| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495359 | A. BUILDING ______ B. WING ______ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB** | **120 DOGWOOD LANE ORANGE, VA 22960** |

| (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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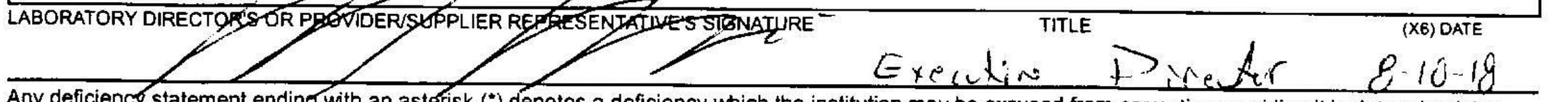
| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 07/24/18 through 07/26/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 7/24/18 through 7/26/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 164 bed certified bed facility was 145 at the time of the survey. The survey sample consisted of 37 current Resident record reviews (Residents #5, 38, 119, 87, 74, 33, 69, 42, 27, 37, 39, 6, 116, 28, 17, 95, 129, 47, 44, 88, 89, 62, 106, 123, 81, 4, 1, 63, 60, 121, 83, 437, 112, 438, 86, 136, and 75) and three closed record reviews (Residents #137, 139, and 138). | F 000 | | |
| F 550 SS=D | 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 | F 550 | 1. The facility has established a corrective action plan for residents #33, #28, #74, for not serving food in a manner to promote dignity in dining areas to include: serving at the same table/time, and for not disposing of spilled food in a dignified manner.<br><br>RECEIVED AUG 14 2018 VDH/OLC | |


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 8-10-18

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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| | VA0180 | A. BUILDING ______ B. WING ______ | 07/26/2018 |

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| DOGWOOD VILLAGE OF ORANGE COUNTY HEALT | 120 DOGWOOD LANE ORANGE, VA 22960 |

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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection was conducted 7/24/18 through 7/26/18. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 164 bed certified bed facility was 145 at the time of the survey. The survey sample consisted of 37 current Resident record reviews (Residents #5, 38, 119, 87, 74, 33, 69, 42, 27, 37, 39, 6, 116, 28, 17, 95, 129, 47, 44, 88, 89, 62, 106, 123, 81, 4, 1, 63, 60, 121, 83, 437, 112, 438, 86, 136, and 75) and three closed record reviews (Residents #137, 139, and 138). | F 000 | | |
| 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>12VAC5-371-140. Policies and procedures.<br>Based on staff interview, employee record review and facility document review, it was determined that the facility staff failed to obtain a license verification prior to employment for one of 25 employee record reviews.<br><br>The facility staff failed to obtain OSM (other staff member) #3's license verification prior to the employee's employment.<br><br>The findings include:<br><br>OSM #3 (a speech language pathologist) was hired for employment on 11/9/16. Review of OSM #3's employee record failed to reveal a license verification for the time period around 11/9/16. The record contained a license verification dated | F 001 | 1.The facility has established a corrective action for failing to obtain license verification prior to the employees' employment.<br><br>2. The employees of the facility have the potential to be affected.<br><br>3. Human Resources will be educated on 8/9/18 to ensure that the employees requiring licensure, have proof of licensure upon hire.<br><br>4. To ensure compliance, audits will be conducted by human resources (or Designee) every week x 4 weeks, then monthly x 3 to ensure the employees of the facility who require licensure have proof prior to employment. This information will be forwarded to QAPI for review. | 9/4/18 |

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

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| F 001 | Continued From Page 1 | F 001 | | |

3/2/17 and a license verification dated 12/27/17.

On 7/25/18 at 11:49 a.m., an interview was conducted with OSM #1 (the director of employee relations). OSM #1 reviewed OSM #3's record and confirmed the above findings. OSM #1 was asked the facility process for obtaining license verifications. OSM #1 stated she completes licensed verifications when she is in the process of pre-employment testing along with background checks and drug tests. When asked why, OSM #1 stated, "To make sure they are licensed and if there is anything against their license."

On 7/25/18 at 6:06 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above findings.

The facility policy titled, "Abuse Prevention" documented, "1. Screening...C.i. State licensure and certification agencies, and applicable registries, will be contacted, prior to hire, to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the registry..."

No further information was presented prior to exit.

12VAC5-371-340. Dietary and Food Service Program
cross reference to F814
12 VAC5-371-200 B.1. Director of Nursing: Resident Services cross references to F658.

12 VAC5-371-220.B Nursing Services cross references to F695.
12VAC5-371-150. Resident Rights cross references to F550.



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| F 001 | Continued From Page 2<br><br>12VAC5-371-250. Resident Assessment and Care Planning cross references to F656.<br><br>12VAC5-371-220. Nursing Services cross references to F693.<br><br>12VAC5-371-180. Infection Control cross references to F880.<br><br>12VAC5-371-300. Pharmaceutical services cross references to F761. | F 001 | | |



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| | 495359 | A. BUILDING ____ B. WING ____ | 07/26/2018 |

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| **DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB** | **120 DOGWOOD LANE ORANGE, VA 22960** |

| (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 550 | Continued From page 1<br>individuality. The facility must protect and promote the rights of the resident.<br><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 observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to serve food in a manner to promote resident dignity for three of 40 residents in the survey sample, Resident #33, 28 and 74.<br><br>1. The facility staff failed to serve food Resident #33 in a manner to promote dignity in the main dining room. Resident #33 was seated at a table | F 550 | 2. The residents of the facility who have meals in dining areas have the potential to be affected.<br><br>3. Facility Nursing staff will be re-educated on 8/9/18 on serving food in a manner to promote dignity in dining areas. This included: serving at the same table/time and for disposing of spilled food in a dignified manner.<br><br>4. To ensure compliance audits will be conducted by Administrative staff (or designee) every week x 4 weeks, then monthly x 3 on serving food in a manner to promote dignity in dining areas, including, serving at the same table/ time and for disposing of spilled food in a dignified manner. This information will be forwarded to QAPI for review.<br><br>12VAC5-371-150 cross reference to F550. | 9/4/18 |

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in the main dining room without his meal for approximately 20 minutes, while his tablemate ate and finished his meal.

2. The facility staff failed to dispose of spilled food in a dignified manner for Resident #28.

3. The facility staff failed to provide a dignified dining experience for Resident #74. Resident #74 was seated at a table with another resident, in the South Ground (SG) social dining area, but was not served her tray until 15 minutes after her tablemate received and ate his meal.

The findings include:

1. Resident #33 was admitted to the facility on 8/26/15 and readmitted on 3/15/18 with diagnoses that included but were not limited to acute kidney injury, type two diabetes, and mild cognitive impairment. Resident #33"s most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/15/18. Resident #33 was coded as having cognitive impairment scoring 05 out of possible 15 on the BIMS (brief interview for mental status) exam.

On 7/24/18 at 11:40 a.m., observation of the main dining room was conducted. At 11:40 a.m., Resident #33 was sitting at a table with another resident. At 12:10 p.m., the tablemate was served his entree (grilled cheese and soup). At 12:20 p.m., the tablemate had finished his meal and was then offered a dessert. At this time, Resident #33 still had not received his entree. At 12:30 p.m., Resident #33 received his entree.

On 7/26/18 at 10:52 a.m., an interview was

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| F 550 | Continued From page 3 | F 550 | | |

conducted with OSM (other staff member) #6. When asked about the dining process in the main dining room, OSM #6 stated when each resident comes into the dining room, fills out a ticket/meal order that is picked up by the dietary staff and brought to the steam table. OSM #6 stated meals were served by order. When asked if two residents sitting at the same table around the same time should be served their meal at the same time, OSM #6 stated that if the residents were sitting at the same table around the same time, their orders should have been taken at that time and brought to the steam table. OSM #6 asked to which residents this writer was referring. OSM #6 stated the resident sitting with Resident #33 usually comes into the dining room at 11:30 a.m., and his order was probably taken first. When OSM #6 was informed that both residents were sitting at the table at 11:40 a.m., OSM #6 stated she understood what this writer was saying but she had no control over the ticket system. When asked how she would feel if she were at a restaurant and received her meal 20 minutes after everyone else, OSM # 6 stated she wouldn't be happy if she had ordered at the same time as everyone else.

On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "The dining experience: Staff Responsibilities," documents in part, the following: "Individuals at the same table will be served and assisted at the same time."

No further information was presented prior to exit.
2. The facility staff failed to dispose of spilled food

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in a dignified manner for Resident #28.

Resident #28 was admitted to the facility on 12/19/14 with diagnoses that included but were not limited to: legal blindness, Alzheimer's disease, high blood pressure and depression.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/25/18 coded the resident as having an eight out of 15 on the BIMS (brief interview for mental status indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living.

An observation was made on 7/24/18 at 12:36 p.m. of Resident #28 and CNA (certified nursing assistant) #7. CNA #7 scooped broccoli in a plastic cup for the resident. The resident began feeding self and pieces of broccoli fell onto the resident's clothing protector. CNA #7 scooped the broccoli off the clothing protector and put it back into the resident's cup while the resident continued to eat out of the cup.

Review of the resident's care plan initiated on 12/31/14 and revised on 5/13/18 documented, "Problem/Need. (Name of resident) HAS FUNCTIONAL STATUS LIMITATION REQUIRING ASSIST WITH ADL'S (activities of daily living) R/T (related to) WEAKNESS, GAIT ABNORMALITY, POOR VISION, COGNITIVE IMPAIRMENT Approaches. ASSIST WITH TRAY SET UP & FEEDING AS NEEDED. FOOD TO BE PLACED IN CUPS FOR EASIER HANDLING FOR INDEPENDENT MEAL INTAKE."

An interview was conducted on 7/25/18 at 2:33

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p.m. with CNA #7. When asked what staff do if a resident spills food onto their clothing, CNA #7 stated, "I would think you would get a tissue and wipe it off." When the above observation was shared, CNA #7 stated, "I guess I wasn't thinking about that, that's a little embarrassing." When asked if that promoted the resident's dignity, CNA #7 stated, "No that wasn't good."

An interview was conducted on 7/25/18 at 3:46 p.m. with RN (registered nurse) #3, the unit manager. When asked what staff should do if a resident dropped food on their clothing, RN #3 stated, "If they can't wipe it off they should offer to change their shirt." When informed of the above observation with Resident #28, RN #3 stated, "That's terrible."

On 7/25/18 at 6:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "Dignity" documented, "Policy: The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Procedure: Staff will carry out the following activities that assist there resident to maintain and enhance his/her self-esteem and self-worth. 12. Refraining from practices demeaning to residents."

No further information was provided prior to exit.
3. The facility staff failed to provide a dignified dining experience for Resident #74. Resident #74 was seated at a table with another resident,



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in the South Ground (SG) social dining area, but was not served her tray until 15 minutes after her tablemate received and ate his meal.

Resident #74 was admitted to the facility on 9/5/14, with diagnoses that included but were not limited to: dementia, depression, chronic pain high blood pressure, arthritis, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/15/18, coded Resident #74 as having both short and long term memory impairment, as well as moderate impairment of daily decision making. Resident #74 was coded as requiring extensive assistance of one person physical assistance for bed mobility, transfers, walking, dressing, toileting and personal hygiene. She was coded as requiring limited assistance of one person physical assistance for locomotion and eating.

On 7/24/18 at 12:11 p.m. an observation of the South Ground (SG) social room dining area was performed. At that time, Resident #74 was sitting at a table, with one other resident, in the sunroom part of the SG dining area.

On 7/24/18 at 12:15 p.m., Resident #74's tablemate was served his tray and he began eating.

On 7/24/18 at 12:30 p.m., Resident #74's tray was placed in front of her and a CNA (certified nursing assistant) uncovered Resident #74's food containers. It was observed at this time that Resident #74's tablemate had completed his meal.

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| F 550 | Continued From page 7<br><br>On 7/25/18 at 2:44 p.m., an interview was conducted with CNA #4. When asked to describe the process for serving tables at mealtime, CNA #4 stated they serve each person at each table at the same time. When informed of the observation of Resident #74 receiving her meal 15 minutes after her tablemate, CNA #4 stated that was unusual and "maybe the resident needed assistance." At that time, CNA #4 stated, "she should have been served at the same time as the other person at the table." CNA #4 acknowledged she personally would not like to be served 15 minutes after everyone else at a table.<br><br>A review of Resident #74's comprehensive care plan, dated 9/5/14 with a most recent revision date of 6/23/18, documented in part, "Assist as needed with eating."<br><br>ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #4, the assistant director of nursing, were made aware of the above concerns on 7/25/18 at 6:04 p.m.<br><br>A review of the facility's policy, "The Dining Experience", documented in part that "8. Individuals at the same table will be served and assisted at the same time."<br><br>No further information was provided prior to exit. | F 550 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment 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 | F 584 | 1.The facility has established a corrective action plan for resident #74 for not having a dining experience in a home like environment related to serving on trays. | |

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| F 584 | Continued From page 8<br>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 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 facility | F 584 | 2. The residents of the facility who eat in dining areas have the potential to be affected.<br><br>3. Facility Nursing staff will be re-educated on 8/9/18 on having a dining experience in a home like environment related to serving on trays.<br><br>4. To ensure compliance, audits will be conducted by Administration staff (or designee) every week x 4 weeks, then monthly x 3, to ensure residents having a dining experience in a home like environment related to serving on trays. Information will be forwarded to QAPI for review. | 9/4/18 |

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document review, it was determined that the facility staff failed to provide a homelike dining experience for five of seven dining areas and one of 40 residents in the survey sample, Resident #74.

1. The facility staff failed to provide a homelike dining experience for residents in the west ground dining area during lunch on 7/24/18 and breakfast on 7/25/18. The residents were served meal plates on serving trays.

2. Resident #74, who was seated in the south ground social dining area, was served her meal on a tray, cafeteria/institutional style and her meal was not removed from the tray for a restaurant/home-like dining experience.

3. The facility staff failed to provide a homelike dining experience during lunch for residents in the facility's South Main Dining Room.

4. The facility staff failed to provide a homelike dining experience in the East Main dining room.

5. The facility staff failed to serve residents in a homelike manner in the West main dining room.

The findings include:

1. The facility staff failed to provide a homelike dining experience for residents in the west ground dining area during lunch on 7/24/18 and breakfast on 7/25/18. The residents were served meal plates on serving trays.

On 7/24/18 at 12:05 p.m. and 7/25/18 at 8:00 a.m., observations of staff serving residents



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meals in the west ground dining area were conducted. The staff served residents their meal plates on serving trays and did not remove the trays while the residents ate their meals. The meals were served on trays to residents who fed themselves and residents who required assistance with feeding. The residents were not cognitively intact.

On 7/25/18 at 1:41 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked why the residents were served meal plates on trays and why the trays were not removed. CNA #1 stated she really did not know the exact answer and that was how she and other staff has always provided meal service. CNA #1 stated maybe that method provided more cleanliness. When asked if serving meal plates on trays was homelike, CNA #1 stated, "No."

On 7/25/18 at 2:00 p.m., CNA #1 came to this surveyor and stated she had an answer for the above question. CNA #1 stated the supervisors and other CNAs said providing meal plates on trays was easier for residents to get what they need, such as items like utensils and condiments, but she would remove the tray if residents asked. When asked how serving meal plates on trays was easier for the residents, CNA #1 stated she thought the contrast of the colors made it easier for residents to see and the tray was kind of like a placemat.

On 7/25/18 at 3:02 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked why residents were served meal plates on trays. RN #1 stated, "I would say it probably helps them with boundaries that way (for) example a demented resident, it sets a



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boundary of where their stuff begins and ends and someone else's begins." When asked if each resident has been assessed to determine if serving meal plates on trays was beneficial for them, RN #1 stated, "I really can't answer that. I don't think we have an assessment available at this time like that." When asked if serving meal plates on trays was homelike, RN #1 stated, "I have done that at home where I was watching TV." When asked if serving meal plates on trays was homelike for someone eating in a dining area, RN #1 stated, "Could be."

On 7/25/18 at 6:06 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "The Dining Experience: Staff Responsibilities" documented, "2. Staff should provide service that will help to make dining a special 'event' that individual patients/residents will look forward to and that will create lasting memories. This includes but is not limited to...b. Providing an attractive, functional, home-like or restaurant-like dining environment (depending on the facility) that is roomy, comfortable with nice decor, contrasting colors, and appropriate furniture..."

No further information was presented prior to exit.

2. Resident #74, who was seated in the South Ground (SG) social dining area, was served her meal on a tray, cafeteria/institutional style and her meal was not removed from the tray for a restaurant/home-like dining experience.

Resident #74 was admitted to the facility on

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9/5/14, with diagnoses that included but were not limited to: dementia, depression, chronic pain high blood pressure, arthritis, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/15/18, coded Resident #74 as having both short and long term memory impairment, as well as moderate impairment of daily decision making. Resident #74 was coded as requiring extensive assistance of one person physical assistance for bed mobility, transfers, walking, dressing, toileting and personal hygiene. She was coded as requiring limited assistance of one person physical assistance for locomotion and eating.

On 7/24/18 at 12:11 p.m. an observation of the South Ground (SG) social room dining area was performed. At that time, Resident #74 was sitting at a table, with one other resident, in the sunroom part of the SG dining area.

On 7/24/18 at 12:11 p.m., the staff began to distribute the food trays to each table. Once the trays were set down, the cover to the entrée was removed but the plate, cups silverware, and condiments remained on each resident's tray.

On 7/24/18 at 12:30 p.m., Resident #74's tray was placed in front of her and a CNA uncovered Resident #74's food containers and left the meal on the cafeteria-like serving tray.

An interview was conducted with CNA (certified nursing assistant) #3 on 7/25/18 at 2:41 p.m. When asked why the food remained on the cafeteria-like trays when placed in front of the

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residents, CNA #3 stated that as long as she has worked there, staff have always served the meal on the tray. When asked why, CNA #3 stated, "I do not specifically know why" but "that is how they [the staff] have done it as long as I have worked here". When asked if this is a home-like way to serve a meal, CNA #3 stated it was not.

An interview was conducted with CNA #4 on 7/25/18 at 2:44 p.m. When asked why the meals were left on the cafeteria-like serving trays, CNA #4 stated it was "The facility's policy and it sets boundaries for each resident's meal area." When asked if serving residents on cafeteria-like trays provided a home-like environment, CNA #4 stated "No."

An interview was conducted with RN (registered nurse) #1 on 7/25/18 at 2:58 p.m. RN #1 was asked why the resident's meals remained on cafeteria-like trays after being served to the residents. RN #1 stated that it "Helps set boundaries for where their [the residents] stuff begins and ends." When asked if residents are assessed to determine if leaving the meals on the cafeteria-like trays helps to maintain eating independence, RN #1 stated she was "Unsure". When asked if she felt leaving the meal on the cafeteria-like tray provided a home-like eating experience, RN #1 stated, "It could be considered homelike." When asked if there was a policy regarding leaving resident's meals on the cafeteria-like trays, RN #1 stated she would have to check.

A review of Resident #74's comprehensive care plan, dated 9/5/14 with a most recent revision date of 6/23/18, documented in part "Assist as needed with eating."

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ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #4, the assistant director of nursing, were made aware of the above concerns on 7/25/18 at 6:04 p.m.

A review of the facility's policy "The Dining Experience: Staff Responsibilities" documented in part that "2.b. Staff should provide service that will help to make dining a special "event" that individual patients/residents will look forward to ...This includes but is not limited to: Providing an attractive, functional, home-like or restaurant-like dining environment."

No further information was provided prior to exit.

3. The facility staff failed to provide a homelike dining experience during lunch for residents in the facility's South Main Dining Room.

On 07/24/18 at 12:35, an observation was conducted in the South Main social area when lunch was being served. Observations revealed six residents were present and seated at three tables in the social area. The resident's lunch meal was served to all six residents on cafeteria trays.

On 07/25/18 at approximately 1:51 p.m., an interview was conducted with CNA (certified nursing assistant) # 3. When asked to describe a home like environment for residents during meals CNA # 3 stated, "No television, table clothes, centerpiece, the table set with plate and utensils." When asked if she assisted in serving lunch to the residents on 07/24/18, CNA # 3 stated, "Yes." When asked if serving a meal on a tray portrays a



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homelike environment for dining, CNA # 3 stated, "No. This is their home and we want to make them feel comfortable. I was never told to remove the trays."

On 07/25/18 at approximately 1:58 p.m., an interview was conducted with RN (registered nurse) # 3, unit manager. When asked to describe a home like environment for residents during meals, RN # 3 stated, "Give a choice of which dining room to eat at, the staff take off the lids and open containers, eating what they prefer, sitting with the residents, having them (residents) sit with others they know. if they want." When asked if serving a resident's meal on a tray was homelike, RN # 3 stated, "Probably not."

On 07/25/18 at approximately 6:00 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, and ASM # 4, assistant director of nursing were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to provide a homelike dining experience in the East Main dining room.

On 7/25/18 at 12:40 p.m., six residents present in the East Main dining room were served their lunch meal on trays, cafeteria/institutional style. The resident's meals were not removed from the trays for a restaurant/home-like dining experience.

On 7/25/18 at 2:13 p.m., CNA #11 (Certified Nursing Assistant) was asked why the residents were served their meals on the trays. CNA #11 stated, "I have been here over a year and that is

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the way I was taught to do that. We always leave the food on the trays. I don't know why. In other facilities I have worked we normally take everything off the tray." When asked if this was homelike, CNA #11 stated, "No. I was taught ever since I got here to serve it on the tray. Even when I was going through orientation, they never said to take the plates off the tray. It is not a homelike dining experience. At other facilities, we were instructed to remove the trays, but not here. It's just more proper. I'm not sure why they didn't instruct us to do that here. I have wondered but we have not had any complaints from the patients."

On 7/25/18 at approximately 6:00 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to serve residents in a homelike manner in the West main dining room.

A dining observation was conducted on 7/24/18 at 12:20 p.m. in the West main dining room. There were four residents seated at each of the two tables. All of the residents were served their lunch on trays.

An interview was conducted on 7/25/18 at 2:15 p.m. with RN (registered nurse) #7. When asked why the residents ate their meals on trays in the dining room, RN #7 stated, "I don't know." When asked if she ate her meals on a tray on the table at home, RN #7 stated, "No. It's my home." When asked what the facility was to the residents, RN #7 stated, "It's their home."

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An interview was conducted on 7/25/18 at 2:24 p.m. with CNA (certified nursing assistant) #17. When asked why the residents were served their meals on trays, CNA #17 stated, "Because it comes up like that. However, we should probably ask if they would like it off the tray." When asked if eating off a tray was homelike, CNA #17 stated, "No."

An interview was conducted on 7/25/18 at 2:30 p.m. with CNA #18. When asked why the residents were served their meals on trays, CNA #18 stated, "I'm not sure." When asked if it was homelike, CNA #18 stated, "No."

On 7/25/18 at 6:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "The Dining Experience: Staff Responsibilities" documented, "Policy: The dining experience will enhance each individual's quality of life through person centered dining: providing nourishing, palatable, and attractive meals that meet the individual's daily nutritional needs and food and beverage preferences. Procedure: 2. Staff should provide service that will help to make dining a special "event" that individual patients/residents will look forward to and that will create lasting memories. This includes but is not limited to: b. Providing an attractive, functional, home-like or restaurant-like dining environment (depending on the facility) that is roomy, comfortable with nice décor, contrasting colors and appropriate furniture."

No further information was provided prior to exit.

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| F 622 SS=E | Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br>(F) The facility ceases to operate.<br>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health | F 622 | 1. The facility has established a corrective action plan for residents #17, #123, #60, #119, #47, and #137 for not providing evidence of the required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) upon transfers to hospital.<br><br>2. The residents of the facility who receive transfer to the hospital have the potential to be affected.<br><br>3. Facility licensed Nurses will be re-educated on 8/9/18 to ensure that the required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) is provided upon transfers to hospital.<br><br>4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 to ensure that the required information (including physician contact information, resident representative contact information, special instructions for | |

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| F 622 | Continued From page 19<br>or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.<br><br>§483.15(c)(2) Documentation.<br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br>(i) Documentation in the resident's medical record must include:<br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for | F 622 | ongoing care, advance directives and comprehensive care plan goals) is provided upon transfers to hospital. Information will be forwarded to QAPI for review. | 9/4/18 |

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ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility for six of 40 residents in the survey sample; Residents #17, #123, #60, #119, #47 and #137.

1. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18, 06/14/18 and 06/29/18.

2. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #123 was transferred to the hospital on 06/06/18.

3. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative

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contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident # 60 was transferred to the hospital on 05/29/18.

4. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #119's hospitalization on 4/25/18.

5. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #47's hospitalization on 4/5/18.

6. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #137 was transferred to the hospital on 4/18/18.

The Findings include:

1. Resident # 17 was admitted to the facility on 01/19/17 and a readmission of 07/01/18 with diagnoses that included but were not limited to anemia (1), gastroesophageal reflux disease, (2), depressive disorder (3) and hypertension (4). Resident # 17's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/04/18, coded Resident # 17 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

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The nurse's note dated "4/25/2018 at 4:48 PM (p.m.)" documented, "4/25/18 at 4:00 PM (p.m.) Resident sent to (Name of Hospital) ER (emergency room) via (by) ambulance. DX (diagnosis): SOB (shortness of breath)/Weight gain, Resident has 17 LB (pound) weight increase in last five days. C/O (complaint of) leg and back pain. Left dialysis early this AM (a.m.) due to pain. Resident is own RP (responsible party)."

The nurse's note for Resident # 17 dated "6/14/2018 at 9:46 PM (p.m.)" documented, "Resident C/O (complaint of) feeling like she is going to die. SOB (shortness of breath) with shallow respirations noted. Diminished lung sounds upon auscultation noted. Low-grade temp (temperature) noted: 99.1 O2 (oxygen) saturation was as low as 70 %-84% RA (room air). O2 applied at 3L (three liters) via (by) nasal cannula. O2 saturation brought up to 95%. Resident skipped dialysis earlier this week. Resident states she would like to go to the hospital if nursing and MD (medical doctor) felt it was appropriate. On call MD notified, N.O. (new order) send out to ER (emergency room) for further evaluation. RP (responsible party) self aware will continue to monitor until paramedics pick-up."

The nurse's note dated "6/29/2018 at 7:35 AM (a.m.)" documented, "Nurse received call from (Name of Dialysis Center); they reported that the resident was sent to (Name of Hospital) via ambulance for SOB (shortness of breath) and low grade fever. Resident is her own RP."

Review of the clinical record and EHR (electronic

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health record) for Resident # 17 failed to evidence, physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18, 06/14/18 and 06/29/18.

On 07/26/18 at approximately 8:02 a.m., an interview was conducted with RN (registered nurse) # 3, unit manager. RN #3 was asked to describe the process staff follows when transferring a resident to the hospital. RN # 3 stated, "We notify the family by phone, send a copy of the resident's face sheet, medication list, transfer summary which includes why the resident is being sent, activities of daily living, resident status, copy of the physician's order sheet, current labs (laboratory tests) , copy of the DNR (do not resuscitate) if applicable." When asked if a copy of the resident's comprehensive care plan or comprehensive care plan goals are sent with the resident, RN # 3 stated, "No."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM (other staff member) # 7, admissions coordinator. When asked about transfer paper work for residents sent to the hospital, OSM # 7 stated, "I set up the 'Orange Folders' and put them at the nurse's station." OSM #7 was asked to describe what the 'Orange Folder' included and the purpose of the folder. OSM # 7 stated, "It includes the bed hold policy and the 'Nursing Home Capabilities List. The folder is sent with the resident when they are transferred to the hospital." OSM # 7 further stated the nurse provides additional information to be sent with the resident and provided a copy

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of the facility's "Post-Acute Facility Readmission Task Force" that documented, "Transfer Information: 1. Face sheet, 2. Bed Hold Policy, 3. Orders - diet, meds [medications], diagnosis, allergies, code status, flu shot order date, 4. Changes in condition form, 5. Quality Improvement Tool - has diagnosis, most recent hospitalizations, why coming (used when physician is called), 6. RN's call report, 7. Doctor's orders, last progress note, 8. RN note, 9. Current labs. At a minimum the information should include: 1. Capabilities List, 2. Change in Condition Form, 3. Face sheet, 4. ADLs/Code Status, 5. Flu/Pneumonia Vaccine."

Review of Resident # 17's clinical record and EHR (electronic health record) failed to evidence documentation that the facility provided physician contact information, resident representative contact information, and special instructions for ongoing care, advance directives and comprehensive care plan goals to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18.

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
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(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

2. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #123 was transferred to the hospital on 06/06/18.

Resident # 123 was admitted to the facility on 02/13/17 and a readmission of 06/12/18 with diagnoses that included but were not limited to schizoaffective disorder (1), gastroesophageal reflux disease, (2), depressive disorder (3) and anxiety (4).

Resident # 123's most recent MDS (minimum data set), a quarterly assessment with an ARD

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(assessment reference date) of 07/06/18, coded Resident # 123 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's note for Resident # 123 dated "6/6/2018 at 3:03 PM (p.m.)" documented, "Resident not feeling well this shift. Resident very tired. Resident continue on 3L (three liters) oxygen via (by) NC (nasal cannula) with humidification. Resident refused to eat breakfast and lunch this shift. Resident in no respiratory distress. Resident hurting all over. Resident medicated with Tylenol 650 mgs (milligrams) per MD (medical doctor) prn (as needed) order. (Name of Nurse Practitioner) notified that the resident was not acting like himself and that he needed to be assessed by him. Signee able to arouse resident by touch. Resident able to verbalize how he feels. After (Name of Nurse Practitioner) assessed resident he stated to send him out 911 for Acute Fluid Overload and possible kidney injury. 911 was called by signee at 2:20 a.m. Resident was assisted by staff to get cleaned up and ready for transport to (Name of Hospital). (Name of Responsible Party) notified of resident being sent out to ER (emergency room) for evaluation and treatment. Resident left facility at 3:05 p.m., by ambulance."

Review of the clinical record and EHR (electronic health record) for Resident # 123 failed to evidence physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital staff when Resident #123 was transferred to the hospital on 06/06/18.

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On 07/26/18 at approximately 8:02 a.m., an interview was conducted with RN (registered nurse) # 3, unit manager. RN #3 was asked to describe the process staff follows when transferring a resident to the hospital. RN # 3 stated, "We notify the family by phone, send a copy of the resident's face sheet, medication list, transfer summary which includes why the resident is being sent, activities of daily living, resident status, copy of the physician's order sheet, current labs (laboratory tests) , copy of the DNR (do not resuscitate) if applicable." When asked if a copy of the resident's comprehensive care plan or comprehensive care plan goals are sent with the resident, RN # 3 stated, "No."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM (other staff member) # 7, admissions coordinator. When asked about transfer paper work for residents sent to the hospital, OSM # 7 stated, "I set up the 'Orange Folders' and put them at the nurse's station." OSM #7 was asked to describe what the 'Orange Folder' included and the purpose of the folder. OSM # 7 stated, "It includes the bed hold policy and the 'Nursing Home Capabilities List. The folder is sent with the resident when they are transferred to the hospital." OSM # 7 further stated the nurse provides additional information to be sent with the resident and provided a copy of the facility's "Post-Acute Facility Readmission Task Force" that documented, "Transfer Information: 1. Face sheet, 2. Bed Hold Policy, 3. Orders - diet, meds [medications], diagnosis, allergies, code status, flu shot order date, 4. Changes in condition form, 5. Quality Improvement Tool - has diagnosis, most recent

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hospitalizations, why coming (used when physician is called), 6. RN's call report, 7. Doctor's orders, last progress note, 8. RN note, 9. Current labs. At a minimum the information should include: 1. Capabilities List, 2. Change in Condition Form, 3. Face sheet, 4. ADLs/Code Status, 5. Flu/Pneumonia Vaccine."

Review of Resident # 123's clinical record and HER (electronic health record) failed to evidence documentation that the facility provided physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18.

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

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(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:
https://medlineplus.gov/ency/article/003213.htm.

(4) Fear. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

3. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident # 60 was transferred to the hospital on 05/29/18.

Resident # 60 was admitted to the facility on 10/04/16 and a readmission of 06/01/18 with diagnoses that included but were not limited to schizophrenia (1), Parkinson's disease, (2), dementia (3) and hypertension (4).

Resident # 60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/15/18, coded Resident # 60 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 60 was coded as requiring extensive assistance

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of one staff member for activities of daily living.

The nurse's note for Resident # 60 dated "6/6/2018 at 3:03 PM (p.m.)" documented, "Resident requested to use the toilet, staff assisted resident to transfer to toilet without issue. After only minutes on the toilet resident became stiff, leaning back against the wall, then dropped her head and began drooling and mouth turned blue, resident began to shake for approximately 20 seconds, this happened twice, eyes rolled back and resident was unresponsive. Signee performed sternal rub and resident grunted but did not return at baseline. Lung sounds diminished and heart rate is weak. Resident was assisted to wheelchair then to the bed. Resident was evaluated by (Name of Physician) and order received to send resident to ER (emergency room). Unit manager present and aware. Message left with RP (responsible party) , (Name of Responsible Party) to call back to facility and RP, (Name of Responsible Party) aware of resident going to ER for evaluation and treatment."

Review of the clinical record and EHR (electronic health record) for Resident # 60 failed to evidence physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital staff when Resident # 60 was transferred to the hospital on 06/06/18.

On 07/26/18 at approximately 8:02 a.m., an interview was conducted with RN (registered nurse) # 3, unit manager. RN #3 was asked to describe the process staff follows when transferring a resident to the hospital. RN # 3

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stated, "We notify the family by phone, send a copy of the resident's face sheet, medication list, transfer summary which includes why the resident is being sent, activities of daily living, resident status, copy of the physician's order sheet, current labs (laboratory tests) , copy of the DNR (do not resuscitate) if applicable." When asked if a copy of the resident's comprehensive care plan or comprehensive care plan goals are sent with the resident, RN # 3 stated, "No."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM (other staff member) # 7, admissions coordinator. When asked about transfer paper work for residents sent to the hospital, OSM # 7 stated, "I set up the 'Orange Folders' and put them at the nurse's station." OSM #7 was asked to describe what the 'Orange Folder' included and the purpose of the folder. OSM # 7 stated, "It includes the bed hold policy and the 'Nursing Home Capabilities List. The folder is sent with the resident when they are transferred to the hospital." OSM # 7 further stated the nurse provides additional information to be sent with the resident and provided a copy of the facility's "Post-Acute Facility Readmission Task Force" that documented, "Transfer Information: 1. Face sheet, 2. Bed Hold Policy, 3. Orders - diet, meds [medications], diagnosis, allergies, code status, flu shot order date, 4. Changes in condition form, 5. Quality Improvement Tool - has diagnosis, most recent hospitalizations, why coming (used when physician is called), 6. RN's call report, 7. Doctor's orders, last progress note, 8. RN note, 9. Current labs. At a minimum the information should include: 1. Capabilities List, 2. Change in Condition Form, 3. Face sheet, 4. ADLs/Code Status, 5. Flu/Pneumonia Vaccine."

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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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Review of Resident # 123's clinical record and EHR (electronic health record) failed to evidence documentation that the facility provided physician contact information, resident representative contact information, and special instructions for ongoing care, advance directives and comprehensive care plan goals to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18.

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. Scoliosis (a sideways curve of your backbone, or spine.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html.

(2) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:

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https://medlineplus.gov/ency/article/000739.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html.

4. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #119's hospitalization on 4/25/18.

Resident #119 was admitted to the facility on 4/8/17 with the diagnoses of but not limited to end stage renal disease, dialysis, high blood pressure, depression, anxiety, schizoaffective disorder, convulsions, asthma, chronic obstructive pulmonary disease, osteoarthritis, obstructive sleep apnea, fluid overload, pancreatitis, and cholelithiasis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/11/18. The resident was cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed an MD (medical doctor) note dated 4/25/18 documented, "...declined dialysis today, "I've been throwing up all night. I just don't feel good at all...Physical Exam: General: Chronically ill appearing adult woman in no acute distress...Respiratory: lungs clear to auscultation bilaterally, breathing comfortably...Cardiovascular: regular rate...Gastrointestinal: soft, nontender, nondistended, normoactive bowel sounds...Musculoskeletal: no edema...Assessment...1. N/V (nausea and vomiting) supportive care, likely viral. monitor closely for dehydration, reassuring exam today...."



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A review of the nurses' notes revealed the following:

- 4/25/18 at 8:49 a.m.: "Resident has facial / body edema, received call from dialysis, stated unable to take her, to send to ER (emergency room), due to fluid over load, has not had dialysis since 4/21/18, refused to come 4/24/18, resident also request to be sent to ER [emergency room]...Dr (doctor) aware to send to ER for eval [evaluation], r/p (RP) aware, 911 called."

Further review of the clinical record failed to reveal any evidence that the required documentation (contact information of the practitioner, resident representative information, advanced directive information, special instructions or precautions, comprehensive care plan goals, other pertinent information) was provided to the receiving facility.

On 7/26/18 at 8:25 a.m., in an interview with LPN #5 (Licensed Practical Nurse), she stated that for transfers, the facility sends an orange folder, the transfer form, current orders, recent labs, and recent physician's note if there is one. She stated that is all that is sent. LPN #5 then provided a blank copy of the orange folder and the documents it contained, and from a file drawer obtained a blank copy of the "Patient Transfer Form."

A review of the "orange folder" revealed it contained two pre-filed documents in the pocket; a bed hold and a "Nursing Home Capabilities List" form, which identified the care, and services the nursing home is able to provide for any admission/readmissions.

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A review of the "Patient Transfer Form" revealed areas to be completed by the facility for resident demographic information, physician information, advanced directives, diagnoses, basic care needs, wound care needs, appliances needs, nursing assessment, immunization status, resident representative information. There was no requirement on the form for the provision of the comprehensive care plan goals. A copy of this form that should have been completed for the 4/25/18 hospitalization was not located in the clinical record.

On 7/26/18 at approximately 12:00 p.m., the facility was provided with a list of documents needed from this resident's record. A copy of the transfer form was requested on this list.

On 7/26/18 at 1:29 p.m., when providing the requested documents, the DON (Director of Nursing - ASM #2 - Administrative Staff Member) was asked about the transfer form, which was not included in the documents provided. ASM #2 stated they didn't have it and that the staff had not been consistently using the transfer form.

On 7/26/18 at 1:50 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #47's hospitalization on 4/5/18.

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Resident #47 was admitted on 1/1/15 and readmitted on 4/8/18 with the diagnoses of but not limited to diabetes, high blood pressure, dementia, osteoporosis, Barrett's esophagus, atrial fibrillation, deep vein thrombosis, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was severely impaired in ability to make daily life decisions.

A review of the clinical record revealed the following notes:

- 4/5/18 at 5:31 PM: "....Unable to obtain blood glucose reading after 5 attempts, a different glucometer, different strips, and different fingers used, glucometer read E-0. Supervisor notified. Resident had CBC {1} drawn this evening and awaiting results. MD (medical doctor) notified."

- 4/5/18 at 11:54 PM: "Nurse was unable to obtain a blood glucose reading on this resident this evening. CBC results received at 8:30 with critical lab value of hemoglobin 5.4. Nurse immediately notified supervisor and called MD with lab results. MD gave order to send to ED (Emergency Department) for evaluation and treatment for a blood transfusion. Nurse spoke with RP (responsible party). RP asked to call nurse right back after discussing with family. RP returned call and gave the ok to send this resident out to ED for evaluation and treatment. Nurse informed resident of the lab results and the need to go to the ED. Nurse informed resident that she had spoke with her sons about going to the hospital and that they were supportive. Resident acknowledged this and was positive and



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understanding of needing to go out to the hospital. Resident was awake and alert at this time, breathing normally and responsive to questions...."

- 4/6/18 at 3:24 PM (social worker note): "resident discharged to hospital yesterday - she is not a bedhold (Sic.) - notification of bedhold (Sic.) policy sent with her in the orange folder and mailed to her RP - belongings remain intact in her room in anticipation of her return."

Further review of the clinical record failed to reveal any evidence that the required documentation (contact information of the practitioner, resident representative information, advanced directive information, special instructions or precautions, comprehensive care plan goals, other pertinent information) was provided to the receiving hospital.

On 7/26/18 at 8:25 a.m., in an interview with LPN #5 (Licensed Practical Nurse), she stated that for transfers, the facility sends an orange folder, the transfer form, current orders, recent labs, and recent physician's note if there is one. LPN #5 stated that is all that is sent. LPN #5 then provided a blank copy of the orange folder and the documents it contained, and from a file drawer obtained a blank copy of the "Patient Transfer Form."

A review of the "orange folder" revealed it contained two pre-filed documents in the pocket; a bed hold and a "Nursing Home Capabilities List" form, which identified the care, and services the nursing home is able to provide for any admission/readmissions.

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A review of the "Patient Transfer Form" revealed areas to be completed by the facility for resident demographic information, physician information, advanced directives, diagnoses, basic care needs, wound care needs, appliances needs, nursing assessment, immunization status, resident representative information. There was no requirement on the form for the provision of the comprehensive care plan goals. A copy of this form that should have been completed for the 4/5/18 hospitalization was not located in the clinical record.

On 7/26/18 at approximately 12:00 p.m., the facility was provided with a list of documents needed from this resident's record. A copy of the transfer form was requested on this list.

On 7/26/18 at 1:29 p.m., when providing the requested documents, the DON (Director of Nursing - ASM #2 - Administrative Staff Member) was asked about the transfer form, which was not included in the documents provided. She stated they didn't have it and that the staff had not been consistently using the transfer form.

On 7/26/18 at 1:50 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

{1} CBC with differential - A CBC (complete blood count) tests measure the number and types of cells in your blood. This helps doctor's check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood



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| F 622 | Continued From page 39 | F 622 | | |

cancers, and immune system disorders. Information obtained from https://medlineplus.gov/bloodcounttests.html

6. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #137 was transferred to the hospital on 4/18/18.

Resident #137 was admitted to the facility on 4/2/18. Resident #137's diagnoses included but were not limited to chest pain, difficulty swallowing and high blood pressure. Resident #137's admission MDS (minimum data set) with an ARD (assessment reference date) of 4/11/18, coded the resident as being cognitively intact.

Review of Resident #137's clinical record revealed a nurse's note dated 4/18/18, signed by LPN (licensed practical nurse) #1, that documented, "Resident c/o (complained of) pain in chest around heart 'firm pain' Stated pain started yesterday and has gotten worse tonight. VS (Vital signs) 97.1 (temperature) 86 apical (pulse) 20 (respirations) 140/88 (blood pressure). Talked with son and she wants to go to hospital. (Name of nurse practitioner) RP (responsible party) aware."

Another nurse's note dated 4/18/18 documented, "Pt (Patient) was sent to (name of hospital) by squad for c/o chest pain. RP (name) will meet them at hospital."

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Further review of Resident #137's clinical record failed to reveal evidence of the information provided to hospital staff.

On 7/25/18 at 3:02 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated a face sheet including demographics and insurance information, physician orders, a set of vital signs and any recent labs [laboratory tests] is provided. RN #1 stated physician contact information and responsible party (resident representative) contact information is documented on the face sheet. RN #1 stated advance directives are sent if they are in the resident's chart but the resident's code status (whether or not to provide cardiopulmonary resuscitation) is documented on the face sheet and physician orders. RN #1 stated special precautions or instructions for care are supposed to be documented on physician orders. When asked if residents' comprehensive care plan goals are provided to hospital staff, RN #1 stated, "No. Normally we don't send that." When asked how the facility staff evidences the information provided to hospital staff, RN #1 stated there was no evidence.

On 7/25/18 at 6:06 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

On 7/26/18 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked to describe to items provided to hospital staff when residents are transferred to the hospital. LPN #1 stated she provides a face sheet, physician



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| F 622 | Continued From page 41 orders, medications given in the last eight hours, any recent lab work, history and physical and the do not resuscitate form. LPN #1 stated a transfer form is usually sent. When asked if she provides the residents' comprehensive care plan goals, LPN #1 stated, "Honestly, I do not."<br><br>On 7/26/18 at 1:25 p.m., ASM #4 (the assistant director of nursing) stated she could not locate a transfer form for when Resident #137 was transferred to the hospital.<br><br>On 7/26/18 at 1:57 p.m., ASM #2 stated the facility staff was not consistently using the transfer form. When asked for a policy regarding hospital transfers, ASM #2 stated the facility did not have a direct policy.<br><br>No further information was presented prior to exit. | F 622 | | |
| F 623 SS=E | Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section. | F 623 | 1.The facility has established a corrective action for residents #17, #123, #60, #19 and #4 related to notification of discharge when a resident is transferred to the hospital.<br><br>2. The residents who are transferred to the hospital have the potential to be affected.<br><br>3. The Facility social services and admission staff were in serviced on August 8, 2018 by the Director of Customer and Community Relations on the importance of providing discharge notification when residents | |

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| F 623 | Continued From page 42<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; | F 623 | are transferred to the hospital.<br><br>4. To ensure compliance, audits will be conducted by Director of Social Services (or Designee) every week x 4 weeks, then monthly x 3, to assure discharge/ transfer notification was provided to the resident/ RPs. | 9/4/18 |



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(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

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Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident representative of a facility initiated transfer to the hospital for five of 40 residents in the survey sample; Residents #17, #123, #60, #119 and #47.

1. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 04/25/18, 06/14/18 and 06/29/18 for Resident # 17.

2. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 06/06/18 for Resident # 123.

3. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 05/29/18 for Resident # 60.

4. The facility staff failed to provide Resident #119's resident representative with written notification for the resident's hospitalizations on 2/13/18, 3/20/18, 4/25/18, and 5/8/18.

5. The facility staff failed to provide Resident #47's resident representative with written notification for the resident's hospitalization on 4/5/18.

The findings include:

1. Resident # 17 was admitted to the facility on 01/19/17, with a readmission on 07/01/18, with diagnoses that included but were not limited to

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anemia (1), gastroesophageal reflux disease, (2), depressive disorder (3) and hypertension (4).

Resident # 17's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/04/18, coded Resident # 17 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 17 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's note dated "4/25/2018 at 4:48 PM (p.m.)" documented, "4/25/18 at 4:00 PM Resident sent to (Name of Hospital) ER (emergency room) via (by) ambulance. DX (diagnosis): SOB (shortness of breath)/Weight gain, Resident has 17 LB (pound) weight increase in last five days. C/O (complaint of) leg and back pain. Left dialysis early this AM (a.m.) due to pain. Resident is own RP (responsible party)."

The nurse's note for Resident # 17 dated "6/14/2018 at 9:46 PM (p.m.)" documented, "Resident C/O (complaint of) feeling like she is going to die. SOB (shortness of breath) with shallow respirations noted. Diminished lung sounds upon auscultation noted. Low-grade temp (temperature) noted: 99.1 O2 (oxygen) saturation was as low as 70 %-84% RA (room air). O2 applied at 3L (three liters) via (by) nasal cannula. O2 saturation brought up to 95%. Resident skipped dialysis earlier this week. Resident states she would like to go to the hospital if nursing and MD (medical doctor) felt it was appropriate. On call MD notified, N.O. (new order) send out to ER (emergency room) for



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further evaluation. RP (responsible party) self aware will continue to monitor until paramedics pick-up."

The nurse's note dated "6/29/2018 at 7:35 AM (a.m.)" documented, "Nurse received call from (Name of Dialysis Center); they reported that the resident was sent to (Name of Hospital) via ambulance for SOB (shortness of breath) and low grade fever. Resident is her own RP."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM # 8 regarding the written notification to the resident and responsible party for Resident # 17's facility initiated transfers to the hospital. OSM # 8 stated the written notification is part of the bed hold form. Review of the bed hold form failed to evidence an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests; information on how to request an appeal hearing. Information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman. When asked if the written notification contained an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests. Information on how to request an appeal hearing; information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman OSM # 8 stated, "No."

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On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:
https://medlineplus.gov/ency/article/003213.htm.

(4) High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html.

2. The facility staff failed to provide written notification to the resident and responsible party (RP) for a facility initiated transfer to the hospital on 06/06/18 for Resident # 123.

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Resident # 123 was admitted to the facility on 02/13/17, and readmitted ofn06/12/18 with diagnoses that included but were not limited to schizoaffective disorder (1), gastroesophageal reflux disease, (2), depressive disorder (3) and anxiety (4).

Resident # 123's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/06/18, coded Resident # 123 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 123 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's note for Resident # 123 dated "6/6/2018 at 3:03 PM (p.m.)" documented, "Resident not feeling well this shift. Resident very tired. Resident continue on 3L (three liters) oxygen via (by) NC (nasal cannula) with humidification. Resident refused to eat breakfast and lunch this shift. Resident in no respiratory distress. Resident hurting all over. Resident medicated with Tylenol 650 mgs (milligrams) per MD (medical doctor) prn (as needed) order. (Name of Nurse Practitioner) notified that the resident was not acting like himself and that he needed to be assessed by him. Signee able to arouse resident by touch. Resident able to verbalize how he feels. After (Name of Nurse Practitioner) assessed resident he stated to send him out 911 for Acute Fluid Overload and possible kidney injury. 911 was called by signee at 2:20 a.m. Resident was assisted by staff to get cleaned up and ready for transport to (Name of Hospital). (Name of Responsible Party) notified of resident being sent out to ER (emergency

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room) for evaluation and treatment. Resident left facility at 3:05 p.m., by ambulance."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM # 8 regarding the written notification to the resident and responsible party for a facility initiated transfer for Resident # 123. OSM # 8 stated the written notification is part of the bed hold form. Review of the bed hold form failed to evidence an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests; information on how to request an appeal hearing. Information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman. When asked if the written notification contained the above information, OSM # 8 stated, "No."

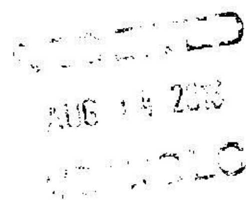
On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

(2) Stomach contents to leak back, or reflux, into





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the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

3. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 05/29/18 for Resident # 60.

Resident # 60 was admitted to the facility on 10/04/16 and a readmission of 06/01/18 with diagnoses that included but were not limited to schizophrenia (1), Parkinson's disease, (2), dementia (3) and hypertension (4).

Resident # 60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/15/18, coded Resident # 60 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 60 was coded as requiring extensive assistance of one staff member for activities of daily living.

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The nurse's note for Resident # 60 dated "6/6/2018 at 3:03 PM (p.m.)" documented, "Resident requested to use the toilet, staff assisted resident to transfer to toilet without issue. After only minutes on the toilet resident became stiff, leaning back against the wall, then dropped her head and began drooling and mouth turned blue, resident began to shake for approximately 20 seconds, this happened twice, eyes rolled back and resident was unresponsive. Signee performed sternal rub and resident grunted but did not return at baseline. Lung sounds diminished and heart rate is weak. Resident was assisted to wheelchair then to the bed. Resident was evaluated by (Name of Physician) and order received to send resident to ER (emergency room). Unit manager present and aware. Message left with RP (responsible party) , (Name of Responsible Party) to call back to facility and RP, (Name of Responsible Party) aware of resident going to ER for evaluation and treatment."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM # 8 regarding the written notification to the resident and responsible party for a facility initiated transfer for Resident # 60. OSM # 8 stated the written notification is part of the bed hold form. Review of the bed hold form failed to evidence an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests. Information on how to request an appeal hearing; information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State

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Long-Term Care ombudsman. When asked if the written notification contained the above information, OSM # 8 stated, "No."

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. Scoliosis (a sideways curve of your backbone, or spine.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html.

(2) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.



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4. The facility staff failed to provide Resident #119's resident representative with written notification for the resident's hospitalizations on 2/13/18, 3/20/18, 4/25/18, and 5/8/18.

Resident #119 was admitted to the facility on 4/8/17 with the diagnoses of but not limited to end stage renal disease, dialysis, high blood pressure, depression, anxiety, schizoaffective disorder, convulsions, asthma, chronic obstructive pulmonary disease, osteoarthritis, obstructive sleep apnea, fluid overload, pancreatitis, and cholelithiasis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/11/18. The resident was cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed an MD (medical doctor) note dated 4/25/18 documented, "...declined dialysis today, "I've been throwing up all night. I just don't feel good at all....Physical Exam: General: Chronically ill appearing adult woman in no acute distress....Respiratory: lungs clear to auscultation bilaterally, breathing comfortably...Cardiovascular: regular rate....Gastrointestinal: soft, nontender, nondistended, normoactive bowel sounds...Musculoskeletal: no edema....Assessment...1. N/V (nausea and vomiting) supportive care, likely viral. monitor closely for dehydration, reassuring exam today...."

A review of the nurses' notes revealed the following notes as relating to all of the identified hospitalizations:

- 2/13/18 at 9:02 a.m.: "Dialysis called facility at approx (approximately) 730a.m. this morning

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reported resident sent to hospital....resident BP (blood pressure) noted to be 198/100, resident was vomiting non-stop, dialysis contacted dialysis DR (doctor) and they requested her to go to the hospital...."

- 2/13/18 at 12:17 p.m.: "Called (name of hospital) for update on resident...Reported that resident has been admitted...New Order: Discharge resident to (hospital), RP (responsible party - name of resident's RP) aware.

- 2/14/18 at 8:55 a.m.: "Resident out to the hospital yesterday - she is a bedhold (sic.) - belongings remain intact in her room."

There was no evidence that the responsible party was provided with written notification of the hospitalization on 2/13/18.

There were no nurse's notes documenting the hospitalization on 3/20/18. However, "Administration" records for medication administration documented medications that were not administered due to "Resident not available. Resident out to ER [emergency room]. Never came back from dialysis today."

- A 3/21/18 (social worker note) at 9:33 a.m. documented: "resident discharged to the hospital yesterday - she is a bedhold (sic.) - belongings remain intact in her room in anticipation of her return."

There was no evidence that the responsible party was provided with written notification of the hospitalization on 3/20/18.

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- A nurses note dated 4/25/18 at 8:49 a.m. documented: "Resident has facial / body edema, received call from dialysis, stated unable to take her, to send to ER (emergency room), due to fluid over load, has not had dialysis since 4/21/18, refused to come 4/24/18, resident also request to be sent to ER...Dr (doctor) aware to send to ER [emergency room] for eval [evaluation], r/p (RP) aware, 911 called."

- A nurses noted dated 4/25/18 at 4:53 p.m. documented: "Spoke with ED (emergency department) at (name of hospital) she was admitted."

- A 4/26/18 (social worker note) at 8:26 a.m. documented: "(Resident #119) was discharged to (hospital) on 4/25/18. Desires BH (bed hold). Personal items to remain in room. Worker sent BH notification and authorization. Will assist with return."

There was no evidence that the responsible party was provided with written notification of the hospitalization on 4/25/18.

- A nurses noted dated 5/8/18 at 9:51 a.m. documented: "Resident had new orders....left detailed message for RP (responsible party - name of RP) about that and also that resident went to the ER to be evaluated for SOB (Shortness of Breath), sent there from dialysis...."

- A nurse's note date 5/8/18 at 9:53 a.m. documented: "Nurse from (dialysis center) called...states that during res (resident) dialysis tx (treatment) res c/o (complained of) SOB and chest pain. Res (resident) was transported from dialysis to (hospital) per res request. RP, UM

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(unit manager) DON (director of nursing), MD (medical doctor) made aware."

- A 5/9/18 (social worker note) at 2:31 p.m. documented: "resident discharged to hospital yesterday - she is a bedhold (sic.) - notice of bedhold (sic) policy sent with her in the orange folder to the hospital - copy of bedhold (sic.) policy and authorization form mailed to rp (name of responsible party). belongings remain intact in her room in anticipation of her return."

There was no evidence that the responsible party was provided with written notification of the hospitalization.

07/26/18, 01:23 p.m. in an interview with OSM #8 (Other Staff Member, the social worker), she stated that they "do not have a written notification that meets the requirement of the regulation."

On 7/26/18 at 1:50 p.m. The executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to provide Resident #47's resident representative with written notification for the resident's hospitalization on 4/5/18.

Resident #47 was admitted on 1/1/15 and readmitted on 4/8/18 with the diagnoses of but not limited to diabetes, high blood pressure,



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dementia, osteoporosis, Barrett's esophagus, atrial fibrillation, deep vein thrombosis, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was severely impaired in ability to make daily life decisions.

A review of the clinical record revealed the following notes:

- 4/5/18 at 5:31 p.m.: "...Unable to obtain blood glucose reading after 5 attempts, a different glucometer, different strips, and different fingers used, glucometer read E-0. Supervisor notified. Resident had CBC {1} drawn this evening and awaiting results. MD (medical doctor) notified."

- 4/5/18 at 11:54 p.m.: "Nurse was unable to obtain a blood glucose reading on this resident this evening. CBC results received at 8:30 with critical lab value of hemoglobin 5.4. Nurse immediately notified supervisor and called MD with lab (laboratory) results. MD gave order to send to ED (Emergency Department) for evaluation and treatment for a blood transfusion. Nurse spoke with RP (responsible party). RP asked to call nurse right back after discussing with family. RP returned call and gave the ok to send this resident out to ED for evaluation and treatment. Nurse informed resident of the lab results and the need to go to the ED. Nurse informed resident that she had spoke (Sic.) with her sons about going to the hospital and that they were supportive. Resident acknowledged this and was positive and understanding of needing to go out to the hospital. Resident was awake and alert at this time, breathing normally and responsive to questions...."

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| F 623 | Continued From page 58<br><br>- 4/6/18 at 3:24 p.m. (social worker note): "resident discharged to hospital yesterday - she is not a bedhold (Sic.) - notification of bedhold (Sic.) policy sent with her in the orange folder and mailed to her RP - belongings remain intact in her room in anticipation of her return."<br><br>There was no evidence that the responsible party was provided with written notification of the hospitalization on 4/5/18.<br><br>07/26/18, at 01:23 p.m. in an interview with OSM #8 (Other Staff Member, the social worker), she stated that they "do not have a written notification that meets the requirement of the regulation."<br><br>On 7/26/18 at 1:50 p.m. the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.<br><br>{1} CBC with differential - A CBC (complete blood count) tests measure the number and types of cells in your blood. This helps doctor's check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders. Information obtained from https://medlineplus.gov/bloodcounttests.html | F 623 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and | F 656 | 1.The facility has established a corrective action for not following the comprehensive care plan and plan of care for Resident #89 related to tube feeding: Resident #37, #39 | |



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| F 656 | Continued From page 59<br>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 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. | F 656 | and #116 related to: administration of oxygen and resident #112 related to a communication computer system.<br><br>2. The residents of facility who have tube feeding, administration of oxygen and communication computer systems have the potential to be affected.<br><br>3. Facility Nursing staff will be re-educated on 8/9/18 to follow comprehensive care plan and plan of care related to tube feeding, administration of oxygen and residents who require a communication computer system.<br><br>4. To ensure compliance audits will be conducted by RAI director (or Designee) every week x 4 weeks, then monthly x 3, to ensure staff are following comprehensive care plans and plan of care regarding: tube feeding, administration of oxygen and communication computer systems. Audits will be forwarded to QAPI for review.<br><br>12VAC5-371-250 cross reference to F656. | 9/4/18 |

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This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop and implement the comprehensive care plan for five of 40 residents in the survey sample, Resident #89, 37, 39, 116, and #112.

1. The facility staff failed to check for residual prior to initiating Resident #89's tube feeding per the comprehensive care plan and plan of care.

2. The facility staff failed to follow Resident # 37's comprehensive care plan for the administration of oxygen.

3. The facility staff failed to implement Resident #39's comprehensive care plan for the administration of oxygen.

4. The facility staff failed to follow Resident #116's comprehensive care plan regarding the administration of oxygen at the physician ordered rate.

5. The facility staff failed to follow the comprehensive care plan to implement the communication computer system for Resident #112.

The findings include:

1. The facility staff failed to check residual prior to initiating Resident #89's tube feeding per the comprehensive care plan and plan of care.

Resident #89 was admitted the facility on 5/30/18 with diagnoses that included but were not limited

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to stroke, muscle weakness, cognitive communication deficit, high blood pressure, type two diabetes, dysphagia (difficulty swallowing) (1) and hemiplegia (paralysis) (2) on the left side. Resident #89's most recent MDS (minimum data set) was a 30 day scheduled assessment with an ARD (assessment reference date) of 6/27/18. Resident #89 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status exam). Resident #89 was coded as requiring extensive assistance from staff with bed mobility, transfers, toileting, personal hygiene; and total dependence on staff with locomotion, eating, and bathing. Resident #89 was coded in Section K "Nutritional Approaches" as having a feeding tube.

Review of Resident #89's July 2018 POS (physician order summary) revealed the following orders:

"Fibersource via g (gastronomy) tube (peg [percutaneous endoscopic gastrostomy (3)]/feeding tube for enteral nutrition) at 130 cc/hr (hour) x 10 hours for Nutrition -Start at 4 PM/stop at 2 AM.

Flush peg tube with 150 ml (milliliters) H20 (water) before and after feeding

Check placement of Peg before administering of medications/feedings/flushes

Check residual every shift hold if more than 60 cc (cubic centimeters) and notify MD (medical doctor)."

Review of the July 2018 MAR (medication

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administration record) revealed that staff were checking residuals at 6 AM, 2 PM and 10 PM. These times did not include prior to his feeding (4PM).

Review of Resident #89's care plan dated 6/8/18 documented the following: "(Name of resident) requires a PEG tube for adequate nutritional intake r/t (related to) (R [right]) MCA (middle cerebral artery) infarct (stroke) w/left hemiparesis (left sided paralysis) resulting in dysphagia...Approaches: check residual before initiating (Name of Resident #89's) feeding, check placement of PEG PER MD ORDERS."

On 7/24/18 at 4 p.m., medication administration observation was conducted with RN (registered nurse) #6. RN #6 stated she was going to give medications to Resident #89. RN #6 told this writer she had already sanitized her hands. RN #6 prepared the following medications:

Gabapentin 100 mg (milligrams); works in the brain to prevent seizures and manage pain related to neurological disorders. (4)
Oxycodone 5 mg 1 tablet; narcotic analgesic used to treat moderate to severe pain. (5)
Thiamine 100 mg 2 tabs; also known as vitamin B1. (6)

RN #6 opened the Gabapentin capsule and placed the contents in a separate cup. RN #6 then crushed the one oxycodone and placed the crushed medication into a medication cup. RN#6 then crushed the thiame and placed the crushed medication in a separate medication cup. RN #6 then added water per order to each medication cup, took a peg tube syringe out of a plastic bag, and attached it to Resident #89's tube feed. RN

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#6 then flushed the peg tube, slowly adding the medications separately. RN #6 was not observed checking the placement of Resident #89's peg tube prior to administering medications.

After RN #6 administered medications to Resident #89, she proceed to hang his fibersource (enteral feed). RN #6 primed the feeding bag and tubing, capped the tip of the tubing and hung it on the pole. RN #6 then took a syringe from a plastic bag and placed it directly on Resident #89's bed. RN #6 uncapped Resident #89's tube feed and placed the syringe directly into his peg tube. RN #6 poured 150 mls (milliliter) of water per order through the syringe and into his peg tube. RN #6 then hooked Resident #89 up to his tube feed and turned on his tube feed.

On 7/24/18 at 4:21 p.m., after RN #6 and this writer were back at the medication cart, RN #6 stated she forgot to check residual of the tube feeding and that she usually does. RN #6 stated it (residual) should be checked prior to initiating the tube feeding.

On 7/26/18 at 9:53 a.m., an interview was conducted with RN #2, another nurse who cares for Resident #89. When asked about the process staff follows prior to initiating a tube feeding, RN #2 stated that prior to setting up the tube feed; she would check the placement of the tube and then check the residual. When asked why checking the placement and residual were important, RN #2 stated to ensure the tube was in place and to ensure the resident was not receiving too much feeding. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to serve as a guide

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on how to provide the best care for the resident. RN #2 stated it was important for the care plan to be accurate. When asked if the care plan was followed if placement of the peg tube and residual was not checked prior to initiating feeding and medications, RN #2 stated that if they were not checked then the care plan was not followed. RN #2 confirmed the above interventions for the care of Resident #89's tube feed. RN #2 clarified that residuals should be checked per shift per order and prior to initiating his feeding per plan of care.

On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Checking gastric residual volume" documents in part, the following: "The purpose of this procedure is to assess tolerance of enteral feeding and minimize the potential for aspiration...review of the resident's care plan and provide for any special needs of the resident."

The facility policy titled, "MDS and Care Planning Process" did not address the above concerns.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and

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with new orders..."

(1) This information was obtained from The National Institutes of Health. https://medlineplus.gov/swallowingdisorders.html.
(2) This information was obtained from The National Institutes of Health. https://medlineplus.gov/paralysis.html.
(3) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114992/.
(4) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010419/?report=details.
(5) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011537/.
(6) This information was obtained from The National Institutes of Health. https://pubs.niaaa.nih.gov/publications/arh27-2/134-142.htm.

2. The facility staff failed to follow Resident # 37's comprehensive care plan for the administration of oxygen.

Resident # 37 was admitted to the facility on 02/12/18 and a readmission of 05/08/18 with diagnoses that included but were not limited to pain, anemia (1), anxiety, (2), depressive disorder (3), and hypertension (4).

Resident # 37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) coding

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Resident # 37 as being unable to complete the BIMS. Under "C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?" was coded as "Yes." Further review of Section C0600 revealed Resident # 37 was coded as a 2 (two) - being moderately impaired of cognition for making daily decisions. Resident # 37 was coded as requiring extensive assistance of two staff members for activities of daily living.

On 07/26/18 at approximately 7:35 a.m., an observation of Resident # 37 revealed she was lying in bed receiving oxygen from an oxygen concentrator through a nasal cannula. Observation of the oxygen flow meter revealed the oxygen was being administered between one and a half and two liters per minute.

On 07/26/18 at approximately 9:29 a.m., an observation of Resident # 37 revealed she was lying in bed receiving oxygen from an oxygen concentrator through a nasal cannula. Observation of the oxygen flow meter revealed the oxygen was being administered between one and a half and two liters per minute.

The physician's orders for Resident # 37 dated July 2018 documented, "O2 (oxygen) @ (at) 2L/MIN (two liters per minute) via (by) nasal cannula as needed for COPD [chronic obstructive pulmonary disease] (5). Start Date: 06/01/18."

The eTAR (electronic treatment administration record) dated July 2018 for Resident # 37 documented, "O2 (oxygen) @ (at) 2L/MIN (two liters per minute) via (by) nasal cannula as needed for COPD [chronic obstructive pulmonary disease] (5). Start Date: 06/01/18." Further review of the eTAR evidenced Resident # 37

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received oxygen at two liters per minute on 07/26/18.

The comprehensive care plan for Resident # 37 dated 02/21/2018 documented, "Problem/Need. (Resident # 37) has impaired gas exchange related to her diagnosis of COPD, and history of smoking. Recent hospital stay with acute chronic resp (respiration) failure with hypoxia present." Under "Approaches" it documented, "Administer oxygen per MD (medical doctor) orders."

On 07/26/18 at approximately 10:00 a.m., an interview was conducted with RN (registered nurse) # 4. When asked to describe the purpose of the care plan RN # 4 stated, "So that the resident is getting the correct care for their specific needs. If it is documented on the care plan it should followed." When asked why is it important to follow the care plan RN # 4 stated, "If it is not being followed the resident is not getting the correct care and could result in injury." When asked what the O2 flow rate should be for Resident # 37, RN # 4 stated, "It should be two." RN # 4 looked at the eTAR (electronic treatment administration record) for Resident # 37 in the EHR (electronic health record) and stated, "It is ordered at two liters." RN # 4 was asked to read the O2 flow rate on Resident # 37's oxygen concentrator. RN # 4 read the flow meter and stated, "It's between one and a half and two." RN # 4 then proceeded to adjust the oxygen flow rate to two liters per minute. When asked how often the oxygen flow rate should be checked, RN # 4 stated, "Every shift." RN # 4 was asked to review Resident # 37's care plan. When asked if the care plan was being followed for Resident # 37's O2 administration, RN # 4 stated, "No."

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On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html.

(5) Disease that makes it difficult to breath that can lead to shortness of breath) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.



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3. The facility staff failed to implement Resident #39's comprehensive care plan for the administration of oxygen.

Resident #39 was admitted to the facility on 1/15/18 with diagnoses that included but were not limited to: heart failure, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, dementia, anxiety and depression.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one or more staff members for bed mobility, transfers, dressing, toileting, eating and personal hygiene. In Section O - Special Treatments, Procedures and Programs, the resident was coded as requiring oxygen therapy and hospice care during the look back period.

A review of the comprehensive care plan dated 01/26/18, with a most recent revision on 6/12/18, documented in part, "Problem/Need: Impaired gas exchange R/T [related to] COPD". In the Approaches section of this problem/need the following was documented in part, "Administer O2 (oxygen) per MD (medical doctor)."

A review of Resident #39's clinical record documented the MD (medical doctor) order stating "O2 at 3 L/min (liters/minute) via nasal cannula (a plastic tube with two prong that are

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inserted just inside the nose) or simple mask to maintain Sats (oxygen saturation) above 90%. Check O2 Sats and flow meter every shift."

Observation on 7/24/18 at 2:31 p.m. and 4:33 p.m. noted Resident # 39 reclining in his bed with oxygen on via nasal cannula connected to an oxygen concentrator with the flow meter set between 2.5-3 L/min.

Observation on 7/25/18 at 8:08 a.m. noted Resident #39 sitting up with breakfast tray and oxygen on via nasal cannula connected to an oxygen concentrator with the flow meter set between 2.5-3 L/min.

An interview was conducted with CNA (certified nursing assistant) #5 on 7/26/18 at 9:39 a.m. CNA #5 was asked the purpose of the care plan and CNA #5 stated, "To see status of resident" and that is should be "Individualized for specific patient." When asked if it was important to follow the care plans, CNA #5 stated, "Yes."

On 7/26/18 at 8:12 a.m., RN (registered nurse) #4, was asked to assess Resident #39's current flow rate. She confirmed it was at 3 L/min. as ordered by the physician. RN #4 was advised that there were several observations of the flow meter reading between 2.5 and 3 L/min during the survey period. When asked how one should read the flow meter to ensure the correct flow of oxygen is being received, RN #4 stated, "The center of the ball should be on the 3 for [Resident #39's name]."

An interview was conducted with RN (registered nurse) #1 on 7/26/18 9:46 a.m. When asked the purpose of the care plan, RN #1 stated, "Tells the

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story of the resident" and should be "personalized for the individual resident needs." When asked if the care plan should be followed, RN #1 stated, "Yes."

ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5, (the medical doctor), where made aware of the above concerns on 7/26/18 at 1:50 p.m.

According to "Lippincott Manual of Nursing Practice", Seventh Edition: by Lippincott Williams & Wilkins, pg. 276 read: "The plan of nursing care (patient care plan) is the written guide that directs the efforts of the nursing team as nurses work with patients to meet their health goals ...Is responsive to the individual characteristics and needs of the patient."

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm
4. The facility staff failed to follow Resident #116's comprehensive care plan regarding the administration of oxygen at the physician ordered rate.

Resident #116 was admitted to the facility on 10/2/14 and readmitted on 6/27/17 with the diagnoses of but not limited to congestive heart failure, high blood pressure, peripheral vascular disease, senile degeneration of the brain, diabetes, depression, anxiety, adult failure to thrive, convulsions, and osteoporosis. The most recent MDS (Minimum Data Set) was a

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significant change assessment with an ARD (Assessment Reference Date) of 7/5/18. The resident was severely cognitively impaired in ability to make daily life decisions. The resident required extensive to total care for all areas of activities of daily living.

A review of the clinical record revealed a physician's order dated 7/9/18 for "Oxygen @ (at) 2 Liters via NC (nasal cannula) as needed for shortness of breath and check 02 (oxygen) sats (saturation) Q (every) shift and flow meter Q shift."

A review of the care plan revealed one dated 10/2/14 and most recently revised on 7/4/18 for "(Resident #116) has decreased cardiac output r/t (related to) dx (diagnoses) of CHF (congestive heart failure), CAD (coronary artery disease), Angina, HTN (high blood pressure), generalized edema, chronic venous insuff (insufficiency), and hx (history) of hypokalemia." This care plan included an intervention, undated, for "Administer O2 (oxygen) per as needed for SOB (shortness of breath) per MD (medical doctor) orders...."

Observations made of Resident #116 on 7/25/18 at 8:17 a.m. and 7/25/18 at 3:25 p.m. revealed the oxygen concentrator flow meter to be set at approximately 1.5 liters and not the ordered 2 liters (as evidenced by the ball in the flow meter being set midpoint between the 1 liter and 2 liter marks).

On 7/25/18 at 3:28 p.m. LPN #5 (Licensed Practical Nurse) was asked to observe the flow meter. LPN #5 stated the line (for the 2-liter mark) should be through the center of the ball. LPN #5 stated it was not and that the oxygen was

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not set at the right rate. When asked if the care plan documented to administer oxygen per orders, and the oxygen was not set at the ordered rate, then was the care plan being followed, LPN #5 stated, "That is a trick question. I will have to ask my manager about that."

On 7/25/18 at 3:44 p.m. LPN #6, the unit manager was asked if the care plan documented to administer oxygen as ordered and the oxygen was not set at the ordered rate, then was the care plan being followed, LPN #6 stated "No, the care plan is not being followed."

On 7/25/18 at approximately 6:00 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to follow the comprehensive care plan to implement the communication computer system for Resident #112.

Resident #112 was admitted to the facility on 9/1/15 and readmitted on 9/6/16 with diagnoses that included but were not limited to: anoxic brain damage (1), hemiplegia (2), feeding tube and inability to speak.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/25/18 coded the resident as rarely to never being understood or to understand. The resident was coded as requiring staff assistance for all activities of daily living.



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An observation was made on 7/24/18 at 11:10 a.m. of Resident #112. The resident was lying in bed with eyes open. There was a light on over the dresser next to the bed. The television was turned on and the curtain was three quarters pulled closed. There was no computer to aid in communication observed.

An observation was made on 7/25/18 at 9:15 a.m. of Resident #112. RN (registered nurse) #7 was administering medication to the resident through the feeding tube. RN #7 was not talking to the resident at the time of the observation.

Review of the comprehensive care plan initiated on 9/8/15 and revised on 6/23/18 documented, "Problem/Need. (Name of resident) HAS COGNITIVE LOSS R/T (related to) ANOXIC BRAIN INJURY AND INABILITY TO COMMUNICATE/APHASIA. HE IS NON - VERBAL DOES APPEAR TO FOLLOW W/EYES (with) BUT NO OTHER MOVEMENT. Approaches. TALK TO HIM AS YOU ARE PROVIDING CARE AND LET HIM KNOW WHAT YOU ARE DOING AS YOU COMPLETE TASKS. ENCOURAGE YES/NO QUESTIONS W/ENCOURAGEMENT OF EYE-BLINK SYSTEM...SPOUSE TO IMPLEMENT COMPUTER SYSTEM WHEN AVAILABLE TO AID IN COMMUNICATION. STAFF TO TRAIN IN USE OF SYSTEM AND ENCOURAGE USE."

An interview was conducted on 7/25/18 at 2:15 p.m. with RN #7. When asked why residents had care plan, RN #7 stated, "So staff know how to take care of them." When asked who used the care plans, RN #7 stated, "Nursing, activities, dietary. The whole building."

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An interview was conducted on 7/25/18 at 3:58 p.m. with RN #3. When asked why residents have care plans, RN #3 stated, "So we know what their plan of care is." When asked if staff were expected to follow the care plan, RN #3 stated yes. When asked why staff hadn't been educated with the computer for Resident #112, RN #3 didn't have an answer.

An interview was conducted on 7/26/18 at 8:16 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked how she communicated with the resident, CNA #8 stated, "Sometimes he'll blink. We go in every two hours to turn him and say hello."

An interview was conducted on 7/26/18 at 9:15 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked how she communicated with Resident #112, LPN #4 stated, "When he first came in the wife said he could blink his answers but we never saw that." When asked if staff used the computer to aid in communication, LPN #4 stated, "His wife uses it when she's here but we've been never trained on it." When asked if she had watched the wife use the computer with the resident, LPN #4 stated she had not. When asked if there would be value in learning how to use the computer with the resident, LPN #4 stated, "Yes, he could tell us how he's feeling." LPN #4 stated, "We keep it locked in the medication room when she's not here." When asked why residents had care plans, LPN #4 stated, "So we know how they like to be cared for. How they transfer, their morning routine." When asked who used the care plan, LPN #4 stated, "The nurses, CNAs (certified nursing assistants)." When asked if staff were expected to follow the care plan, LPN #4 stated,

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"Yes, ma'am."

An interview was conducted on 7/26/18 at 9:30 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked how staff communicated with Resident #112, ASM #4 stated, "She (the wife) wants him to use it (the computer). He is not so willing to use it." When asked why residents had care plans, ASM #4 stated, "We have a care plan to let us know how to care for the resident." When asked why staff had not been educated on the use of the computer as documented on the care plan, ASM #4 did not think the resident liked to use the computer.

On 7/26/18 at 12:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to ext.

1. Anoxic brain damage (lack of oxygen) - Anoxia is the third most frequent cause of coma, after trauma and vascular lesions. The most common causes of post-anoxic coma in adults are: cardiopulmonary arrest, stroke, respiratory arrest and carbon monoxide poisoning. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3814506/

2. Hemiplegia - Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This

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| F 656 | Continued From page 77<br>information was obtained from:<br>https://medlineplus.gov/paralysis.html | 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 staff interview and clinical record review, it was determined that the facility staff failed to revise the care plan for one of 40 residents in the survey sample, Resident # 37. | F 657 | 1. The facility has established a corrective action for resident #37 on 7/25/18 to ensure the comprehensive care plan was updated to identifying the behavior of removing nasal cannula.<br><br>2. The residents of the facility who wear nasal cannulas have the potential to be affected.<br><br>3. Facility Nursing staff will be re-educated on 8/9/18 on updating the comprehensive care plans of residents who remove their nasal cannula.<br><br>4. To ensure compliance audits will be conducted by Director of Nursing or Designee every week x 4 weeks then monthly x 3 to ensure the updating of comprehensive care plans of residents who remove their nasal cannula. | 9/4/18 |

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The facility staff failed to revise Resident # 37's comprehensive care plan to address her behavior of removing the nasal cannula (1).

The findings include:

Resident # 37 was admitted to the facility on 02/12/18 and a readmission of 05/08/18 with diagnoses that included but were not limited to pain, anemia (2), anxiety, (3), depressive disorder (4), and hypertension (5).

Resident # 37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) coding Resident # 37 as being unable to complete the BIMS. Under "C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?" was coded as "Yes." Further review of Section C0600 revealed Resident # 37 was coded as a 2 (two) - being moderately impaired of cognition for making daily decisions. Resident # 37 was coded as requiring extensive assistance of two staff members for activities of daily living.

On 07/24/18 at approximately 2:16 p.m., an observation of Resident # 37 revealed she was lying in her bed the oxygen concentrator running and the oxygen tubing and nasal cannula lying on the bed uncovered.

On 07/25/18 at approximately 4:45 p.m., an observation of Resident # 37 revealed she was lying in her bed the oxygen concentrator running and the oxygen tubing and nasal cannula draped over the top of the oxygen concentrator. The



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nasal cannula was hanging on the backside of the oxygen concentrator uncovered.

On 07/25/18 at approximately 6:10 p.m., an observation of Resident # 37 revealed she was sitting in her wheelchair in her room. A nurse was present in the room administering medications to Resident # 37. The oxygen concentrator running and nasal cannula was lying on the bed uncovered.

The physician's orders for Resident # 37 dated July 2018 documented, "O2 (oxygen) @ (at) 2L/MIN (two liters per minute) via (by) nasal cannula as needed for COPD [chronic obstructive pulmonary disease] (6). Start Date: 06/01/18."

The comprehensive care plan for Resident # 37 dated 02/21/2018 documented, "Problem/Need. (Resident # 37) has impaired gas exchange related to her diagnosis of COPD, and history of smoking. Recent hospital stay with acute chronic resp (respiration) failure with hypoxia present." Under "Approaches" it documented, "Administer oxygen per MD (medical doctor) orders."

On 07/26/18 at approximately 10:00 a.m., an interview was conducted with RN (registered nurse) # 4. RN #4 was asked to describe the process for storing a nasal cannula when it is not being used. RN #4 stated, "It should be placed in a plastic bag for infection control purposes." RN # 4 further stated, "The resident takes off her cannula when she wants." When asked if that was documented on the care plan, RN stated, "I don't know." Further review of Resident # 37's comprehensive care plan dated 02/21/2018 with RN # 4 failed to evidence Resident # 37's behavior of removing her nasal cannula.

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On 07/26/18 at approximately 10:28 a.m., an interview was conducted with OSM (other staff member) # 12, MDS coordinator. When asked to describe the process of developing a comprehensive care plan OSM # 12 stated, "Initially the comprehensive care plan is developed during the comprehensive assessment period no later than day 21 from admission. It is a working document; the care plan is always being updated and revised from information from the IDT (interdisciplinary team). When asked about Resident # 37's behavior of removing her oxygen OSM # 12 stated, "It should it be part of the care plan." When asked why it is important to update or revise a resident's care plan OSM # 12 stated, "It individualizes it for the resident, provides the staff with the needed information to evaluate the resident and show any trends of behavior." OSM # 12 further stated, "Based on what you told me the care plan for Resident # 37 should be revised."

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:

(1) a device for delivering oxygen by way of two small tubes that are inserted into the nares. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/nasal+cannula.

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| F 657 | Continued From page 81<br>(2) Low iron. This information was obtained from the website:<br>https://www.nlm.nih.gov/medlineplus/anemia.html<br>.<br><br>(3) Fear. This information was obtained from the website:<br>https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.<br><br>(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:<br>https://medlineplus.gov/ency/article/003213.htm.<br><br>(5) High blood pressure. This information was obtained from the website:<br>https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.<br><br>(6) Disease that makes it difficult to breath that can lead to shortness of breath) This information was obtained from the website:<br>https://www.nlm.nih.gov/medlineplus/copd.html. | F 657 | | |
| F 658 SS=D | 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 | F 658 | 1.The facility has established a corrective action for resident #69. A clarification order was written on 7/25/18 regarding use of parameters with pain medication and for resident #116 who was seen by nurse practioner on 8/8/18 that showed no negative response related staff not checking 02 sats. | |

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| F 658 | Continued From page 82<br>by:<br>Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to follow professional standards of practice for two of 40 residents in the survey sample, Residents # 69 and 116.<br><br>1. The facility staff failed to clarify the physician's orders for pain medication for Resident #69.<br><br>2. The facility staff failed to follow professional standards of practice to document the respiratory assessment of Resident #116 that indicated the need for the use of oxygen, which was ordered to be administered as needed.<br><br>The findings include:<br><br>1. Resident #69 was admitted to the facility on 2/14/17 with diagnoses that included but were not limited to: diabetes, chronic pain, low back pain, muscle weakness and fatigue.<br><br>The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/18/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one or more staff members for bed mobility, transfers, dressing, toileting, eating and personal hygiene. In Section N - Medications, the resident was coded as using opioids during the look back period.<br><br>The physician order dated, 2/27/17, documented, | F 658 | 2. The residents of the facility who receive the administration of oxygen and have parameters for pain medication have the potential to be affected.<br><br>3. Facility Nursing staff will be re-educated on 8/9/18 to follow physician orders regarding residents who have one or more pain medications ordered have parameters in place and residents who receive the administration of oxygen.<br><br>4. To ensure compliance audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 to ensure that the Nursing staff to follow physician orders for residents who receive one or more pain medications, to ensure parameters are placed and administration of oxygen. Information will be forwarded to QAPI for review.<br><br>12VAC5-371-200 cross reference to F658. | 9/4/18 |



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"Acetaminophen 325 mg (milligram) tablet: take 2 tabs by mouth every 6 hours as needed for pain." The physician order dated 12/5/17, documented: "Norco 5-325 (a hydrocodone and acetaminophen combination product used to relieve moderate-to-severe pain. It is in a class of medications called opiate (narcotic) analgesics (1)) mg tablet: one tab by mouth three times daily as needed [for] Dx (diagnosis): pain." Neither order documented which pain medication should be used based on the resident's pain level.

The July 2018 MAR (medication administration record) documented the above physician orders. The Norco 5-325 was documented as administered on 7/7/18 at 8:40 a.m. for a pain level of 8; on 7/8/18 at 4:59 a.m. for a pain level of 8; on 7/11/18 at 2:49 a.m. for a pain level of 7; on 7/16/18 at 8:23 a.m. for a pain level of 8; on 7/18/18 at 8:56 a.m. for a pain level of 8; and on 7/20/18 at 8:45 a.m. for a pain level of 8.

The July 2018 MAR documented the above physician order. The Acetaminophen was documented as administered on 7/11/18 at 12:02 p.m. for a pain level of 8.

The comprehensive care plan dated 2/23/17, with a most recent revision date of 5/23/18, documented in part, "Problem/Need: Is at risk for alteration in comfort related to pain." The "Approaches" documented in part, "Give meds [medications] per order; see EMAR [electronic medication administration record]".

An interview was conducted with RN (registered nurse) #2 on 7/26/18 at 9:46 a.m. When asked how staff determined which pain medication is given to a resident when the resident has multiple

F 658 Continued From page 84 F 658

orders for pain medications, RN #1 stated, "We ask them the pain level or to number the pain they are having." When asked to review the above order for Norco 5-325 and Acetaminophen, RN #2 stated, "We need to ask the doctor to clarify which level of pain requires which pain medication."

ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5, (the medical doctor), where made aware of the above concerns on 7/26/18 at 1:50 p.m.

According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a601006.html

2. The facility staff failed to follow professional standards of practice to document the respiratory

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assessment of Resident #116 that indicated the need for the use of oxygen, which was ordered to be administered as needed.

Resident #116 was admitted to the facility on 10/2/14 and readmitted on 6/27/17 with the diagnoses of but not limited to congestive heart failure, high blood pressure, peripheral vascular disease, senile degeneration of the brain, diabetes, depression, anxiety, adult failure to thrive, convulsions, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 7/5/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living.

Observations made of Resident #116 on 7/25/18 at 8:17 a.m., and 7/25/18 at 3:25 p.m., revealed the resident was using oxygen at that time.

A physician's order dated 7/9/18, documented, "Oxygen @ (at) 2 Liters via NC (nasal cannula) as needed for shortness of breath and check 02 (oxygen) sats (saturation) Q (every) shift and flow meter Q shift."

Review of the clinical record failed to reveal a nurse's note for 7/25/18 documenting a respiratory assessment that indicated the need for the use of as-needed oxygen on 7/25/18.

On 7/25/18 at 3:28 p.m., LPN #5 (Licensed Practical Nurse) stated an assessment should be documented.

On 7/25/18 at 3:44 p.m., in an interview with LPN

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| F 658 | Continued From page 86<br>#6 (Licensed Practical Nurse) she stated that oxygen is considered a medication and that nurses should be checking it. LPN #6 stated that Resident #116 "desats" (desaturation - oxygen level drops) frequently and the facility tries to keep oxygen sats at 90% or above. LPN #6 stated that a respiratory assessment should be documented, if the resident is using the oxygen. LPN #6 stated the documentation should include any signs or symptoms the resident was having that indicated the need to use the oxygen.<br><br>On 7/25/18 at approximately 6:00 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.<br><br>According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription. Policies and standing orders often permit the nurse to administer oxygen in emergency situations if the physician is not immediately available to write an order. Although oxygen is generally safe when used properly, certain precautions must be observed. As with all drugs, the potential exists for causing harm with misuse." On page 852, Procedure 36-5, "3. Identify client and proceed with 5 rights of medication administration...Rationale: Oxygen is a drug and administering using the 5 rights avoids potential errors....11. Document procedure and observations. Rationale: Maintains legal record and communicates with healthcare team members." | F 658 | | |
| F 676 | Activities Daily Living (ADLs)/Mntn Abilities | F 676 | 1.The facility has established a | |

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F 676 SS=D

Continued From page 87
CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)

§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.

F 676

corrective action for resident #112 for not following (a) the implementation of a communication computer to assist with communication, (b) not assisting residents who are dependent on staff for activities of daily living (to include transfers), and who are provided assistance daily by staff, to transfer out of bed.

2. Residents of the facility have the potential to be affected who use communication computers to assist with communication, and require staff assistance for activities of daily living, including transfers.

3. Facility Nursing staff educated on 8/9/18 on how to use communication computers to assist with communication as well as assisting residents for activities of daily living, including transfers to get out of bed.

4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3, to ensure staff are allowing residents who use communication computers for communication have assistance, and residents who require assistance for activities of daily living including

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| F 676 | Continued From page 88 | F 676 | transfers are provided assistance by staff to transfer out of bed. Information will be forwarded to QAPI for review. | 9/4/18 |

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide activities of daily living assistance to promote maximum level of functioning for one of 40 residents in the survey sample, Resident #112.

1. a. The facility staff failed to ensure Resident #112, who was coded as dependant on staff for activities of daily living including transfers, was provided assistance daily by staff to transfer out of bed.

1. b. The facility staff failed to learn how to implement the communication computer to assist Resident #112 with communicating, as per the plan of care for Resident #112.

The findings include:

Resident #112 was admitted to the facility on 9/1/15 and readmitted on 9/6/16 with diagnoses that included but were not limited to: anoxic brain damage (1), hemiplegia (2), feeding tube and inability to speak.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/25/18 coded the resident as rarely to never being understood or to understand. The resident was coded as dependent on staff for all ADLS (activities of daily living).

An observation was made on 7/24/18 at 11:10 a.m. of Resident #112. The resident was lying in bed with eyes open. There was a light on over the

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dresser next to the bed. The television was turned on to a country western music channel. The curtain was three quarters pulled closed. There was no computer to aid in communication observed.

An observation was made on 7/24/18 at 2:49 p.m. of Resident #112. The resident was lying in bed with eyes closed. The light was on over the dresser. The television was on the same channel. The curtain was three quarters pulled closed.

An observation was made on 7/25/18 at 8:04 a.m. of Resident #112. The resident was lying in bed with eyes closed. The lights were off. The television was on the same channel. The curtain was closed.

An observation was made on 7/25/18 at 10:20 a.m. of Resident #112. The resident had been turned a little on his side. The room remained the same.

An observation was made on 7/25/18 at 12:15 p.m. of Resident #112. The resident appeared to be in the same position. The lights remained off, the curtains were closed and the television was on the same channel.

An observation was made on 7/25/18 at 2:05 p.m. of Resident #112. The resident was lying on his back with his eyes closed. The lights remained off, the curtains were closed and the television was on the same channel.

Review of the resident's care plan initiated on 9/7/15 and revised on 6/23/18 documented, "Problem/Need. (Name of resident) HAS FUNCTIONAL STATUS LIMITATIONS



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REQUIRING ASSIST WITH ADL'S (activities of daily living) R/T ANOXIC BRAIN DAMAGE. HE IS TOTAL ASSIST FOR ALL ADLS/MOBILITY/HYGIENE. Approaches. HE IS TOTAL CARE FOR BED MOBILITY, TRANSFERS..."

Review of the July 2018 physician's orders documented, "MAY GET OUT OF BED IN GERICHAIR AS TOLERATED."

At interview was conducted on 7/25/18 at 1:59 p.m. with RN (registered nurse) #7, the resident's nurse. When asked why residents got out of bed RN #7 stated, "It lifts their spirits. They need a morale boost." When asked what activities Resident #112 participated in, RN #7 stated, "We try to get him up a couple times a week. He sits out here (indicating the dining/social area)." When asked why the resident didn't get out of bed everyday like the other residents, RN #7 stated, "No reason. He does sit out here."

An interview was conducted on 7/25/18 at 2:30 p.m. with CNA #12. When asked if it was important for residents to get out of bed, CNA #12 stated, "Yes." When asked why, CNA #12 stated, "They need to be up and moving around." When asked which of her residents did not get out of bed, CNA #12 mentioned Resident #112. When asked why the resident did not get out of bed, CNA #12 stated, "I'm not sure I think he should be up, I'll find out. We should we still try to stimulate those residents."

An interview was conducted on 7/25/18 at 2:33 p.m. with CNA (certified nursing assistant) #7. When asked why the resident stays in a dark room with the curtain closed, CNA #7 stated,

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"That's how it's been since I've been here. I don't know why."

An interview was conducted on 7/25/18 at 3:58 p.m. with RN #3, the unit manager. When asked when residents got out of bed, RN #3 stated, "Everyone should be offered to get out of bed." When asked why, RN #3 stated, "Quality of life. Getting them socialized with other people, getting them out of bed." When asked why Resident #112 was left in a dark room with the curtains closed, RN #3 stated, "He gets up. They should get up a couple times a week. He shouldn't be in the dark all day."

An interview was conducted on 7/26/18 at 8:16 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked when the resident got out of bed, CNA #8 stated, "He's supposed to get up Monday, Wednesday and Friday, his shower days. He really likes music. He doesn't have many visitors, his wife comes in on the weekends usually and hangs out for the day."

An interview was conducted on 7/26/18 at 9:15 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked how often the resident got out of bed, LPN #4 stated, "I know they were getting him up on shower days, he was sitting in his geri chair." When asked if there was value in getting out of bed, LPN #4 stated, "Yes. It relieves pressure on the areas they've been laying on for a while. Social interaction." When asked if there was any reason for the resident not to bet out of bed everyday, LPN #4 stated, "I know the wife thinks it can be over-stimulating for him." When asked what the resident looked like when he was over-stimulated, LPN #4 did not know.

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An interview was conducted on 7/26/18 at 9:30 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked why the resident only got out of bed on his shower days, ASM #4 stated, "The wife doesn't want him over-stimulated." When asked what that looked like, ASM #4 stated she didn't know. When asked if it was important for residents to get out of bed, ASM #4 stated, it was. ASM #4 stated, "I would like to see him do something everyday." A request for the resident's activities of daily living documented by the CNAs was made at that time.

A review of the resident's activities of daily living forms documented that the resident got out of bed for his shower six times in July 2018. There was no other evidence that the resident had been out of bed or engaged in activities during that time.

On 7/26/18 at 12:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

1. Anoxic brain damage (lack of oxygen) - Anoxia is the third most frequent cause of coma, after trauma and vascular lesions. The most common causes of post-anoxic coma in adults are: cardiopulmonary arrest, stroke, respiratory arrest and carbon monoxide poisoning. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3814506/

2. Hemiplegia - Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages



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pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from: https://medlineplus.gov/paralysis.html

1. b. The facility staff failed to learn how to use the communication computer as per the plan of care for Resident #112.

An observation was made on 7/24/18 at 11:10 a.m. of Resident #112. The resident was lying in bed with eyes open. There was a light on over the dresser next to the bed. The television was turned on to a country western music channel. The curtain was three quarters pulled closed. There was no computer to aid in communication observed.

An observation was made on 7/25/18 at 9:15 a.m. of Resident #112. RN (registered nurse) #7 was administering medication to the resident through the feeding tube. RN #7 was not talking to the resident at the time of the observation.

Review of the care plan initiated on 9/8/15 and revised on 6/23/18 documented, "Problem/Need. (Name of resident) HAS COGNITIVE LOSS R/T (related to) ANOXIC BRAIN INJURY AND INABILITY TO COMMUNICATE/APHASIA. HE IS NON - VERBAL DOES APPEAR TO FOLLOW W/EYES (with) BUT NO OTHER MOVEMENT. Approaches. TALK TO HIM AS YOU ARE PROVIDING CARE AND LET HIM KNOW WHAT YOU ARE DOING AS YOU COMPLETE TASKS. ENCOURAGE YES/NO QUESTIONS W/ENCOURAGEMENT OF EYE-BLINK

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SYSTEM...SPOUSE TO IMPLEMENT COMPUTER SYSTEM WHEN AVAILABLE TO AID IN COMMUNICATION. STAFF TO TRAIN IN USE OF SYSTEM AND ENCOURAGE USE."

An interview was conducted on 7/25/18 at 3:58 p.m. with RN #3, the unit manager. When asked why staff hadn't been educated on the use of the computer for Resident #112, RN #3 didn't have an answer.

An interview was conducted on 7/26/18 at 8:16 a.m. with CNA (certified nursing assistant)#8, the resident's aide. When asked how she communicated with the resident, CNA #8 stated, "Sometimes he'll blink. We go in every two hours to turn him and say hello." When asked how the resident communicated with them, CNA #8 stated, "I don't know."

An interview was conducted on 7/26/18 at 9:15 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked how she communicated with the resident, LPN #4 stated, "When he first came in the wife said he could blink his answers but we never saw that." When asked if staff used the computer to aid in communication, LPN #4 stated, "His wife uses it when she's here but we've been never trained on it." When asked if she had watched the wife use the computer with the resident, LPN #4 stated she had not. When asked if there would be value in learning how to use the computer with the resident, LPN #4 stated, "Yes, he could tell us how he's feeling."

An interview was conducted on 7/26/18 at 9:30 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked

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| F 676 | Continued From page 95<br>how staff communicated with the resident, ASM #4 stated, "She (the wife) wants him to use it (the computer). He is not so willing to use it." When asked if there would be value in having staff learn how to use the computer to communicate with the resident, ASM #4 stated it would. ASM #4 stated, "We're really not sure how aware he is."<br><br>Review of the clinical record failed to reveal any documentation evidencing Resident #112 was not willing to use the communication computer. There was no documentation evidencing the staff was using or trained on the use of the communication computer.<br><br>On 7/26/18 at 12:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.<br><br>No further information was provided prior to ext. | F 676 | | |
| F 679 SS=D | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, it | F 679 | 1.The facility has established a corrective action for resident #112 for not documenting that the facility offered and engaged an ongoing program of activities to meet resident's needs.<br><br>2. The residents of the facility have the potential to be affected.<br><br>3. Activities Staff will be re-educated on 8/9/18 related to documenting the offering and engaging residents in an ongoing program of activities to meet resident's needs. | |

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| F 679 | Continued From page 96<br>was determined that the facility staff failed to provide a complete activity program for one of 40 residents in the survey sample, Resident #112.<br><br>The facility staff failed to provide evidence staff offered and engaged Resident #112 in an ongoing program of activities to meet the residents needs for the months of April, May, June and July (2018).<br><br>The findings include:<br><br>Resident #112 was admitted to the facility on 9/1/15 and readmitted on 9/6/16 with diagnoses that included but were not limited to: anoxic brain damage (1), hemiplegia (2), feeding tube and inability to speak.<br><br>The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/25/18 coded the resident as rarely to never being understood or to understand. The resident was coded as requiring staff assistance for all activities of daily living.<br><br>An observation was made on 7/24/18 at 11:10 a.m. of Resident #112. The resident was lying in bed with eyes open. There was a light on over the dresser next to the bed. The television was turned on to a country western music channel. The curtain was three quarters pulled closed. There was no computer to aid for communication observed.<br><br>An observation was made on 7/24/18 at 2:49 p.m. of Resident #112. The resident was lying in bed with eyes closed. The light was on over the dresser. The television was on the same channel. The curtain was three quarters pulled closed. | F 679 | 4. To ensure compliance audits will be conducted by Activities Director (or Designee), every week x 4 weeks, then monthly x 3, to ensure staff are documenting the offering and engaging in ongoing programs of activities to meet resident's needs. | 9/4/18 |

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An observation was made on 7/25/18 at 8:04 a.m. of Resident #112. The resident was lying in bed with eyes closed. The lights were off. The television was on the same channel. The curtain was closed.

An observation was made on 7/25/18 at 10:20 a.m. of Resident #112. The resident had been turned a little on his side. The room remained the same.

An observation was made on 7/25/18 at 12:15 p.m. of Resident #112. The resident appeared to be in the same position. The lights remained off, the curtains were closed and the television was on the same channel.

An observation was made on 7/25/18 at 2:05 p.m. of Resident #112. The resident was lying on his back with his eyes closed. The lights remained off, the curtains were closed and the television was on the same channel.

Review of the resident's comprehensive care plan initiated on 9/7/15 documented, "Problem/Need. (Name of resident) NEED FOR SOCIALIZATION AND SUPPORT (illegible) INJ (injury) NEED FOR LONG TERM CARE, PER WIFE SOMEONE TO READ TO HIM AND ENJOYS MUSIC. WIFE BROUGHT IN BOOKS ONTAPE (sic), TELEVISION AND RADIO ON STAFF TURN ON T.V. Approaches. WIFE BROUGHT IN BOOKS ON TAPE, CD PLAYER IN ROOM,SIC, AND WATCHES WESTERN ON TELEVISION THAT STAFF TURN ON TELEVISION AND RADIO."

At interview was conducted on 7/25/18 at 1:59 p.m. with RN (registered nurse) #7, the resident's

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nurse. When asked why residents had activities, RN #7 stated, "It keeps them busy. Lifts their spirits. They need a morale boost." When asked if activities were important even for resident who could not speak, RN #7 stated, "Yes." When asked what activities Resident #112 participated in, RN #7 stated, "We try to get him up a couple times a week. He sits out here (indicating the dining/social area)." When asked why the resident didn't get out of bed everyday like the other residents, RN #7 stated, "No reason. He does sit out here."

An interview was conducted on 7/25/18 at 2:33 p.m. with CNA (certified nursing assistant) #7. When asked why Resident #112 stays in a dark room with the curtain closed, CNA #7 stated, "That's how it's been since I've been here. I don't know why."

An interview was conducted on 7/25/18 at 4:47 p.m. with OSM (other staff member) #11, the director of activities. When asked what activities Resident #112 engaged in, OSM #11 stated, "He does get out of bed and goes to some of the music shows." When asked what other activities the resident was provided, OSM #11 stated, "We have a volunteer who comes to see him every week. He stays an hour and reads to him. He hasn't been here the past month." A request for the resident's activity record was made at this time. OSM #11 returned with the resident's activity records. In April 2018 the resident attended two out of ten music activities. In May 2018 the resident attended one of 14 music activities. In June 2018 the resident attended three of 14 music activities. In July 2018 the resident had attended one of ten music activities.



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An interview was conducted on 7/26/18 at 8:16 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked when the resident got out of bed, CNA #8 stated, "He's supposed to get up Monday, Wednesday and Friday, his shower days. He really likes music. He doesn't have many visitors; his wife comes in on the weekends usually and hangs out for the day."

An interview was conducted on 7/26/18 at 9:30 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked what activities the resident was engaged in, ASM #4 stated, "I know he has the music on the TV. I have seen him in the social area." When informed of how many activities the resident was engaged in in the last four months, ASM #4 stated, "I would like to see him do something everyday." A request for the resident's activities of daily living documented by the CNAs was made at that time.

A review of the resident's activities of daily living forms documented that the resident got out of bed for his shower six times in July 2018. There was no other evidence that the resident had been out of bed or engaged in activities during that time.

On 7/26/18 at 12:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Activities/Leadership" documented, "Activity Types. Cognitive Stimulation should be implemented daily through various trivia games and word games. Activities that concentrate on cognitive stimulation are card games and board

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| F 679 | Continued From page 100<br>games."<br><br>Review of the facility's policy titled, "Independent Programming or In-Room Visits" documented, "Procedure: Resident's individual participating in leisure activities will be assessed and continuously promoted."<br><br>No further information was provided prior to exit.<br><br>1. Anoxic brain damage (lack of oxygen) - Anoxia is the third most frequent cause of coma, after trauma and vascular lesions. The most common causes of post-anoxic coma in adults are: cardiopulmonary arrest, stroke, respiratory arrest and carbon monoxide poisoning. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3814506/<br><br>2. Hemiplegia - Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from: https://medlineplus.gov/paralysis.html | F 679 | | |
| F 693 SS=D | Tube Feeding Mgmt/Restore Eating Skills<br>CFR(s): 483.25(g)(4)(5)<br><br>§483.25(g)(4)-(5) Enteral Nutrition<br>(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 | F 693 | 1.The facility has established a corrective action for resident #89 for failure to check for residual prior to initiating tube feeding according to physician orders and comprehensive care plan. | |

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ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff to provide treatment and services for the care of a tube feed for one of 40 residents in the survey sample, Resident #89.

The facility staff failed to check for residual prior to initiating Resident #89's tube feeding per the physician's orders and comprehensive care plan.

The findings include:

Resident #89 was admitted the facility on 5/30/18 with diagnoses that included but were not limited to stroke, muscle weakness, cognitive communication deficit, high blood pressure, type two diabetes, dysphagia (difficulty swallowing) (1) and hemiplegia (paralysis) (2) on the left side. Resident #89's most recent MDS (minimum data set) was a 30 day scheduled assessment with an

F 693

2. The residents of the facility who receive tube feedings have the potential to be affected.

3. Facility Licensed Nurses will be re-educated on 8/9/18 on checking residual prior to initiating tube feeding per physician orders and the comprehensive care plan.

4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3, to include: checking residual prior to initiating tube feeding per physician orders and the comprehensive care plan. All information will be forwarded to QAPI for review.

12VAC5-371-220 cross reference F693.

9/4/18

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ARD (assessment reference date) of 6/27/18. Resident #89 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status exam). Resident #89 was coded as requiring extensive assistance from staff with bed mobility, transfers, toileting, personal hygiene; and total dependence on staff with locomotion, eating, and bathing. Resident #89 was coded in Section K "Nutritional Approaches" as having a feeding tube.

Review of Resident #89's July 2018 POS (physician order summary) revealed the following orders:

"Fibersource via g (gastronomy) tube (peg [percutaneous endoscopic gastrostomy (3)]/feeding tube for enteral nutrition) at 130 cc/hr (hour) x 10 hours for Nutrition -Start at 4 PM/stop at 2 AM.

Flush peg tube with 150 ml (milliliters) H20 (water) before and after feeding

Check placement of Peg before administering of medications/feedings/flushes

Check residual every shift hold if more than 60 cc (cubic centimeters) and notify MD (medical doctor)."

Review of the July 2018 MAR (medication administration record) revealed that staff were checking residuals at 6 AM, 2 PM and 10 PM. These times did not include prior to his feeding (4PM).

Review of Resident #89's care plan dated 6/8/18

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documented the following: "(Name of resident) requires a PEG tube for adequate nutritional intake r/t (related to) (R [right]) MCA (middle cerebral artery) infarct (stroke) w/left hemiparesis (left sided paralysis) resulting in dysphagia...Approaches: check residual before initiating (Name of Resident #89's) feeding, check placement of PEG PER MD ORDERS."

On 7/24/18 at 4 p.m., medication administration observation was conducted with RN (registered nurse) #6. RN #6 stated she was going to give medications to Resident #89. RN #6 told this writer she had already sanitized her hands. RN #6 prepared the following medications:

Gabapentin 100 mg (milligrams); works in the brain to prevent seizures and manage pain related to neurological disorders. (4)
Oxycodone 5 mg 1 tablet; narcotic analgesic used to treat moderate to severe pain. (5)
Thiamine 100 mg 2 tabs; also known as vitamin B1. (6)

RN #6 opened the Gabapentin capsule and placed the contents of the capsule in a separate cup. RN #6 then crushed the one oxycodone and placed the crushed medication into a medication cup. RN#6 then crushed the thiame and placed the crushed medication in a separate medication cup. RN #6 then added water per order to each medication cup, took a peg tube syringe out of a plastic bag, and attached it to Resident #89's tube feed. RN #6 then flushed the peg tube, slowly adding the medications separately. RN #6 was not observed checking the placement of Resident #89's peg tube prior to administering medications.

After RN #6 administered medications to

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Resident #89, she proceed to hang his fibersource (enteral feed). RN #6 primed the feeding bag and tubing, capped the tip of the tubing and hung it on the pole. RN #6 then took a syringe from a plastic bag and placed it directly on Resident #89's bed. RN #6 uncapped Resident #89's tube feed and placed the syringe directly into his peg tube. RN #6 poured 150 mls (milliliter) of water per order through the syringe and into his peg tube. RN #6 then hooked Resident #89 up to his tube feed and turned on his tube feed.

On 7/24/18 at 4:21 p.m., after RN #6 and this writer were back at the medication cart, RN #6 stated she forgot to check residual of the tube feeding and that she usually does. RN #6 stated it (residual) should be checked prior to initiating the tube feeding.

On 7/26/18 at 9:53 a.m., an interview was conducted with RN #2, another nurse who cares for Resident #89. When asked about the process staff follows prior to initiating a tube feeding, RN #2 stated that prior to setting up the tube feed; she would check the placement of the tube and then check the residual. When asked why checking the placement and residual were important, RN #2 stated to ensure the tube was in place and to ensure the resident was not receiving too much feeding. RN #2 clarified that residuals should be checked per shift per order and prior to initiating his feeding per plan of care.

On 7/26/18 at 11:19 a.m., further interview was conducted with RN #6. When asked the process prior to initiating a tube feed, RN #6 stated that she would first check placement of the tube feed and then check the residual. When asked how

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placement was checked, RN #6 stated that she would use her stethoscope, place it on the resident's abdomen, and listen as she injected air. When asked if she checked placement prior to administering medications on 7/24/18 to Resident #89, RN #6 stated that she did check placement before this writer observed her give medications. RN #6 stated that she should have checked placement with this writer present and that she was having a bad day. RN #6 could not determine why she did not tell this writer beforehand that she had already checked Resident #89's placement. When asked why it was important for residual to be checked, RN #6 stated to ensure the resident was not receiving too much of the feeding. When RN #6 was then informed, she had stated she did not check Resident #89's residual prior to initiating his feeding on 7/24/18. RN #6 stated she did check residual at the same time she checked placement before this writer observed her administer medications. When asked why she would admit to not checking residual after medication pass on 7/24/18, RN #6 stated, "I meant to say I should have checked it front of you."

On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Checking gastric residual volume" documents in part, the following: "The purpose of this procedure is to assess tolerance of enteral feeding and minimize the potential for aspiration...review of the resident's care plan and provide for any special needs of the resident."



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| DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB | 120 DOGWOOD LANE ORANGE, VA 22960 |

| (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 693 | Continued From page 106<br>(1) This information was obtained from The National Institutes of Health. https://medlineplus.gov/swallowingdisorders.html.<br>(2) This information was obtained from The National Institutes of Health. https://medlineplus.gov/paralysis.html.<br>(3) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114992/.<br>(4) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010419/?report=details.<br>(5) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011537/.<br>(6) This information was obtained from The National Institutes of Health. https://pubs.niaaa.nih.gov/publications/arh27-2/134-142.htm. | F 693 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, and clinical record review it | F 695 | 1.The facility has established a corrective action for not following physician orders for residents #39, #116, #37 related to oxygen administration.<br><br>2. The residents of the facility who receive the administration of oxygen have the potential to be affected.<br><br>3. Facility Licensed Nurses will be re-educated on 8/9/18 on following physician orders related oxygen administration. | |

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| F 695 | Continued From page 107<br>was determined that the facility staff failed to provide respiratory care and services for three of 40 residents in the survey sample, Residents # 39, 116, and 37.<br><br>1. The facility staff failed to administer Resident # 39's oxygen according to the physician's orders.<br><br>2. The facility staff failed to administer oxygen to Resident #116 at the physician ordered rate.<br><br>3. The facility staff failed to administer Resident # 37's oxygen according to the physician's orders.<br><br>The findings include:<br><br>1. Resident #39 was admitted to the facility on 1/15/18 with diagnoses that included but were not limited to: heart failure, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, dementia, anxiety and depression.<br><br>The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one or more staff members for bed mobility, transfers, dressing, toileting, eating and personal hygiene. In Section O - Special Treatments, Procedures and Programs, the resident was coded as requiring oxygen therapy and hospice care during the look back period. | F 695 | 4. To ensure compliance audits will be conducted by Director of Nursing or Designee every week x 4 weeks then monthly x 3 to ensure staff are following physician orders related to oxygen administration. This information will be forwarded to QAPI for review.<br><br>12VAC5-371-220B cross reference to F695. | 9/4/18 |

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A review of Resident #39's clinical record documented the MD (medical doctor) order stating "O2 at 3 L/min (liters/minute) via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) or simple mask to maintain Sats (oxygen saturation) above 90%. Check O2 Sats and flow meter every shift."

Observation on 7/24/18 at 2:31 p.m. and 4:33 p.m. noted Resident # 39 reclining in his bed with oxygen on via nasal cannula connected to an oxygen concentrator with the flow meter set between 2.5-3 L/min.

Observation on 7/25/18 at 8:08 a.m. noted Resident #39 sitting up with breakfast tray and oxygen on via nasal cannula connected to an oxygen concentrator with the flow meter set between 2.5-3 L/min.

Observation on 7/25/18 at 4:30 p.m. noted Resident # 39 reclining in his bed with oxygen on via nasal cannula connected to an oxygen concentrator set at 3 L/min.

A review of the comprehensive care plan dated 01/26/18, with a most recent revision on 6/12/18, documented in part, "Problem/Need: Impaired gas exchange R/T [related to] COPD". In the Approaches section of this problem/need it is documented in part, "Administer O2 (oxygen) per MD (medical doctor)."

On 7/26/18 at 8:12 a.m., RN (registered nurse) #4, was asked to assess Resident #39's current flow rate. She confirmed it was at 3 L/min. as ordered by the physician. RN #4 was informed that there were several observations of the flow meter reading between 2.5 and 3 L/min during

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the survey period. When asked how one should read the flow meter to ensure the correct flow of oxygen is being received, she stated, "The center of the ball should be on the 3 for [Resident #39's name]."

The oxygen concentrator manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min prescribed".

ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5, (the medical doctor), where made aware of the above concerns on 7/26/18 at 1:50 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm

2. The facility staff failed to administer oxygen to Resident #116 at the physician ordered rate.

Resident #116 was admitted to the facility on 10/2/14 and readmitted on 6/27/17 with the diagnoses of but not limited to congestive heart failure, high blood pressure, peripheral vascular disease, senile degeneration of the brain, diabetes, depression, anxiety, adult failure to thrive, convulsions, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 7/5/18. The

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resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living.

A review of the clinical record revealed a physician's order dated 7/9/18 for "Oxygen @ (at) 2 Liters via NC (nasal cannula) as needed for shortness of breath and check 02 (oxygen) sats (saturation) Q (every) shift and flow meter Q shift."

A review of the care plan revealed one dated 10/2/14 and most recently revised on 7/4/18 for "(Resident #116) has decreased cardiac output r/t (related to) dx (diagnoses) of CHF (congestive heart failure), CAD (coronary artery disease), Angina, HTN (high blood pressure), generalized edema, chronic venous insuff (insufficiency), and hx (history) of hypokalemia." This care plan included an intervention, undated, for "Administer O2 (oxygen) per as needed for SOB (shortness of breath) per MD (medical doctor) orders...."

Observations made of Resident #116 on 7/25/18 at 8:17 a.m., and 7/25/18 at 3:25 p.m., revealed the oxygen concentrator flow meter set at approximately 1.5 liters and not the ordered 2 liters (as evidenced by the ball in the flow meter being set midpoint between the 1 liter and 2 liter marks).

On 7/25/18 at 3:28 p.m., LPN #5 (Licensed Practical Nurse) was asked to observe Resident #116's oxygen concentrator flow meter. LPN #5 stated that the line (for the 2-liter mark) should be through the center of the ball. LPN #5 stated it was not and that the oxygen was not set at the right rate.



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A review of the facility policy, "Oxygen Administration" documented, "Verify physician orders and assess any special needs of resident such as cyanosis, hypoxia, oxygen toxicity, vital signs, lung sounds, oxygen sats, and lab (laboratory) results."

On 7/25/18 at approximately 6:00 PM, the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.
3a. The facility staff failed to administer Resident # 37's oxygen according to the physician's orders.

Resident # 37 was admitted to the facility on 02/12/18 and a readmission of 05/08/18 with diagnoses that included but were not limited to pain, anemia (1), anxiety, (2), depressive disorder (3), and hypertension (4).

Resident # 37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) coding Resident # 37 as being unable to complete the BIMS. Under "C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?" was coded as "Yes." Further review of Section C0600 revealed Resident # 37 was coded as a 2 (two) - being moderately impaired of cognition for making daily decisions. Resident # 37 was coded as requiring extensive assistance of two staff members for activities of daily living.

On 07/26/18 at approximately 7:35 a.m., an

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observation of Resident # 37 revealed she was lying in bed receiving oxygen from an oxygen concentrator through a nasal cannula. Observation of the oxygen flow meter revealed the oxygen was being administered at between one and a half and two liters per minute.

On 07/26/18 at approximately 9:29 a.m., an observation of Resident # 37 revealed she was lying in bed receiving oxygen from an oxygen concentrator through a nasal cannula. Observation of the oxygen flow meter revealed the oxygen was being administered at between one and a half and two liters per minute.

The physician's orders for Resident # 37 dated July 2018 documented, "O2 (oxygen) @ (at) 2L/MIN (two liters per minute) via (by) nasal cannula as needed for COPD [chronic obstructive pulmonary disease] (5). Start Date: 06/01/18."

The eTAR (electronic treatment administration record) dated July 2018 for Resident # 37 documented, "O2 (oxygen) @ (at) 2L/MIN (two liters per minute) via (by) nasal cannula as needed for COPD [chronic obstructive pulmonary disease] (5). Start Date: 06/01/18." Further review of the eTAR evidenced Resident # 37 received oxygen at two liters per minute on 07/26/18.

The comprehensive care plan for Resident # 37 dated 02/21/2018 documented, "Problem/Need. (Resident # 37) has impaired gas exchange related to her diagnosis of COPD, and history of smoking. Recent hospital stay with acute chronic resp (respiration) failure with hypoxia present." Under "Approaches" it documented, "Administer

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oxygen per MD (medical doctor) orders."

On 07/26/18 at approximately 10:00 a.m., an interview was conducted with RN (registered nurse) # 4. When asked to describe how the O2 (oxygen) flow meter is read, RN # 4 stated, "The line should be in the middle of the ball and it should be read at eye level." When asked what the O2 flow rate should be for Resident # 37, RN # 4 stated, "It should be two." RN # 4 looked at the eTAR (electronic treatment administration record) for Resident # 37 in the EHR (electronic health record) and stated, "It is ordered at two liters." RN # 4 was asked to read the O2 flow rate on Resident # 37's oxygen concentrator. RN # 4 read the flow meter and stated, "It's between one and a half and two." RN # 4 then proceeded to adjust the oxygen flow rate to two liters per minute. When asked how often the oxygen flow rate should be checked, RN # 4 stated, "Every shift." When asked why is it important to ensure the O2 flow rate is set correctly, RN # 4 stated, "There won't be enough oxygen to the brain and other organs."

The "Operator's Manual" for (Name of Oxygen Concentrator" documented, "Flowrate. NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.



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References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(2) Fear. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:
https://medlineplus.gov/ency/article/003213.htm.

(4) High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Disease that makes it difficult to breath that can lead to shortness of breath) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/copd.html.

3b. The facility staff failed to store Resident # 37's nasal cannula in a sanitary manner.

On 07/24/18 at approximately 2:16 p.m., an observation of Resident # 37 revealed she was lying in her bed, the oxygen concentrator was

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| F 695 | Continued From page 115<br>running and the oxygen tubing and nasal cannula were lying on the bed uncovered.<br><br>On 07/25/18 at approximately 4:45 p.m., an observation of Resident # 37 revealed she was lying in her bed, the oxygen concentrator was running and the oxygen tubing and nasal cannula were draped over the top of the oxygen concentrator. The nasal cannula was hanging on the backside of the oxygen concentrator uncovered.<br><br>On 07/25/18 at approximately 6:10 p.m., an observation of Resident # 37 revealed she was sitting in her wheelchair in her room. A nurse was present in the room administering medications to Resident # 37. The oxygen concentrator was running and the nasal cannula was lying on the bed uncovered.<br><br>On 07/26/18 at approximately 10:00 a.m., an interview was conducted with RN (registered nurse) # 4. When asked to describe the process for storing a nasal cannula when it is not being used, RN # 4 stated, "It should be placed in a plastic bag for infection control purposes." When informed of the above observations of Resident # 37's nasal cannula not being covered, RN # 4 did not have a reply.<br><br>On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.<br><br>No further information was provided prior to exit. | F 695 | | |
| F 761 | Label/Store Drugs and Biologicals | F 761 | 1. The facility has established a | |

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F 761 SS=D

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CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
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.

§483.45(h) Storage of Drugs and Biologicals

§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.

§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 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.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure medications were dated when opened for two of the four facility medication carts inspected, East Ground Unit and East main Unit medications carts, (the facility had a total of eight medication carts).

The facility staff failed to ensure Calcitonin nasal spray was dated when the medication was

F 761

corrective action for having medications in carts that were not dated upon opening as required.

2. The residents of the facility who receive medications have the potential to be affected.

3. Facility licensed Nurse will be re-educated on 8/9/18 to ensure that medications are dated upon opening as required.

4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 to ensure medications are dated upon opening as required. Information will be forwarded to QAPI for review.

12VAC5-371-300 cross reference to F761.

9/4/18

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opened to determine when the medication should be discarded, on the East Ground Unit medication cart; and failed to ensure Latanoprost ophthalmologic eye drops were dated when opened to determine when the medication should be discarded, on the East Main medication cart.

The findings include:

On 7/26/18 at approximately 12:55 p.m., a medication cart on the East Ground unit was inspected. The following concern was identified: Calcitonin {1} nasal spray which had a pharmacy label on it that documented the order was filled on 7/24/18 and documented to "discard 35 days after opening," had been opened but there was no open date documented.

On 7/26/18 at 12:55 p.m., in an interview with LPN #7 (Licensed Practical Nurse) she stated that it should have been dated when it was opened.

On 7/26/18 at approximately 1:12 p.m., a medication cart on the East Main unit was inspected. The following concern was identified: Latanoprost {2} ophthalmologic eye drops, which had a pharmacy label on it, that documented the order was filled on 6/29/18 and documented to "discard 28 days after opening," had been opened but there was no open date documented.

On 7/26/18 at 1:12 p.m., in an interview with LPN #5 (Licensed Practical Nurse) she stated that it should have been dated when opened.

A review of the facility policy "General Guidelines for Medication Storage" documented, "Medications and biological's are stored safely,

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securely and properly following manufacturer's recommendations or those of the supplier...."
The policy provided did not document to date a medication when it is opened.

On 7/26/18 at 1:50 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

{1} Calcitonin salmon is used to treat osteoporosis in women who are at least 5 years past menopause and cannot or do not want to take estrogen products. Osteoporosis is a disease that causes bones to weaken and break more easily. Calcitonin is a human hormone that is also found in salmon. It works by preventing bone breakdown and increasing bone density (thickness).
Information obtained from https://medlineplus.gov/druginfo/meds/a601031.html

{2} Latanoprost ophthalmic is used to treat glaucoma (a condition in which increased pressure in the eye can lead to gradual loss of vision) and ocular hypertension (a condition which causes increased pressure in the eye). Latanoprost is in a class of medications called prostaglandin analogs. It lowers pressure in the eye by increasing the flow of natural eye fluids out of the eye.

F 814 SS=F Dispose Garbage and Refuse Properly
CFR(s): 483.60(i)(4) F 814

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| F 814 | Continued From page 119<br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain the dumpsters in good repair.<br><br>Multiple cracks were observed in two of three dumpsters.<br><br>The findings include:<br><br>On 7/25/18 at 7:40 a.m., observation of the facility dumpsters was conducted. The following was observed:<br><br>-One crack (approximately two inches long by less than one half inch wide) resembling a back slash symbol was observed near the bottom of the far left dumpster (while facing the dumpsters). White debris was visible.<br>-One crack (approximately two vertical inches long by less than one half inch wide) was observed approximately 18 inches from the bottom of the dumpster on the far left dumpster (while facing the dumpsters). White debris was visible.<br>-Multiple cracks (large enough to place a hand through) were observed on the plastic lids of the far left dumpster (while facing the dumpsters).<br>-Multiple cracks (large enough to place a hand through) were observed on the plastic lids of the far right dumpster (while facing the dumpsters).<br><br>On 7/25/18 at 9:00 a.m., an interview was conducted with OSM (other staff member) #2 (the director of maintenance). OSM #2 stated the | F 814 | 1. The facility accomplished corrective action for the two dumpsters cited on the most recent annual inspection 7/26/18. The facility received two dumpsters that were free from cracks and were in good repair on 7/30/18.<br><br>2. The other dumpster located on the property has the potential to be affected by the same deficient practice. The facility inspected the other dumpster of the facility on 7/27/18 to ensure that it was in good repair as required.<br><br>3. The Dining Services will be in-serviced by Executive Director on 8/9/18 regarding the importance of maintaining dumpsters that are free from cracks and are in good repair as required.<br><br>4. To ensure compliance the Director of Dining Services or designee will round weekly for 4 weeks and then monthly for 3 months to ensure that the dumpsters are free from cracks and are in good repair as required. Variances will be corrected. The audits will be revived by the Administrator or designee for trends and report to monthly QAPI for | |



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| F 814 | Continued From page 120<br>dumpsters were owned by the county. When asked about the facility process for ensuring the dumpsters are maintained in good repair, OSM #2 stated someone from the maintenance department makes sure the drain in the ground near the dumpsters is not stopped up and makes sure the dumpsters are closed every day. When asked if the facility staff ensures the dumpsters are intact, OSM #2 stated, "Yes." When asked if there should be any cracks in the dumpsters, OSM #2 stated, "Not that go all the way through. No." When asked why, OSM #2 stated, "Because of infection control. You can have critters get in there and spreading trash." OSM #2 was made aware of the above findings. OSM #2 stated he was not aware of the cracks in the dumpsters.<br><br>On 7/25/18 at 6:06 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern.<br><br>On 7/26/18 at 11:57 a.m., a list that requested multiple policies was provided to ASM #4 (the assistant director of nursing). On 7/26/18 at 1:32 p.m., ASM #4 returned the list. The list documented the facility had no policy regarding the maintenance of the dumpsters.<br><br>No further information was presented prior to exit.Information obtained from https://medlineplus.gov/druginfo/meds/a697003.html | F 814 | additional oversight and recommendations.<br><br>12VAC5-371-340 cross reference to F814. | 9/4/18 |
| 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 | F 880 | 1.The facility has established a corrective action for residents #5, #28, and #89 for<br>(a) not touching items/other residents/not picking up food with | |

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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.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

F 880

their bare hands without washing or sanitizing hands.
(b) Replacing linen when dirty or soiled in proper manner.
(c) Disposing of a brief in a sanitary manner.
(d) Proper placement of equipment during a tube feeding.

2. The other residents of the facility have the potential to be affected.

3. Facility Nursing staff will be re-educated 8/9/18 on (a) not touching items or other residents not picking up food with their bare hands without washing or sanitizing hands (b) replacing dirty or soiled linens in a proper manner (c) disposing of a brief in a sanitary manner and (d) proper placement of equipment during a tube feeding.

4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 related to:
(a) Not touching items or other residents and not picking up food with their bare hands without washing or sanitizing hands.
(b) Replacing linen when dirty or soiled in proper manner.

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| F 880 | Continued From page 122<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 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 and facility document review, it was determined facility staff failed to maintain infection control practices for three of 40 residents in the survey sample, Residents #28, #5 and #89.<br><br>1. The facility staff CNA (certified nursing assistant) #7 was observed touching another resident and her pager, then picked up Resident #28's dinner roll and buttered the roll, with their bare hands, without washing or sanitizing her hands.<br><br>2. The facility staff failed to replace soiled linens | F 880 | (c) Disposing of a brief in a sanitary manner.<br>(d) Proper placement of equipment during a tube feeding.<br>This information will be forwarded to QAPI for review.<br><br>12VAC5-371-180 cross reference to F880. | 9/4/18 |



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before putting it back on the resident's bed and failed to dispose of briefs in a sanitary manner for resident #5.

5. The facility staff failed to follow infection control practices while flushing Resident #89's peg tube.

The findings include:

Resident #28 was admitted to the facility on 12/19/14 with diagnoses that included but were not limited to: legal blindness, Alzheimer's disease, high blood pressure and depression.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/25/18 coded the resident as having an eight out of 15 on the BIMS (brief interview for mental status indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living.

An observation was made on 7/24/18 at 1:13 PM of Resident #28 and CNA (certified nursing assistant) #7. CNA #7 was assisting the resident with her meal when she got out of her chair and went over to another resident who was trying to get out of her chair. CNA #7 encouraged the resident to sit back down and rubbed her back. CNA #7 then took her pager out of her pocket and put it back. CNA #7 then sat down next to Resident #28 and picked up her dinner roll with her bare hands, buttered the roll and gave it to the resident. CNA #7 did not sanitize her hands after touching the other resident or her pager.

Review of the resident's care plan initiated on 12/31/14 and revised on 5/13/18 documented,

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"Problem/Need. (Name of resident) HAS FUNCTIONAL STATUS LIMITATION REQUIRING ASSIST WITH ADL'S (activities of daily living) R/T (related to) WEAKNESS, GAIT ABNORMALITY, POOR VISION, COGNITIVE IMPAIRMENT Approaches. ASSIST WITH TRAY SET UP & FEEDING AS NEEDED. FOOD TO BE PLACED IN CUPS FOR EASIER HANDLING FOR INDEPENDENT MEAL INTAKE."

An interview was conducted on 7/25/18 at 2:30 p.m. with CNA #12. When asked if it was acceptable to hold a resident's food in your bare hands, CNA #12 stated, "No. It's not sanitary."

An interview was conducted on 7/25/18 at 2:33 p.m. with CNA #7. When asked if staff should pick up a residents food with their bare hands, CNA #7 stated, "Never." When asked why, CNA #7 stated, "Because it's sanitary reasons. There's germs." When made aware of the above observation, CNA #7 stated, "I don't know how to do it any other way."

An interview was conducted on 7/25/18 at 3:46 p.m. with RN (registered nurse) #3, the unit manager. When asked when staff should hold a resident's food with their bare hands, RN #3 stated, "They shouldn't be doing that." When asked why, RN #3 stated, "Infection control."

On 7/25/18 at 6:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "Hand Hygiene Using Alcohol Hand Rubs for Residents

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and Employees" documented, "Policy. It is the policy of this facility to guide proper hygiene techniques to help prevent transmission of infections. This policy is designed for the protection of all persons including staff and patients. Procedure. Staff may use Alcohol Hand Rub in the following situations: Before director contact with patient."

No further information was provided prior to exit.

2. The facility staff failed to replace soiled linens before putting it back on the resident's bed and failed to dispose of briefs in a sanitary manner for resident #5.

Resident #5 was admitted to the facility on 10/27/10 with diagnoses that included but were not limited to: bone infection, irregular heart beat, high blood pressure, dementia, and depression.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/25/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was set-up.

An observation was made on 7/24/18 at 4:30 p.m. of Resident #5 and LPN (licensed practical nurse) #4 and LPN #8. LPN #8 picked the resident's blanket up off the floor and placed it back over the resident. LPN #4 picked a pillow up off the floor and placed it under the resident's head.

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On 7/25/18 at 9:36 a.m. an observation was made of Resident #5, RN (registered nurse) #7 and CNA (certified nursing assistant) #12. The resident was requesting that the briefs be removed from underneath her. The resident had thrown her sheet and pillow on the floor. CNA #7 pulled the three briefs from under the resident and placed them on the floor. RN #5 picked the pillow and sheet up off the floor, placed the pillow under the resident's head and the sheet over the resident. CNA #7 then picked the briefs up off the floor and disposed of them in the trash.

An interview was conducted on 7/25/18 at 3:36 p.m. with RN #3, the unit manager. When asked how used briefs were to be discarded, RN #3 stated, "I was always taught to place them on the foot of the over-bed table and then put them in the trash and throw them away." When asked if it was acceptable to place the briefs directly on the floor, RN #3 stated, "No." When asked why, RN #3 stated it was an infection control issue.

On 7/25/18 at 6:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the assistant director of nursing were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to follow infection control practices while flushing Resident #89's peg tube.

Resident #89 was admitted the facility on 5/30/18 with diagnoses that included but were not limited to stroke, muscle weakness, cognitive communication deficit, high blood pressure, type



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two diabetes, dysphagia (difficulty swallowing) (1) and hemiplegia (paralysis) (2) on the left side. Resident #89's most recent MDS (minimum data set) was a 30 day scheduled assessment with an ARD (assessment reference date) of 6/27/18. Resident #89 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status exam). Resident #89 was coded as requiring extensive assistance from staff with bed mobility, transfer, toileting, personal hygiene; and total dependence on staff with locomotion, eating, and bathing. Resident #89 was coded in Section K "Nutritional Approaches" as having a feeding tube.

Review of Resident #89's POS (physician order summary) revealed the following orders: "Fibersource via g (gastronomy) tube (peg [percutaneous endoscopic gastrostomy (3)]/feeding tube for enteral nutrition) at 130 cc/hr (hour) x 10 hours for Nutrition -Start at 4 PM/stop at 2 AM."

Flush peg tube with 150 ml (milliliters) H20 (water) before and after feeding."

On 7/24/18 at 4 p.m., medication administration observation was conducted with RN (registered nurse) #6. After RN #6 administered medications to Resident #89, she proceed to hang his fibersource (enteral feed). RN #6 primed the feeding bag and tubing, capped the tip of the tubing and hung it on the pole. RN #6 then took a syringe from a plastic bag and placed it directly on Resident #89's bed. The tip of the syringe that was going to be inserted into the peg tube was directly touching the bed surface. RN #6 uncapped Resident #89's tube feed and placed



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the syringe directly into his peg tube. RN #6 poured 150 mls (milliliters) of water per order through the syringe and into his peg tube. RN #6 then hooked Resident #89 up to his tube feed and turned on his tube feed.

On 7/26/18 at 11:19 a.m., an interview was conducted with RN #6. RN #6 confirmed that she had placed the syringe directly on the bed and should not have done this. RN #6 stated it was an infection control issue and nurses should avoid picking up any extra germs when flushing a peg tube.

On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Gastric Feeding Tubes" did not address the above concerns. No further information was presented prior to exit.

(1) This information was obtained from The National Institutes of Health. https://medlineplus.gov/swallowingdisorders.html.
(2) This information was obtained from The National Institutes of Health. https://medlineplus.gov/paralysis.html.
(3) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114992/.



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