trimmed.<br>2. An audit of resident's nails was conducted and residents needing nail care were identified and care provided accordingly.<br>3. Clinical staff educated on providing nail care as required based on residents preference.<br>4. DON/Designee will assess 10 residents weekly x 4 weeks and monthly x2 for clean/trimmed nails per resident reference. Findings will be reported to QAPI monthly for 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 677 | Continued From page 37<br>stated, "Anyone can do nail care." The LPN stated that nails can be cleaned by nurses and CNA's (certified nursing assistants) and should be completed on bath days. The LPN stated, "I can look and see when his bath days are." The LPN stated that the resident gets baths on Mondays and Thursday on the 3-11 shift. The LPN was made aware that the resident had been observed on Tuesday morning, as well as multiple times through out the survey process and the nails were the same each and every day, soiled with visibly dark, dirt/debris under the nails. The LPN stated that she would check in to it.<br><br>On 06/21/18 at approximately 5:30 p.m., the DON and administrator were made aware of the above information.<br><br>No information and/or documentation was presented prior to the exit conference on 06/21/18. | F 677 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to ensure a safe room environment for two of 31 residents. Resident # 7 and Resident | F 689 | F689: Free of Accident Hazards/Supervision/Devices<br><br>1. Resident # 7 dycem was replaced on bedside table per care plan. Resident # 3 shampoo was placed in the treatment cart and cologne along with the razor was removed from the residents' room and will be provided when requested per care plan.<br>2. Residents with falls in the last 30 days were reviewed and observed to ensure that interventions were in place per care plan. Resident rooms were audited for personal hygiene items left at bedside | |

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| F 689 | Continued From page 38<br>#3.<br><br>1. Resident # 7 did not have Dycem (a gripping aide) on her bedside table as directed on her comprehensive care plan.<br><br>2. Resident #3 did not have brut liquid cologne, selsun blue medicated shampoo, and razors properly stored in his room.<br><br>Findings were:<br><br>1. Resident #7 was originally admitted to the facility on 03/08/2018 and was most recently readmitted on 06/06/2018. Her diagnoses included but were not limited to: Bilateral below knee amputations, acute respiratory failure, hypertension, diabetes mellitus, psoriasis, and breast cancer.<br><br>A significant change MDS (minimum data set) with an ARD (assessment reference date) of 06/06/2018, assessed Resident #7 as cognitively intact with a summary score of "15".<br><br>The clinical record was reviewed on 06/20/2018 at approximately 10:00 a.m. The care plan contained a focus area: "..at risk for falls r/t [related to] gait/balance problems". Interventions included but were not limited to: Antitippers to wc [wheelchair], Dycem to top of tray table, Provide a safe environment..." The revision date with the addition of the Dycem to the tray table top was 05/27/2018.<br><br>The progress note section was reviewed. Resident #7 had a fall in her room on 05/27/2018. Her phone fell on to the floor and when she reached over to pick it up, she fell out of the chair | F 689 | and items left at bedside were stored appropriately per policy.<br>3. Clinical staff were provided education on ensuring residents fall interventions are in place per resident's plan of care.<br>4. DON/Designee will review falls weekly x4 and monthly x2 to ensure interventions are put into place and followed per plan of care. Findings will be reported to QAPI monthly for 3 months to review compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 689 | Continued From page 39<br>and turned her wheelchair over on top of herself. She was sent to the emergency room for X-rays which were negative. The intervention for the Dycem to her table top was added at that time to keep her items from slipping off and on to the floor.<br><br>On 06/20/2018 at approximately 10:45 a.m., Resident #7 was observed sitting in her wheelchair. Both lower extremities were elevated straight out from her body and resting on a footboard. Resident #7 was interviewed about her fall on 05/27/2018. She stated, "My phone slid off and down on the floor. I leaned over too far to get it and flipped the whole chair over...that was right before I had this leg cut off [pointed to left leg]." The bedside table was observed, there was no Dycem on the table. Resident #7 was asked about the care planned intervention for the Dycem to her bedside table. She stated, "I don't know why that's not on there."<br><br>The above information was discussed with the DON (director of nursing) and the administrator during a meeting on 06/21/2018 at approximately 8:15 a.m. The DON stated that she didn't know why the Dycem was not in place, she stated, "It was on there the last time I was in her room...I'll check on it."<br><br>On 06/21/2018 at approximately 1:30 p.m., the DON was asked what had been ascertained regarding the Dycem. She stated, "It wasn't on there, but it is now."<br><br>No further information was obtained prior to the exit conference on 06/21/2018.<br>2. Resident #3 was admitted to the facility on 03/20/17 with a readmission on 10/09/17. | F 689 | | |

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| F 689 | Continued From page 40<br>Diagnoses for Resident #3 included cerebral palsy, muscle weakness, hyperlipidemia, seizure disorder, anxiety disorder, depression, dysphasia, moderate intellectual disability, constipation, pain, tracheostomy, and gastro-esophageal reflux disease (GERD). The minimum data set (MDS) dated 06/06/18 assessed Resident #3 as severely cognitively impaired.<br><br>On 6/20/18 at 3:37 p.m., Resident #3's bedside table was observed to have the following items laying on top:<br>-7 oz. Brut Splash liquid cologne containing the following ingredients: alcohol, water, fragrance, propylene glycol, and yellow #5. The label displayed "Warning: Flammable, do not use when smoking, near fire or heat. Warning-external use only."<br>-11.5 oz. bottle of Selsun Blue medicated shampoo containing the following ingredients: selenium sulfide 1%, anti-dandruff. The label displayed "Warning, external use only."<br>-blue safety-shaving razor<br><br>On 6/20/18 at 4:00 p.m. accompanied with the licensed practical nurse (LPN #2) who was providing care for Resident #3, the items were observed laying on top of the bedside table. LPN #2 stated Resident #3 normally kept the cologne in drawers of the bedside table because he liked to dab it on his face and neck. LPN #2 was asked if Resident #3 had been assessed as safe to have these items in the room or bedside table. LPN #2 stated she was not aware if Resident #3 or other residents were assessed to keep personal care items in their rooms. LPN #2 stated she would talk with Resident #3 to see if he would agree to keep the medicated shampoo on the nurses' treatment cart. LPN #2 stated | F 689 | | |

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| F 689 | Continued From page 41<br>Resident #3 was very particular about where his personal items were kept and the staff makes sure to keep other residents out of his room to keep them from agitating Resident #3. LPN #2 removed the blue safety razor and said she was not sure how or when he obtained the razor.<br><br>On 06/21/18 at 8:17 a.m., these findings were reviewed with the administrator and director of nursing. The director of nursing (DON) was interviewed regarding if Resident #3 was assessed to have these items in the room or bedside table. The DON stated the facility staff knows Resident #3. The DON was asked what was the expectation regarding the assessment to have personal care items in the room or stored at the bedside table. The DON stated there are some residents who have locked boxes for personal items, but the facility has not assessed if these types of items (cologne, shampoo) should be considered locked. There was no indication that Resident #3 was assessed as safe to have these items in the room or bedside table. The DON stated Resident #3's sister does visit and will bring him personal items, which is where the medicated shampoo may have come from without the faculty's knowledge. The DON stated she did not know how or where Resident #3 could have obtained the razor. The DON stated staff does assist Resident #3 with his care needs, however razors are not left out on treatment carts or areas where residents have access to pick up the razors.<br><br>No further information was received by the survey team prior to the exit conference on 06/21/18 at 6:00 p.m. | F 689 | | |
| F 692 | Nutrition/Hydration Status Maintenance | F 692 | | |

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| F 692 SS=D | Continued From page 42<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to ensure acceptable nutritional parameters for the prevention of weight loss for one of 31 residents in the survey sample, Resident # 41.<br><br>The facility staff failed to ensure interventions were implemented and/or followed for Resident # 41 for the prevention of weight loss. Resident # 41 had total weight loss of over 25 lbs (pounds) from January 2018 to present (June 2018).<br><br>Findings include: | F 692 | F692: Nutrition/Hydration Status Maintenance<br><br>1. Resident #41 continues to reside at the facility. Resident #41 is now being assist by staff with meals and care plan has been reviewed and revised to include weight loss interventions. Resident #41 is receiving fortified foods with meals.<br>2. DON/Designee conducted an audit of residents with significant weight loss to ensure interventions are in place and followed per MD order.<br>3. The DON/Designee will educate RD and Dietary staff on ensuring meal ticket accuracy. The DON/Designee will educate IDT team and clinical staff on adhering to weight loss interventions and identifying residents with changes in level of feeding independence.<br>4. The DON/Designee will audit 10 resident's meal tickets weekly x 4 weeks and monthly x 2 to ensure accuracy. The DON/Designee will audit/inspect 10 resident weekly x4 and monthly x2 to ensure that weight loss interventions are implemented accurately and reflected in the plan of care. Findings will be reported to QAPI committee monthly x3 for 3 months to ensure compliance.<br>5. Date of compliance: July 20th, 2018 | |

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| F 692 | Continued From page 43<br>Resident # 41 was admitted to the facility on 12/14/17. Diagnoses for Resident # 41 included, but was not limited to: Alzheimer's disease, dysphagia, osteoarthritis, and osteoporosis.<br><br>The most current MDS (minimum data set) was a quarterly assessment dated 04/17/18. This MDS assessed the resident with a cognitive score of 5, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from staff for most ADL's (activities of daily living) and assessed as set up with limited assistance for nutritional intake.<br><br>On 06/19/18 at 1:15 PM, Resident # 41 was sitting in his wheelchair with his bedside table in front of him. The resident's meal tray was delivered, opened and set up by aides. The aides then left the room. Resident # 41's tray had pasta, garlic bread, mixed vegetables, a power shake (sysco strawberry/banana) in a small carton, and a mixed fruit bowl. Resident # 41 picked up the bowl of fruit and asked to 'open' it, no staff members were present. The resident then picked up his shake and put finger down in the opening. The resident then picked up the bread and took a bite. The resident continued to handle the shake, pulling on the carton opening (it was already opened) and then picked up his fork and stuck the fork in the shake carton. No staff members were present or available to assist the resident. Resident # 41 was having difficulty feeding himself.<br><br>Resident # 41's current POS (physician's order set) was reviewed and documented that the resident was to have a NAS (no added salt) mechanical soft texture with thin consistency. | F 692 | | |

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| F 692 | Continued From page 44<br><br>The resident's current CCP (comprehensive care plan) documented, "...potential nutritional problem...monitor/document/report...dysphagia, pocketing, choking, coughing...several attempts to swallow...appears concerned during meals...monitor/record/report...signs/ symptoms of malnutrition...significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months...weigh per orders...consult with dietitian and change if chewing/swallowing problems are noted..."<br><br>Resident 41 was observed on 06/20/18 at approximately 9:00 a.m. The resident's tray was in front of him with approximately 30-50% of the meal eaten, and 100% of the milk consumed. The resident was asked if he wanted more to eat and the resident stated that he didn't want anymore. The resident had scrambled eggs, oatmeal, 2% milk, coffee and juice. No assistance was observed with the resident's meal consumption.<br><br>On 06/20/18 06:09 PM Resident # 41 was in bed covered, the resident's dinner tray was brought in by the activity director, who assisted the resident with eating. The activity director was attempting to engage the resident and was feeding the resident bites of food. The resident's tray consisted of pulled barbecue, potatoes, cabbage, cornbread, and watermelon chunks. The resident also had chocolate milk, and coffee. Resident # 41 stated, "I don't want anymore" as the staff member was feeding. The resident stated several times to the activities director, "That's plenty, that's enough." The resident ate approximately 50 % of the meal and drank all of the chocolate milk. The activity director went and | F 692 | | |

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| F 692 | Continued From page 45<br>got a second chocolate milk for the resident.<br><br>On 06/21/18 at approximately 8:55 a.m., the resident was observed in bed with his bedside table in front of him with his breakfast tray. The resident had scrambled eggs, 2 pancakes, ground sausage and oatmeal. The resident's tray had 4 opened packets of sugar on it, along with one opened syrup pack (observed on the pancakes), and one unopened butter packet. The resident had one carton of 2% milk. The resident was feeding himself with little difficulty. The resident stated, "Can you cut that [pancakes] my mouth ain't that big." The resident drank all of his milk and ate approximately 50% of the meal. The resident did not eat any of the oatmeal. No assistance was observed with meal consumption.<br><br>On 06/21/18 at approximately 9:15 a.m., the DON and administrator were made aware of the above information regarding Resident # 41 and was asked for an interview with the registered dietitian (RD). Information regarding fortified foods was also requested at this time.<br><br>Resident # 41's admission nutrition assessment dated 12/20/17 documented the resident had vision and hearing impairment; weight 160 lbs and was 60 inches tall; that the resident had a 16 lb weight loss during a hospitalization; eats wells, nutritional interventions NAS diet, and encouragement at meals to promote optimal intake.<br><br>The resident's weight record revealed the following weights:<br><br>01/02/18-160.8<br>01/11/18-165.4 | F 692 | | |

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| F 692 | Continued From page 46<br>01/24/18-170.4<br>01/30/18-171.8<br>02/28/18-164.2<br><br>The resident lost a total of 7.6 lbs in approximately 1 month, from 01/30/18 to 02/28/18. The resident weight records reveled that the resident was being weighed on a weekly from admission (December 2017) through March 2018.<br><br>A RD note dated 02/04/18 documented a weight of "171.8 returning the resident to previous baseline" and identifying the resident as "remains at high risk for unintentional weight loss related to diagnoses and age."<br><br>A nutritional review dated 03/14/18 was reviewed. This review did not specify the resident's highest level of dependence. The review documented the resident's last weight on 03/09/18 as 165.2 and documented that the resident was stable and continue to monitor, continue POC (plan of care).<br><br>The resident's weight record revealed the following weights:<br><br>02/28/18-164.2<br>03/09/18-165.2<br>04/06/18-146.9<br><br>The resident lost a total of 18.3 lbs in approximately 1 month, from 03/09/18 to 04/06/18. A total loss to date was 24.9 lbs in less than 3 months; the resident's weight records revealed that the resident had been weighed on a weekly basis, but did not get weighed at all for nearly a month during which time he experienced a significant weight loss. | F 692 | | |

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| F 692 | Continued From page 47<br><br>An RD noted dated 04/23/18 documented, "...Weight Warning: Value: 147.4...may be 'down' and that may be impacting his appetite...has refused dinner trays at times..fortified foods, 120 cc med pass every day...weekly weights..."<br><br>Nursing notes were reviewed, no documentation was found regarding resident refusing meals.<br><br>An RD note dated 05/13/18 documented, "...151.6...res with history of weight change...requires cueing/assistance related to Alzheimer's...fortified foods and med pass 120 cc every day...monitoring..."<br><br>An RD note dated 06/11/18 documented, "...146.4...fortified foods began on 04/23, 120 cc med pass began on 04/24 related to history of weight loss...continues with confusion...continue POC..."<br><br>The resident's Kardex was then reviewed and documented, "...monitor, document and record signs and symptoms of dysphagia, pocketing food, refusing to eat...significant weight loss 3 lbs in 1 week, greater than 5% in one month, 7.5% in 3 months, or greater than 10% in 6 months..."<br><br>On 06/21/18 at approximately 11:00 a.m., the RD was interviewed. The RD was made aware of concerns regarding Resident # 41's significant weight loss. The RD was asked about fortified foods. The RD presented a list of items and stated, "It's basically added fats and calories" and went on to explain that it would consist of food items, such as oatmeal, mashed potatoes, and whole milk. | F 692 | | |

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| F 692 | Continued From page 48<br><br>The list was reviewed and documented, "fortified cereal, hot of choice portion size 3/4 cup, oatmeal, cream of wheat, and rice" and "fortified potatoes, mashed portion size 1/2 cup."<br><br>The RD was asked how is it ensured that a resident gets fortified foods. The RD couldn't answer the question. The RD was informed of Resident # 41's 7.6 lb weight loss in a month. The RD stated, "We couldn't verify a cause of the weight loss, he was eating the same amounts." The RD was again asked how to ensure fortified foods are given to resident's who need them. The RD stated that there is really no way of knowing.<br><br>The RD was given Resident # 41's meal ticket for 06/21/18 breakfast. The ticket documented, NAS mechanical soft FORTIFIED FOODS Pancakes 2, margarine 1, syrup 1, ground sausage patty 2 ounces, cream gravy 2 ounces, oatmeal 3/4 cup, and milk 8 ounces. The RD was made aware that the resident's milk was 2% that morning, not whole and the meal ticket did not specify whole milk, the resident's margarine was not opened and the resident did not get the gravy. The resident did not eat the oatmeal.<br><br>The RD stated that he understood, but could not explain how a resident with fortified foods is tracked to ensure they are getting the foods.<br><br>The RD was then asked about the resident's weight record and the RD stated that the resident was on weekly weights. The RD was made aware that the resident did not get weighed for one month and lost about 18 lbs during that month. The RD stated that he did not know why | F 692 | | |

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| F 692 | Continued From page 49<br>the resident was not weighed, as there was nothing to indicate that the weights be stopped.<br><br>No further information and/or documentation was provided prior to the exit conference on 06/21/18 to evidence that Resident # 41's significant weigh loss was unavoidable. | F 692 | F755: Pharmacy services<br>1. The physician was notified regarding residents #41 calcium gluconate order and gave a telephone order to DC the calcium gluconate and start calcium with vit D supplement. The medication was administered per MD order on 6/21/2018.<br>2. An audit of current residents physicians ordered medications was completed to ensure medication availability.<br>3. DON/Designee will educate licensed nurses on proper medication administration and procedure for obtaining medications from pharmacy.<br>4. DON/Designee will complete random medications administration observations weekly x4 weeks and then monthly x2 to ensure nurses are administering medications per physician order. Unit managers will audit 5 residents weekly to ensure all mediations are available and have bene re-ordered per policy. Findings will be reported to QAPI committee monthly x 3 months for review and recommendations.<br>5. Date of compliance: July 20th, 2018 | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>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.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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 | F 755 | | |

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| F 755 | Continued From page 50<br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a medication was available for administration to one of 31 residents in the survey sample.<br><br>The medication Calcium Gluconate was not available to administer to Resident #41 during the medication pass observation.<br><br>The findings include:<br><br>Resident #41 was admitted to the facility on 12/14/17 with diagnoses that included high blood pressure, Alzheimer's, osteoarthritis, osteoporosis and dysphagia. The minimum data set (MDS) dated 4/7/18 assessed Resident #41 with severely impaired cognitive skills.<br><br>A medication pass observation was conducted on 6/20/18 at 8:15 a.m. the LPN #5 administering medications to Resident #41. Medications given to Resident #105 did not include the medication Calcium Gluconate. LPN #5 looked in the medication cart, medication supply room, and checked with another nursing unit and found no supply of the Calcium Gluconate.<br><br>Resident #41's clinical record documented a physician's order dated 12/14/17 for Calcium Gluconate 500 mg to be given twice per day for treatment of osteoporosis.<br><br>On 6/20/18 at 9:00 a.m., LPN #5 was interviewed | F 755 | | |

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| F 755 | Continued From page 51<br>about the omitted Calcium Gluconate. LPN #5 stated the Calcium Gluconate was not available to give. LPN #5 stated the medication must not have been re-ordered from the pharmacy.<br><br>On 6/20/18 at 12:00 p.m., LPN #5 stated she had not yet given the Calcium Gluconate to Resident #41 because a supply had not been delivered from pharmacy.<br><br>On 6/20/18 at 1:56 p.m., LPN #5 stated she never received the Calcium Gluconate. LPN #5 stated she was a "traveling nurse" and did not know why the medication supply was not available.<br><br>On 6/20/18 at 2:00 p.m., the unit manager (LPN #1) was interviewed about the unavailable medication. LPN #1 stated the Calcium Gluconate was not available this morning (6/20/18) for Resident #41. LPN #1 stated the Calcium Gluconate was normally a "stock" medication. LPN #1 stated if nurses see a medication supply running low, they were supposed to request the medication from central supply.<br><br>On 6/20/18 at 2:46 p.m., the supply coordinator was interviewed about the unavailable Calcium Gluconate. The supply coordinator stated nurses kept a list of needed stock medications in the medication storage room. The supply clerk stated an order was placed once per week with medications usually delivered on Friday each week. The supply coordinator stated the Calcium Gluconate was not on the request list so the supply had not been reordered.<br><br>The facility's policy titled Medication Ordering & Prescribing: Reorders (effective 2/2009) stated, | F 755 | | |

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| F 755 | Continued From page 52<br>"Nurse will examine supply of medication remaining to ascertain when a reorder/refill is needed for the resident..."<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 6/21/18 at 8:15 a.m. | F 755 | F759: Free of medication errors<br>1. The physician was notified regarding residents #41 calcium gluconate order and gave a telephone order to DC the calcium gluconate and start calcium with vit D supplement. The medication was administered per MD order on 6/21/2018. Resident #105 received the scheduled dose of Lasix that morning from the facility backup stock and the correct dose of Lasix was delivered that evening.<br>2. An audit of current residents physician ordered medications was completed to ensure medication availability.<br>3. DON/Designee will educate licensed nurses on proper medication administration and procedure for obtaining medications from pharmacy.<br><br>4. DON/Designee will complete random medications administration observations weekly x4 weeks and then monthly x2 to ensure nurses are administering medications per physician order. Unit managers will audit 5 residents weekly to ensure all mediations are available and have bene re-ordered per policy. Findings will be reported to QAPI committee monthly x 3 months for review and recommendations.<br>5. Date of compliance: July 20th, 2018 | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on a medication pass observation, staff interview and clinical record review, facility staff failed to ensure a medication error rate of less than 5%. There were two observed medication errors with 36 opportunities resulting in a medication error rate of 5.56%.<br><br>The findings include:<br><br>a) Resident #105 was administered 10 mg (milligrams) of the medication Lasix when the physician's order required a 20 mg dose.<br><br>A medication pass observation was conducted on 6/20/18 at 7:55 a.m. with licensed practical nurse (LPN #5) administering medications to Resident #105. During this pass, LPN #5 administered the medication Lasix 10 mg (milligrams) to Resident #105.<br><br>Resident #41's clinical record documented a | F 759 | | |

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| F 759 | Continued From page 53<br>physician's order dated 6/18/18 for Lasix 20 mg to be administered once per day for renal insufficiency.<br><br>On 6/20/18 at 9:00 a.m., LPN #5 was interviewed about administering Lasix 10 mg instead of 20 mg as ordered. LPN #5 the 20 mg dose was a new order and the supply had not been received from pharmacy yet. LPN #5 stated she gave the medication that was available in the cart. LPN #5 displayed the medication card used for Resident #105. The card was from a previous order and was only a 10 mg dose instead of 20 mg. LPN #5 stated while waiting for medications from pharmacy, she "used stock on hand" until the new order arrived. LPN #5 reviewed the order in the computer and stated the resident was supposed to get 20 mg of Lasix instead of 10 mg.<br><br>b) Resident #41 was not administered the medication Calcium Gluconate as ordered by the physician during the medication pass.<br><br>A medication pass observation was conducted on 6/20/18 at 8:15 a.m. with LPN #5 administering medications to Resident #41. Medications given to Resident #41 did not include the medication Calcium Gluconate. LPN #5 looked in the medication cart, medication supply room, and checked with another nursing unit and found no supply of the Calcium Gluconate available.<br><br>Resident #41's clinical record documented a physician's order dated 12/14/17 for Calcium Gluconate 500 mg to be given twice per day for treatment of osteoporosis.<br><br>On 6/20/18 at 9:00 a.m., LPN #5 was interviewed about the omitted Calcium Gluconate. LPN #5 | F 759 | | |

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| F 759 | Continued From page 54<br>stated the Calcium Gluconate was not available to give. LPN #5 stated the medication must not have been re-ordered from the pharmacy. On 6/20/18 at 12:00 p.m., LPN #5 stated she had not yet given the Calcium Gluconate to Resident #41 because the medication had not been delivered from pharmacy. On 6/20/18 at 1:56 p.m., LPN #5 stated she never received the Calcium Gluconate. LPN #5 stated she was a "traveling nurse" and did not know why the medication supply was not available.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 6/21/18 at 8:15 a.m. | F 759 | | |
| F 760 SS=G | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure one of 31 residents in the survey sample was free from a significant medication error.<br><br>Resident #135's daily dosage of the anti-seizure medication Dilantin (Phenytoin) was increased in error when it should have been decreased. The increased dosage caused the resident's Dilantin level to exceed therapeutic levels resulting in slurred speech, headache, chest pain and a decline in physical function. The resident was hospitalized for four days due to Dilantin toxicity. | F 760 | Past noncompliance: no plan of correction required. | |

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| F 760 | Continued From page 55<br>The findings include:<br><br>Resident #135 was admitted to the facility on 3/25/16 with a re-admission on 4/20/17. Diagnoses for Resident #135 included convulsions, high blood pressure, neurogenic bladder, paraplegia, lymphedema and osteoporosis. The minimum data set (MDS) dated 4/27/18 assessed Resident #135 as cognitively intact.<br><br>Resident #135's clinical record documented a physician's order dated 3/7/17 for Dilantin 400 mg (milligrams) once per day for treatment of seizures. The resident's medication administration record (MAR) documented the Dilantin was administered as ordered.<br><br>A lab test report dated 4/3/17 documented the resident's Dilantin level was high with reading of 22.8 ug/mL (micrograms per milliliter) with a reference range of 10.0 to 20.0 ug/mL. The nurse practitioner (NP) was notified and entered an order on 4/4/17 to change the resident's Dilantin dosage from 400 mg per day to 350 mg twice per day with a repeat Dilantin level check in four weeks.<br><br>The clinical record documented the order was entered as written with the resident administered 350 mg of Dilantin twice per day starting on 4/4/17. The record documented no questioning or clarification of the order that actually increased the resident's daily Dilantin dose instead of decreasing the dose.<br><br>Following the Dilantin dose change on 4/4/17, nursing notes documented the resident was assessed with chest pain and inability to assist | F 760 | | |

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| F 760 | Continued From page 56<br>with transfers starting on 4/12/17. The record documented the NP was notified and entered an order on 4/12/17 to send the resident to emergency room for evaluation. A note dated 4/12/17 at 12:31 p.m. documented the resident stated she was not short of breath, only felt weak and did not want to go the to the emergency room. The NP ordered additional lab work, a chest x-ray and an EKG. The NP evaluated Resident #135 on 4/13/18, assessed the resident with cough and nasal congestion and ordered Claritin, azithromycin (antibiotic) and Mucinex for treatment of an upper respiratory infection. There was no re-check of the resident's Dilantin level.<br><br>A nursing note dated 4/14/17 documented the resident complained of feeling lethargic and was unable to hold her eating utensils during dinner. A note dated 4/15/17 documented, "Resident presents with slurred speech, lethargy and severe throbbing headache." A physician's order was entered on 4/15/17 to send the resident to the emergency room for evaluation and treatment.<br><br>The emergency room report dated 4/15/17 documented, "Phenytoin [Dilantin] toxicity: Presented with slurred speech, AMS [altered mental status], nystagmus [involuntary eye movement]...in the setting of increasing in dilantin dose at her SNF [skilled nursing facility] (increased from 400 mg daily to 350 mg BID [twice per day] in setting of already elevated level for unclear reasons). Also has been on azithromycin since 4/14 [2017] which could increase serum dilantin level. Dilantin level was high at 54.2." (sic) The resident was hospitalized for four days with the Dilantin held until level returned to therapeutic range. The resident was re-admitted to the facility on 4/20/17. | F 760 | | |

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| F 760 | Continued From page 57<br><br>A facility reported incident form to the state agency dated 4/17/17 documented Resident #135 was diagnosed with Dilantin toxicity due to a medication error. The facility's investigation documented the resident had a slightly elevated Dilantin level of 22.8 (normal range of 10 to 20 ug/ml) on 4/4/17. The nurse practitioner (NP) was notified and entered an order changing the resident's Dilantin dose from 400 mg once per day to 350 mg twice per day. The investigation stated, "The NP thought that she was decreasing the dose but mistakenly increased the dose to twice a day." The facility investigation stated, "...The MD [physician] wrote order to change Dilantin dose to 350 mg BID [twice per day]. The original order was for 400 mg QD [each day] so medication was increased as opposed to decreased...At hospital was noted with a Dilantin level of 54.8..."<br><br>On 6/20/18 at 11:09 a.m., the director of nursing (DON) was interviewed about the Dilantin error with Resident #135 resulting in toxicity. The DON stated the resident's routine Dilantin level checked on 4/3/17 indicated the level was high and above the therapeutic range. The DON stated the NP wrote the order wrong and increased the resident's dose instead of lowering the dose. The DON stated the nurses entered the order as written and administered the Dilantin as ordered. The DON stated nursing did not question why the dosage was increased even though the resident's Dilantin level was already high. The DON stated their investigation did not reveal a transcription error but that the NP ordered the wrong dosage and the dosage error was not caught or questioned until after the resident had symptoms and went to the | F 760 | | |

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| F 760 | Continued From page 58<br>emergency room.<br><br>The NP that wrote the order for the increased Dilantin dosage was not available for interview, as she no longer worked at the facility.<br><br>The DON presented a plan of correction to address the Dilantin medication error that was implemented with a correction date of 5/19/17. The corrective plan included the following: 1. Resident #135 was sent to the emergency room, Dilantin was held until the level returned to therapeutic range, dose adjusted to maintain therapeutic level. 2. Audit of 100% of all residents in the facility on anti-seizure medications, labs were obtained with therapeutic levels and dosages verified. 3. Education to 100% of licensed nurses regarding medication orders, dosages and therapeutic lab levels. 4. Audit of all new seizure medication orders, order changes and lab testing three times per week for 4 weeks and then monthly for 3 months.<br><br>During the current survey, a list of any medication errors since 5/19/17 was requested. There were no further medication errors on record in the facility since the incident with Resident #135 in April 2017. There were no significant medication errors cited during the current survey.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 6/21/18 at 8:15 a.m.<br><br>The Nursing 2017 Drug Handbook on page 1171 describes Dilantin (phenytoin) as an anticonvulsant used to control seizures. Page 1174 of this reference lists signs and symptoms of overdose as decreased muscle coordination, | F 760 | | |

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| F 760 | Continued From page 59<br>nystagmus, lethargy and slurred speech. Nursing considerations listed on page 1174 include, "Monitor drug level. Therapeutic level of total phenytoin is 10 to 20 mcg/mL [micrograms/milliliter]..." (1)<br><br>This deficiency was cited as past non-compliance.<br><br>This was a complaint deficiency.<br><br>(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017. | F 760 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to | F 761 | | |

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| F 761 | Continued From page 60<br>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility document review and staff interview, facility staff failed to ensure proper storage of drugs subject to abuse on one of four nursing units. Four vials of the medication Lorazepam were stored in the medication refrigerator along with other medicines on unit 2. The vials of Lorazepam were not stored in a separate, permanently affixed lock box.<br><br>The findings include:<br><br>On 6/20/18 at 8:33 a.m., accompanied by licensed practical nurse (LPN) #6, the medication storage refrigerator on unit 2 was inspected. There were four 1-milliliter vials of Lorazepam stored in the refrigerator along with other standard medications. LPN #6 was interviewed at this time about the storage of the Lorazepam. LPN #6 stated she did not know why the Lorazepam was stored with other medications. LPN #6 stated they previously had a refrigerator with a separate, permanently affixed lock box for all controlled medications. LPN #6 stated they recently got a new refrigerator and the new refrigerator did not have a separate lock box for narcotics. LPN #6 stated all narcotics were usually kept in the separate lock box.<br><br>The facility's policy titled Medication: Controlled Drugs (revised 4/11/14) stated, "Narcotics will be kept under double lock and will be counted by on-coming and off-going nurse at the end of each shift...A separate locked compartment for | F 761 | F 761: Label/Store Drugs and Biologicals<br><br>1. Unit 2's refrigerator had a locked compartment installed for narcotics.<br>2. An audit of all refrigerators was conducted to ensure proper medication storage.<br>3. DON/Designee educated on ensuring controlled drugs are secure in a separately locked permanently affixed compartment.<br>4. Medication refrigerators will be audited randomly weekly for 4 weeks and then monthly x2 months to ensure proper mediation storage. Findings will be reported to QAPI monthly x3 for review and recommendations.<br>5. Date of compliance: July 20th, 2018 | |

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| F 761 | Continued From page 61<br>controlled drugs is provided within a locked cabinet...The compartment has a special lock and key and must be kept locked at all times..."<br><br>The Nursing 2017 Drug Handbook on page 902 describes Lorazepam as a scheduled IV controlled substance (anxiolytic) used for the treatment of anxiety and management of seizures. Nursing considerations listed on page 903 of this reference include, "Use of this drug may lead to abuse and addiction." (1)<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/21/18 at 8:15 a.m.<br><br>(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017. | F 761 | | |
| F 801 SS=F | Qualified Dietary Staff<br>CFR(s): 483.60(a)(1)(2)<br><br>§483.60(a) Staffing<br>The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)<br><br>This includes:<br>§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- | F 801 | F801: Qualified Dietary Staff<br>1. Facility has hired a qualified dietary manager<br>2. An audit of the dietary manager's qualifications was reviewed to ensure that the new hire meets the requirements for dietary manager.<br>3. ED educated the Regional Director of HCSG on the qualifications specific to dietary managers.<br>4. Random audit of dietary manager qualifications will be conducted with every Dietary Manager change for 90 days. Findings will be reported to QAPI for 3 months for review.<br>5. Date of compliance: July 20th, 2018 | |

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| F 801 | Continued From page 62<br>(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.<br>(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.<br>(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.<br>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.<br><br>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-<br>(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:<br>(A) A certified dietary manager; or<br>(B) A certified food service manager; or | F 801 | | |

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| F 801 | Continued From page 63<br>(C) Has similar national certification for food service management and safety from a national certifying body; or<br>D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and<br>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and<br>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility document review, the facility staff failed to employ a qualified dietary manager.<br><br>Findings were:<br><br>On 06/19/2018 at approximately 3:30 p.m., the Dietary Manager (OS-Other Staff #8) was interviewed. He was asked what his background was and what type of education/certification he had regarding food services. He stated that he did not have any education or certifications in food services.<br><br>On 06/19/2018 at approximately 4:30 p.m., an interview was conducted with the Corporate Director of Operations (OS #12) and the District Dietary Manager (OS #13) regarding the operating procedures in the kitchen. OS #12 explained that his company was a contract company hired by the facility to oversee/run food services, housekeeping and laundry services. He | F 801 | | |

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| F 801 | Continued From page 64<br>stated that all staff in those areas were employees of his company and not the facility. He was asked who was responsible for ensuring that staff met regulatory qualifications. He stated, "We are."<br><br>Qualifications of the Dietary Manager (OS #8) were discussed. The District Dietary Manager and the Corporate Director of Operations were asked what qualified the Dietary Manager (OS #8) to work in his position. The District Dietary Manager stated, "He has experience, he worked in the facility across the street. He has been in food services for years." The Corporate Director of Operations asked the District Dietary Manager if OS #8 had completed the "Serve Safe" course. The District Dietary Manager stated, "No." The District Dietary Manager and the Corporate Director of Operations reviewed OS #8's training record. The Corporate Director of Operations stated, "He has completed the trainings required by our company...I came here two weeks ago...at that time I identified that we aren't in regulatory compliance...I told [Name of OS #8] that I was going to replace him...I'm bringing in someone from [name of city]...he is certified..." The Corporate Director of Operations was asked what he meant by "not in compliance". He stated, "We can't keep staff, we have a high turnover rate...the kitchen is just not being run efficiently."<br><br>The Corporate Director of Operations and the District Dietary Manager were asked if the RD (registered dietitian) was full time at the facility. The District Dietary Manager stated, "No, the RD works 24 hours every two weeks...we have a "Diet Tech" who works four days a week...she does assessments, care plans and checks on the line but she isn't full time." The Corporate | F 801 | | |

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| F 801 | Continued From page 65<br>Director of Operations stated, "That's why [name of District Dietary Manager] is coming in here every day, trying to get things together and trying to get us in compliance."<br><br>A copy of the job description for the dietary manager was requested on 06/21/2018 and received. Per the job description, "KNOWLEDGE, SKILLS & ABILITIES...Certificates: A facility that employs a qualified dietitian less than full-time requires a full-time Director of Dining Services who is: 1. A certified Dietary Manger; or 2. A Certified food service manager; or 3. Has similar national certification for food service management and safety from a national certifying body; or 4. Has an associate's degree or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and 5. In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers..."<br><br>During a meeting on 06/21/2018 with the DON (director of nursing) and the administrator the above information was discussed.<br><br>No additional information was obtained prior to the exit conference on 06/21/2018. | F 801 | F802: Sufficient Dietary Support Personnel<br>1. Kitchen currently has sufficient staff to carry out the functions of the food and nutrition services.<br>2. An audit was conducted of the current dietary staffing schedule to ensure sufficient staffing is being adhered to.<br>3. ED has educated Dietary Manager in-serviced on scheduling sufficient staff to carry out the functions of dietary department.<br>4. ED will audit the dietary schedule and hours worked will be conducted weekly x4 and then monthly x2 to ensure sufficient staffing to meet the needs of the facility. Findings will be reported to QAPI for review monthly x 3 months.<br>5. Date of compliance: July 20th, 2018 | |
| F 802 SS=F | Sufficient Dietary Support Personnel<br>CFR(s): 483.60(a)(3)(b)<br><br>§483.60(a) Staffing<br>The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. | F 802 | | |

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| F 802 | Continued From page 66<br>taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.60(a)(3) Support staff.<br>The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review, the facility staff failed to ensure sufficient staff was available in the kitchen to carry out the functions of the food and nutrition services.<br><br>Findings were:<br><br>Initial tour of the kitchen was conducted at approximately 10:45 a.m., on 06/19/2018 with the dietary manager, OS (other staff) #8. During the tour plates, bowls and tray lids that were ready to be used for lunch were observed wet nested and with dry debris. The Dietary Manager stated, "They know better than this...they are rushing...we don't have enough people, that's no excuse but that's what's happening...they no show/no call and there are no consequences...the ones that are in here working are rushing around trying to get everything done...we just don't have enough staff in here." | F 802 | | |

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| F 802 | Continued From page 67<br>On 06/19/2018 at approximately 4:30 p.m., an interview was conducted with the Corporate Director of Operations (OS #12) and the District Dietary Manager (OS #13) regarding the operating procedures in the kitchen. OS #12 explained that his company was a contract company hired by the facility to oversee/run food services, housekeeping and laundry services. He stated that all staff in those areas were employees of his company and not the facility. He was asked who was responsible for ensuring that staff met regulatory qualifications/guidelines. He stated, "We are."<br><br>During the interview the Corporate Director of Operations stated, "...I came here two weeks ago...at that time I identified that we aren't in regulatory compliance..." The Corporate Director of Operations was asked what he meant by "not in compliance". He stated, "We can't keep staff, we have a high turnover rate...the kitchen is just not being run efficiently...I have three positions open right now that I am trying to fill...I am trying to do exit interviews with the ones leaving to see why they are leaving...we have others that just don't show up and then we have to try to get their shift covered."<br><br>The above information was discussed during a meeting with the DON (director of nursing) and the administrator on 06/21/2018 at approximately 8:15 a.m.<br><br>A copy of the as worked schedule was requested from another district dietary manager (OS #14) who was in the kitchen on 06/21/2018. The as worked schedule was received and reviewed with OS #13 on 06/21/2018 at approximately 4:00 p.m. Per the schedule provided for a thirteen day | F 802 | | |

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| F 802 | Continued From page 68<br>period there were a total of 18 "Call offs or no shows" listed. He was asked if there was enough staff in the kitchen. He stated, "We have two new hires that just started, I still need three people...that's why there is extra managers in the kitchen right now, we are trying to fill in."<br><br>No further information was obtained prior to the exit conference on 06/21/2018. | F 802 | | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, group interview, staff interview and a test tray observation, the facility staff failed to ensure food served was palatable and at a preferred temperature.<br><br>Food served during the evening meal on 06/20/2018 on the 100 hall was lukewarm and the cabbage was watery and mushy.<br><br>Findings were:<br><br>During a group interview conducted in the facility 6/20/18 beginning at 10:45 a.m. with eight cognitive residents in attendance. The residents were asked about food temperatures when meals | F 804 | F804: Nutritive Value/Appear Palatable/prefer temp<br><br>1. A Test tray on the 100 hall was conducted and food was palatable, attractive, and at a safe appetizing temperature.<br>2. An audit of a test tray was conducted on each unit to ensure food was palatable, attractive, and at a safe appetizing temperature.<br>3. ED will in-service the regional and dietary manager on ensuring that the food is palatable, attractive and at a safe appetizing temperature.<br>4. Weekly audits will be conducted to ensure the food is palatable, attractive and at a safe appetizing temperature weekly x4 and then monthly x2. Findings will be reported to QAPI monthly x3 for review and recommendations.<br>5. Date of compliance: July 20th, 2018 | |

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| F 804 | Continued From page 69<br>were served. The resident comments included: "The food is frequently cold when served. The plate may have hot items plated with cold items, and the cold item is no longer cold due to being affected by the hot item, so that all the food on the plate is warmish." The residents verbalized they did not ask staff to heat a tray due to "They are so busy! They are out there running around and we feel they are too busy to heat up a tray." The residents also verbalized the vegetables often "mushy" and bread is not in a "baggie" but placed on top of the vegetables and is soggy. The group stated they did not know if the cold trays were a product of delivery service, or the food temperatures were not hot enough when plated in the kitchen.<br><br>An individual interview was conducted on 06/20/2018 at approximately 4:00 p.m. with Resident #103.<br><br>Resident #103 was admitted to the facility on 01/02/2018. Her diagnoses included but were not limited to: Major depressive disorder, Atrial flutter, hypothyroidism, end stage renal disease with dialysis, hypertension, and cerebrovascular disease.<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/18/2018. Resident #103 was assessed as being cognitively intact with a summary score of "15".<br><br>Resident #103 was asked about the food at the facility. She stated, "My hall gets served last...If I eat in my room the food is cold." She was asked if the staff would heat it up for her. She stated, "I can't even get a cup of coffee when I want it. If | F 804 | | |

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| F 804 | Continued From page 70 | F 804 | | |

they heat it up it would be about the time they are coming to get the tray and take it back...If you eat in the dining room it isn't like that."

Based on the group interview, the resident interview, and other concerns regarding food temperatures identified during the initial tour of the kitchen, the survey team determined that a test tray was needed.

On 06/20/2018 at approximately 4:45 p.m., food line temperatures were obtained by OS (other staff) #14. Temperatures recorded for a regular diet were: cabbage 200 degrees, BBQ 144 degrees, the BBQ was stirred by OS #14 and temped at 154; baked beans 212 degrees. Corn bread was also being served with regular diet trays and was at room temperature. The first cart of food left the kitchen to go the main dining room at 4:56 p.m. OS #11 then began to plate food to go to the resident rooms. She stated the trays were sent to the 400 hall, 300 hall, 200 hall, and the 100 hall last.

Plates for resident meals were kept in a plate warmer, each plate was placed on a heated metal charger and covered with a lid, the trays were placed in a cart and the door closed when the cart was filled. All of the food for the meal observed was on the same plate and a piece of cornbread was placed on top of the food.

Trays for the 400 hall were started at 5:01 p.m., and completed at 5:12 p.m. Trays for the 300 hall were started at 5:12 p.m., and completed at 5:30 p.m. Trays for the 200 hall were started at 5:31 p.m. At 5:37 p.m., At that time there was no cabbage left to plate the trays. OS #11 stated, "We send the same amount of food to the dining

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| F 804 | Continued From page 71 | F 804 | | |

room as we keep down here. When they get through serving upstairs they'll bring that food back down here." The food from the dining room returned to the kitchen at 5:42 p.m. The food was re-temped: Cabbage 154; BBQ 146. The tray line resumed and trays for the second floor were completed at 5:45 p.m.

The 100 hall trays were started at 5:45 p.m. OS #14 was asked to place a tray with a regular diet on the cart as the first one in. The test tray was placed on the cart at 5:46 p.m., and the tray line continued. At 5:56 p.m., there were no more baked beans on the tray line. OS #11 asked where the beans were from the dining room. When told that there were none left, The District Dietary Manager, OS #13 opened a can of baked beans and heated them up on stove top. At 6:01 p.m., the baked beans were temped at 193 and the line resumed. The cart for the 100 hall was completed at 6:04 p.m.

This surveyor asked the District Dietary Manager to accompany her to the 100 unit with a thermometer to take the temperature of the trays. The cart was taken to the floor. Upon arrival approximately 10 staff members were observed removing trays from the cart and taking them to resident rooms. The last tray was removed from the cart and served at 6:12 p.m. When the last tray was removed OS #13 was asked to obtain the test tray so temperature and palatability of the food could be ascertained.

At 6:13 p.m., the food on the test tray was temped by OS #13. The BBQ was 122.4 (a decrease of 31.6), the baked beans were 124.1 (a decrease of 87.9 degrees), and the cabbage was 123.2 (a decrease of 76.8). The food was

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| F 804 | Continued From page 72<br>tasted by this surveyor and OS #13. The baked beans had good flavor and were at a preferred temperature. The BBQ had good flavor but the temperature was cold and not appetizing; the cabbage was also not at a preferred temperature and was mushy. The cornbread was not warm, but had also not gotten "soggy" as reported by the resident council. OS #13 agreed with these findings.<br><br>The above information was discussed with the DON (director of nursing) and the administrator during meeting on 06/21/2018 at approximately 8:15 a.m. | F 804 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by: | F 812 | | |

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| F 812 | Continued From page 73<br>Based on observation, and staff interview, the facility staff failed to store, prepare and serve food in a sanitary manner in the main kitchen.<br><br>Plates, bowls, and tray lids were stored wet and nested and not clean.<br><br>Findings were:<br><br>Initial tour of the kitchen was conducted at approximately 10:45 a.m., on 06/19/2018 with the dietary manager, OS (other staff) #8. During the tour the following was observed:<br><br>A plate warmer at the tray line was filled with white plates. The dietary manager was asked to lift some of the plates up so they could be observed. The dietary manager picked up the top 12 plates in the middle of three stacks in the plate warmer. The 12 plates were nested wet, 3 also had dried debris present. The DM stated, "I'm sending these all back through the dishwasher. They know better than this." Ten racks of bowls were observed beside the food line. Each rack contained 16 bowls. The top rack of bowls was observed, the DM was asked to turn the bowls over so this surveyor could see inside. One bowl was observed with a dirty tissue/napkin inside, two bowls had wet lettuce stuck to the inside; the second rack was observed with more lettuce stuck to the bowls. The DM stated that the bowls would also need to be washed before lunch. This surveyor and the DM went to the dishwashing area where a table was observed with plate covers stacked on top. The DM was asked if the tray tops were ready for usage. He stated, "Yes, they are ready to go." The plate tops were nested one inside the other. This surveyor asked to see inside the plate covers. Each top was observed | F 812 | F812: Food Procurement, Store, Prepare, Serve/Sanitary<br><br>1. The dietary department plates, bowls and tray lids are now stored and cleaned in a sanitary manor.<br>2. An audit was conducted of the main kitchen to ensure proper storage and cleaning of food service items.<br>3. ED educated the Dietary Manager on maintaining sanitary standards based on the state and federal guidelines.<br>4. A sanitation audit will be conducted weekly x4 and monthly x2 in the main kitchen to ensure that food preparation items are cleaned and stored in a sanitary manor per guidelines.<br>5. Date of compliance: July 20th, 2018 | |

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| F 812 | Continued From page 74<br>with water inside. The DM was asked if the plate covers were suppose to be stored wet and nested. He stated, "No, there isn't enough room on the rack where we stack them on their sides, they are suppose to stack them over here on the counter. That fan is blowing on them and will get them dry."<br><br>The above information was discussed during a meeting with the DON (director of nursing) and the administrator on 06/21/2018 at approximately 8:15 a.m.<br><br>No further information was obtained prior to the exit conference on 06/21/2018. | F 812 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 | F 880 | | |

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| F 880 | Continued From page 75<br>conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility 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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of | F 880 | F 880: Infection Prevention and Control<br><br>1. RN #2 is no longer employed at the facility. The LPN that was observed during the medication pass observation to not use proper hand hygiene was educated on proper infection control/hand hygiene practices.<br>2. An audit of licensed staff was conducted to ensure PPE and handwashing are being completed per policy.<br>3. DON/designee will educate license staff on the standards of practice for proper hand hygiene and PPE usage per facility policy.<br>4. Random PPE and hand hygiene audits will be conducted weekly x4 and monthly x2. Findings will be reported to QAPI monthly x 3 months for review.<br>5. Date of compliance: July 20th, 2018 | |

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| F 880 | Continued From page 76<br>infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to follow infection control practices for one of 31 residents in the survey sample, Resident # 292, and failed to ensure proper hand hygiene during a medication pass and pour observation.<br><br>1. The facility staff failed to use appropriate PPE (personal protective equipment) (gloves) for Resident # 292 during a mouth inspection.<br><br>2. The facility staff failed to ensure proper hand hygiene during a medication pass and pour observation.<br><br>Findings include:<br><br>Resident # 292 was admitted to the facility on 07/05/13, and remained until the resident expired (death) at the facility on 08/27/17. Diagnoses for Resident # 292 included, but were not limited to: dementia, seizure disorder, cerebrovascular disease, depression, HTN (high blood pressure), the resident was also a hospice resident.<br><br>On 06/21/18 at 08:59 AM, a complaint regarding Resident # 292 was investigated. An allegation within the complaint alleged that a nurse (identified as RN [Registered Nurse] # 2) put her bare fingers in the mouth of Resident # 292 to | F 880 | | |

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| F 880 | Continued From page 77<br>check the resident for thrush.<br><br>On 06/20/18 at approximately 2:00 p.m., the DON (director of nursing) was interviewed and asked for any information (issues/concerns) regarding Resident # 292 during the time of the complaint allegations (August 2017). The DON stated that she would look to see if she had anything.<br><br>On 06/20/18 at 2:15 PM, LPN (Licensed Practical Nurse) # 1 identified in the complaint intake information, was interviewed regarding the above information. LPN # 1 stated that she was in the room that day and remembered the allegation of RN # 2 putting her finger(s) in the resident's mouth to check the resident for thrush in her mouth. The LPN stated, "Yes, the resident was on hospice and I was in the room, but I didn't see that, I wasn't looking at her [the nurse] so I didn't see her do it, but I was in the room and I heard the daughter [residents daughter] say to the nurse, why are you putting your hands in her [the resident] mouth, shouldn't you [RN] have gloves on, and the nurse [RN # 1] said, I washed my hands." The LPN stated that the RN was thinking the resident had thrush and was checking the resident's mouth. The LPN stated that the RN no longer worked for the facility.<br><br>The DON presented a folder of information regarding the incident at approximately 2:45 p.m. The information was reviewed and documented that the RN was educated on appropriate PPE and that some staff were in serviced regarding infection control/PPE as evidenced by the signature page. The DON was asked if all staff (nurses/CNA's) were in serviced. The DON stated that she would look for more documentation regarding in-service information. | F 880 | | |

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| F 880 | Continued From page 78<br><br>The DON presented a nursing note dated 08/17/17 that documented, "...nurse examined resident mouth reports of yeast like rash on tongue. Hands intensely washed and scrubbed for over 3 minutes prior to exam...mucus membranes moist..."<br><br>On 06/21/18 08:30 AM The DON, administrator and Unit managers were made aware of concerns regarding the above information in a meeting with the survey team. No additional information was presented at this time.<br><br>On 06/21/18 at 3:15 p.m., the administrator and DON were again informed of the above information. No further information and/or documentation was presented prior to the exit conference on 06/21/18.<br><br>This is a complaint deficiency.<br>2. A medication pass observation was conducted on 6/19/18 at 4:00 p.m. with licensed practical nurse (LPN) #3. LPN #3 administered oral medications to the first resident in the medication pass. LPN #3 touched the resident's personal water cup, straw and then discarded the medication cup used by the resident to place tablets in his mouth. Without performing hand hygiene, LPN #3 prepared and administered medications to the next resident in the medication pass.<br><br>On 6/19/18 at 4:55 p.m., LPN #3 was interviewed about hand hygiene. LPN #3 stated she was supposed to perform hand hygiene between residents when giving medications. LPN #3 stated hand sanitizer was available in each room. LPN #3 stated she did not recall performing hand | F 880 | | |

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| F 880 | Continued From page 79<br>hygiene after the first resident in the medication pass.<br><br>The facility's policy regarding hand hygiene (2016) stated, "Practicing hand hygiene is a simple but effective way to prevent the spread of infections by breaking the chain of infection. Proper cleaning of hands can prevent the spread of germs...When hands are not visibly soiled, alcohol-based hand sanitizers are the preferred method for cleaning hands in this healthcare setting...When to perform Hand Hygiene...Before and after direct contact with a resident's intact skin...After contact with inanimate objects including medical equipment in the immediate vicinity of the residents...For care between residents..."<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/21/18 at 8:15 a.m. | F 880 | | |
| F 908 SS=F | Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)<br><br>§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility staff failed to ensure working ovens in the main kitchen.<br><br>One oven in the main kitchen did not work at all, the other oven only heated when the thermostat was set at 500 degrees.<br><br>Findings were: | F 908 | | |

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| | 495153 | A. BUILDING _____ B. WING _____ | C 06/21/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 908 | Continued From page 80<br><br>On 06/19/2018 at approximately 11:45 a.m., tray line temperatures were observed. The temperatures were obtained by OS (other staff) #9. A pan of lasagna was pulled from the oven and placed on the tray line. The temperature of the lasagna was 123 degrees, the top was a dark brown. OS #9 told one of the cooks to place the lasagna in the steamer to bring it up to temperature. This surveyor questioned the temperature versus the appearance of the food. The cook stated, "It's because the oven is broken." The DM (dietary manager) was at the tray line and was asked to clarify. He stated, "The one oven was power washed last week and they blew it up...the other one quit working and only cooks on 500." He was asked how food was prepared for the residents with the temperature only cooking at 500. He stated, "It's hard. We have to watch the food and rotate it." The DM was asked if a work order had been put in for the oven repair. He stated that maintenance was aware.<br><br>At approximately 1:15 p.m. on 06/19/2018, the Maintenance director was interviewed regarding the ovens in the kitchen. He stated that the people from HSCG (a contract company that runs the kitchen) had come in and power washed the convection oven on Wednesday (June 12, 2018). "I found out about it Thursday...I was praying it was the switch, I ordered one and replaced it on Friday, it didn't work, they got water all in the elements and the panels. Then I found out that the other one was only cooking/heating at 500 degrees....I never got a work order on that. I think the element is shot...I ordered one but it still isn't here...I went yesterday and borrowed one from a buddy of mine at another facility, I'm going to put | F 908 | F908 Essential Equipment, Safe Operating Condition<br><br>1. The Oven was repaired and is in good working condition<br>2. An audit of kitchen equipment was conducted to ensure it is all in good working condition.<br>3. ED will educate the dietary staff on entering repair needs in the facility TELS system.<br>4. Maintenance Director will audit dietary equipment to ensure it is all in good working order weekly x4 and monthly x2 and findings will be reported to QAPI for review.<br>5. Date of compliance: July 20th, 2018 | |

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| F 908 | Continued From page 81<br>it in today."<br><br>At 3:30 p.m., this surveyor returned to the kitchen. A worker from the maintenance department, OS #10 was in the kitchen putting an element in one of the ovens.<br><br>At 5:00 p.m., the temperatures for the evening meal were observed. OS #11 was interviewed regarding the oven. She stated that the oven was still not working. She stated that while she was cooking the chicken for the evening meal the oven had cut off and by the time she realized it the oven was cold. She stated she had to turn the oven up to 500 degrees again before it would heat. The chicken was taken out of the oven and the temperature obtained. The chicken breasts were 199 and 201 degrees. The smaller pieces (wings/legs) had blackened areas on them. She stated, "The air isn't blowing evenly in there, we are going to throw these pieces away." The District Dietary Manager stated, "I'll call maintenance and have them come look at it." The cook stated, "[Name of maintenance worker] said he didn't know how these ovens are suppose to work, when he was down here earlier."<br><br>On 06/20/2018 the tray line was observed. At approximately 5:00 p.m., OS #11 was asked if the oven was in working order. She stated, "The one is still not working at all...the other one is only cooking on 500 degrees...I have to watch it. When it gets hot, I have to turn it back and then watch it, when it starts to cool down I have to turn it back up to 500 degrees again to get it to heat back up."<br><br>The above information was discussed during a meeting with the DON (director of nursing) and | F 908 | | |

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| F 908 | Continued From page 82<br>the administrator on 06/21/2018 at approximately 8:15 a.m. The administrator was asked if he had been made aware that there was not a properly working oven in the main kitchen. He stated, "No, I was told it only cooked up to 500 degrees not that it only cooked when you turned it up to 500 degrees."<br><br>No further information was obtained prior to the exit conference on 06/21/2018. | F 908 | | |

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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection was conducted 6/19/18 through 6/21/18. The facility was in not compliance with the Virginia Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 143 bed facility was 131 at the time of the survey. The survey sample consisted of 25 current Resident reviews and six closed record reviews. | F 000 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br><br>To remain in compliance with all Federal and State regulations, the facility has taken or will take the action set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>The facility was not in compliance with the following Regulations for the Licensure of Nursing Facilities:<br><br>12VAC 5- 371-140 Policies and Procedures<br>12VAC 5- 371-140 (F.6) Cross Reference to F-567<br><br>12VAC 5- 371- 150 Resident Rights<br>12VAC 5- 371- 150 (B) Cross Reference to F-550<br>12VAC 5- 371- 150 (B) Cross Reference to F-561<br><br>12VAC 5- 371-180 Infection Control<br>12VAC 5- 371-180 (C.3) Cross Reference to F=880<br><br>12VAC 5- 371-200 Director of Nursing<br>12VAC 5- 371-200 (B.1) Cross Reference to F-658<br><br>12VAC 5- 371-220 Nursing Services<br>12VAC 5- 371-220 (D) Cross Reference to F-677 | F 001 | See Federal Tag F550<br><br>See Federal Tag F561<br><br>See Federal Tag F677<br><br>See Federal Tag F759 | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason J. Nunno | TITLE: Administrator | (X6) DATE: 7/9/18

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| F 001 | Continued From Page 1<br><br>12VAC 5- 371-220 (C.5) Cross Reference to F-692<br>12VAC 5- 371-220 (B) Cross Reference to F-759<br>12VAC 5- 371-220 (B) Cross Reference to F-760<br><br>12VAC 5- 371-250 Resident Assessment and Care Planning<br>12VAC 5- 371-250 (A) Cross Reference to F-636<br>12VAC 5- 371-250 (D) Cross Reference to F-641<br>12VAC 5- 371-250 (G) Cross Reference to F-656<br>12VAC 5- 371-250 (F) Cross Reference to F-657<br><br>12VAC 5- 371-300 Pharmaceutical Services<br>12VAC 5- 371-300 (A) Cross Reference to F-755<br>12VAC 5- 371-300 (B) Cross Reference to F-761<br><br>12VAC 5- 371-340 Dietary and Food Service Program<br>12VAC 5- 371-340 (B) Cross Reference to F-801<br>12VAC 5- 371-340 (G) Cross Reference to F-802<br>12VAC 5- 371-340 (A) Cross Reference to F-812<br><br>12VAC 5- 371-370 Maintenance and Housekeeping<br>12VAC 5- 371-370 (A) Cross Reference to F-584<br>12VAC 5- 371-370 (A) Cross Reference to F-689<br>12VAC 5- 371-370 (A) Cross Reference to F-908<br><br>32.1-126.01. Employment for compensation of persons convicted of certain offenses prohibited: criminal record checks required; suspension or revocation of license.<br><br>A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange.<br><br>Based on review of employee files and staff | F 001 | See Federal Tag F760<br>See Federal Tag F636<br>See Federal Tag F641<br>See Federal Tag F656<br>See Federal Tag F657<br>See Federal Tag F755<br>See Federal Tag F761<br>See Federal Tag F801<br>See Federal Tag F802<br>See Federal Tag F812<br>See Federal Tag F584<br>See Federal Tag F689<br>See Federal Tag F908 | |

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| F 001 | Continued From Page 2<br><br>interview, the facility failed to obtain criminal record checks in a timely manner. A review of 25 employee files for individuals hired in the last two year period revealed 11 employees did not have criminal record checks completed within 30 days of hire.<br><br>The findings were:<br><br>A list of employees hired during the past two years was requested from the facility. From that list, 25 employee files were selected for review. Eleven of the 25 files reviewed did not have criminal record checks completed within 30 days of hire.<br><br>Following is a list of employees, their position, hire date, and date the criminal record check was completed:<br><br>A receptionist hired 8/24/17 - criminal record check completed 1/17/18<br>A clinical liaison (Marketing Director) hired 8/10/17 - criminal record check completed 1/17/18<br>A Certified Nursing Assistant (CNA) hired 3/1/17 - criminal record check completed 1/17/18<br>A CNA hired 9/25/17 - criminal record check completed 1/22/18<br>A CNA hired 9/1/17 - criminal record check completed 1/17/18<br>A Licensed Practical Nurse (LPN) hired 7/21/17 - criminal record check completed 1/17/18<br>A LPN hired 10/1//17 - criminal record check completed 1/17/18<br>A LPN hired 12/17/16 - criminal record check completed 1/17/18<br>A LPN hired 4/30/17 - criminal record check completed 1/17/18<br>A Registered Nurse (RN) 9/25/17 - criminal record check completed 1/17/18<br>The Maintenance Director hired 10/23/17 - criminal record check completed 1/22/18 | F 001 | 1. The facility has obtained background checks for all 11 personal files reviewed.<br>2. HR/designee will review 100% of current employee personnel files to validate completion of criminal background checks.<br>3. HR/designee will obtain criminal background checks for new employees prior to orientation. HR/designee will review the employee file for new hires to validate completion of the criminal background check prior to scheduling orientation.<br>4. HR/designee will audit 10% of the personnel file of new employees monthly to validate completion of criminal background checks. Findings will be reported to the QAPI committee monthly for 3 months for review and recommendations.<br>5. Date of compliance: July 20th, 2018<br><br>RECEIVED<br>JUL 10 2018<br>VDH/OLC | |

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| F 001 | Continued From Page 3<br><br>Each of the 11 files contained the following memo from the Human Resources Manager:<br><br>"A file audit of several employee files was completed by (name), Human Resources Manager. During the audit it was discovered that some employees were missing Virginia State Police Backgrounds. Virginia State Police Backgrounds were conducted for those employees."<br><br>At 10:30 a.m. on 6/21/18, the Human Resources (HR) Manager was interviewed regarding the memo she had written. The HR Manager said that when she started at the facility in late December of 2017, she did a review of all personnel files and found a number of employees, including the 11 listed above, that did not have criminal record checks. The HR Manager said she had the criminal record checks done, and then placed the memo in the files to explain why the checks were not done on time.<br><br>The administrative staff, including the Administrator and Director of Nursing, were advised of the finding during a meeting with the survey team at 4:00 p.m. on 6/21/18. | F 001 | | |