STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 8/8-10/2017. Corrections are required for compliance with CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 54 at the time of the survey. The survey sample consisted of 12 current resident reviews (Resident #1-10, #11, and #14), and 5 closed record reviews (Residents #12 and #13, and #15-#17)	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225		9/20/17

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

Electronically Signed | 08/22/2017

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F 225	Continued From page 1	F 225		

licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

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F 225	Continued From page 2 corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to report an allegation of verbal abuse. Resident #9 reported a CNA (certified nursing assistant) had yelled into her face and wiped her roughly during toileting. This was not reported to the Administrator by staff, and was not reported to the state agency. The findings included: Resident #9, a female, was admitted to the facility 5/31/16. Her diagnoses included congestive heart failure, anxiety, depression, atrial fibrillation and chronic obstructive pulmonary disease. Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/20/17 was coded as a quarterly assessment. She was coded as having a BIMS (brief interview of mental status) of "10" indicating mild cognitive impairment, but on 8/9/17 she was noted to be alert and oriented x 4. She was also coded as requiring extensive of one staff member to perform her activities of daily living, such as toileting. Resident #18 was coded as having no behaviors during the look back period. Resident #9 was observed on 8/9/17 at 2:15 p.m. She was sitting in her wheelchair in the dining room. She was present for the Resident Council meeting. During the meeting she verbalized a CNA had verbally abused her, "yelling into my face" and wiping her roughly during toileting. She	F 225	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F225 1- A Facility Reported Incident was sent to the appropriate agencies on 8/10/17 to report an allegation of verbal abuse regarding Resident # 9. 2- The Administrator or Designee will review facility related incidents and Customer Service Concern reports of current residents for any indication of abuse and ensure that these incidences are reported to the State Agency appropriately. 3- The Staff Development Coordinator or designee will educate all current licensed nursing staff on the procedure to follow in reporting any allegations of abuse to the Administrator or designee so that the incident can be reviewed and reported to the State Agency as applicable. 4-The Administrator or designee will review shift report and Service Concern	

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F 225	Continued From page 3 stated she reported the incident to the Administrator on Monday. Review of the facility's service concern report revealed: "Resident stated that a CNA on Sunday 8/10/17 was rude to her and wiped her hard while changing her brief." On 8/8/17, the assignment was adjusted , the resident and staff were interviewed and educated. Further review of the interviews revealed that the LPN (licensed practical nurse) on duty had been told by the resident, "Resident said that her aide that she had all day yelled and was mean to her." The incident was not reported to the Administrator. Review of the statement by the CNA who was reported included the following: "I didn't do anything to her she was in a bad mood because she was feeling uncomfortable so she decided to take it out on me." Review of the abuse policy was conducted and contained the following: The "Procedure" section on page 70 read "4. Any and all suspected or witnessed incidents of patient/ patient abuse, neglect, theft, and/ or exploitation or any reasonable suspicion of a crime against a patient/ patient Center brought to the attention of the Center's Administration will result in internal investigation, appropriate and timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as corrective action." The "Procedure" section on page 73 read "Centers must report all alleged or reasonable suspected instances of mistreatment when	F 225	reports for residents on a weekly basis to ensure that any allegations of abuse are reported to the State Agency, as applicable. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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F 225	Continued From page 4 Center staff is suspected of mistreatment, neglect, abuse (including injuries of unknown origin), or misappropriation of patient property." On 8/10/17 at 9:00 AM, Resident #9 was interviewed. She stated, "(Name of CNA) was leaning over my bed, hollering in my face, pounding on the bed , yelling what's wrong." Resident #9 stated she told the CNA "You hurt me bad when you cleaned me." Resident #9 was asked if she felt frightened or threatened; she stated, "Oh, yes, she acted like she was crazy." She went on to state that the CNA no longer came in her room, but that she was still here. On 8/10/17 at 11:15 AM, the Administrator was interviewed. He stated, "We didn't consider this to be abuse." He also stated that he was notified by the resident, not by staff. On 8/10/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226		9/20/17

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F 226	Continued From page 5 (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to operationalize their policies and procedures for abuse relating to an incident of alleged verbal abuse. Resident #9 reported a CNA (certified nursing assistant) had yelled into her face and wiped her roughly during toileting. This was not reported to the Administrator by staff, and was not reported to the state agency. The findings included: Resident #9, a female, was admitted to the facility 5/31/16. Her diagnoses included congestive heart failure, anxiety, depression, atrial fibrillation	F 226	F226 1- A Facility Reported Incident was sent to the appropriate agencies on 8/10/17 to report an allegation of verbal abuse regarding Resident # 9. 2- The Administrator or Designee will review facility related incidents and Customer Service Concern reports of current residents for any indication of abuse and ensure that these incidences are reported to the State Agency and the facility abuse policy is followed appropriately. 3-The Corporate Nurse Consultant or designee will educate all Administrative staff on the facility policy on abuse guidelines and reporting requirements.	

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F 226	Continued From page 6 and chronic obstructive pulmonary disease. Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/20/17 was coded as a quarterly assessment. She was coded as having a BIMS (brief interview of mental status) of "10" indicating mild cognitive impairment, but on 8/9/17 she was noted to be alert and oriented x 4. She was also coded as requiring extensive of one staff member to perform her activities of daily living, such as toileting. Resident #18 was coded as having no behaviors during the look back period. Resident #9 was observed on 8/9/17 at 2:15 p.m. She was sitting in her wheelchair in the dining room. She was present for the Resident Council meeting. During the meeting she verbalized a CNA had verbally abused her, "yelling into my face" and wiping her roughly during toileting. She stated she reported the incident to the Administrator on Monday. Review of the facility's service concern report revealed: "Resident stated that a CNA on Sunday 8/10/17 was rude to her and wiped her hard while changing her brief." On 8/8/17, the assignment was adjusted , the resident and staff were interviewed and educated. Further review of the interviews revealed that the LPN (licensed practical nurse) on duty had been told by the resident, "Resident said that her aide that she had all day yelled and was mean to her." The incident was not reported to the Administrator. Review of the statement by the CNA who was reported included the following: "I didn't do	F 226	4- The Administrator will review facility related incidents and Service Concerns on a weekly basis to ensure that the incidents are investigated and reported as appropriate, according to the federal abuse guidelines and facility abuse policy. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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F 226	Continued From page 7	F 226		

anything to her she was in a bad mood because she was feeling uncomfortable so she decided to take it out on me."

Review of the abuse policy was conducted and contained the following: The "Procedure" section on page 70 read "4. Any and all suspected or witnessed incidents of patient/ patient abuse, neglect, theft, and/ or exploitation or any reasonable suspicion of a crime against a patient/ patient Center brought to the attention of the Center's Administration will result in internal investigation, appropriate and timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as corrective action."

The "Procedure" section on page 73 read "Centers must report all alleged or reasonable suspected instances of mistreatment when Center staff is suspected of mistreatment, neglect, abuse (including injuries of unknown origin), or misappropriation of patient property."

On 8/10/17 at 9:00 AM, Resident #9 was interviewed. She stated, "(Name of CNA) was leaning over my bed, hollering in my face, pounding on the bed , yelling what's wrong." Resident #9 stated she told the CNA "You hurt me bad when you cleaned me." Resident #9 was asked if she felt frightened or threatened; she stated, "Oh, yes, she acted like she was crazy." She went on to state that the CNA no longer came in her room, but that she was still here.

On 8/10/17 at 11:15 AM, the Administrator was interviewed. He stated, "We didn't consider this to be abuse." He also stated that he was notified by the resident, not by staff.

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F 226	Continued From page 8 On 8/10/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.	F 226		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and the facility staff failed to for two Residents, Resident #6 and Resident #7 in a survey sample of 17 residents, to complete a significant change in status assessment. 1. Resident #6 had six areas of decline from the previous assessment; a significant change in status assessment (SCSA) was not completed. 2. For Resident #7, the facility failed to complete a significant change assessment on 2 separate opportunities in quarterly assessments. The findings included:	F 274	F274 1-A significant change assessment for Resident #7 was completed 8/17/17. 2-The MDSC will complete a 100% audit of current residents completed within the last quarter with noted decline or improvement in functional abilities to assess the need for a significant change assessment. 3-The Regional Data Analyst and Verification Specialist will educate the MDSC on requirements for significant change in status-decline or improvement. 4-The MDSC or designee will review and discuss residents with the Interdisciplinary	9/20/17

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F 274	Continued From page 9 1. Resident #6 had six areas of decline from the previous assessment; a significant change in status assessment (SCSA) was not completed. Resident #6, was initially admitted to the facility 6/14/15. Diagnoses included: Dementia, chronic obstructive pulmonary disease, diabetes and glaucoma. Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/13/17 was coded as a quarterly assessment. Resident #6 was coded as having short and long term memory deficits and required moderate assistance in making daily life decisions. Resident #6 was coded as needing extensive assistance in transferring with two staff members, required total assistance with eating, total care in toileting and hygiene and was incontinent of bowel and bladder. Review of the quarterly assessment with an ARD of 4/12/17 revealed the resident had declined in the following areas: Transfer- declined from extensive to total assistance Dressing- declined from extensive to total assistance Eating- declined from extensive to total assistance Hygiene- declined from extensive to total assistance Toileting- declined from extensive to total assistance Bladder Incontinence- declined from frequent incontinence to total incontinence	F 274	team on a weekly basis to determine any residents with a noted decline or improvement in functional abilities and complete significant change assessments as appropriate. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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On 8/10/17 at 10:25 AM, an interview was conducted with the Corporate MDS coordinator (Administration D). She stated: "We should have done a SCSA."

On 8/10/17 at the end of the day exit, the DON (director of nursing) and the Administrator were notified of above findings.

2. For Resident #7, the facility failed to complete a significant change assessment on 2 separate opportunities in quarterly assessments.

For Resident #7, the facility staff failed to assess the Resident for a significant change in condition on 2 different assessments, after the Resident's functional status improved, or declined. Bathing improved, while range of motion declined in the upper extremity and improved in the lower extremity in the February 2017 assessment, and transferring declined while eating and bladder function improved in the May 2017 assessment.

Resident #7 was originally admitted to the facility on 10-10-16. Diagnoses included; Stroke, dysphagia, type 2 diabetes, high cholesterol, hypertension, glaucoma, gout, and cardiac disease.

Resident #7's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 5-7-17. The Resident was coded with a Brief interview for mental status (BIMS), indicating severe cognitive impairment. The Resident was coded as requiring extensive to total dependence on staff for all activities of daily living with the exception of eating. The Resident was also

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coded as frequently incontinent of bladder, and always incontinent of bowel.

All MDS assessments were reviewed from admission and compared. The changes experienced by Resident #7 between the 12-23-16 significant change full assessment and the two following assessments are below.

The full significant change (SCSA) assessment dated 12-23-16 revealed Resident #7 required total dependence on one staff member for bathing, and no range of motion impairments in the upper extremities, while impaired in both lower extremities.

The Next Quarterly assessment dated 2-4-17 coded Resident #7 as requiring only extensive assistance for bathing, and now having upper extremity range of motion impairment on one side and only impaired on one side in the lower extremities.

The Next Quarterly assessment dated 5-7-17 coded Resident #7 as totally dependent for transferring, when previously he was in need of only extensive help, independent with eating (set up help only), and previously extensive help was needed, and was at this assessment now frequently incontinent of bladder instead of always incontinent.

Review of these documents reveals significant changes in 2 to 3 functional areas for each of the 2-4-17, and 5-7-17 assessments. This revealed an overall significant change during the time after the 12-23-16 assessment, without a significant change assessment being completed after each of the 2 opportunities during these changes.

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F 274	Continued From page 12 On 8-9-17 The Director of Nursing (DON) was notified of the deficient practice, and stated she would have the MDS nurse, who was responsible for MDS documentation completion in the facility, made aware of the need for a significant change assessment. On 8-10-17 at 10:00 a.m., the Corporate MDS coordinator stated that "travelers" had been completing the assessments, as the vacancy in this position at the facility had only recently been filled, and errors had been made. She was made aware, at that time, that 2 opportunities to complete a SCSA were missed, and that it revealed changes for this Resident after admission, which had not been captured. She stated she would send a correction to CMS (Centers for Medicare & Medicaid Services). On 8-9-17, and 8-10-17 at the end of the day debrief, the Administrator and DON (director of nursing) were notified of the findings, and no further documentation was presented by the facility.	F 274		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	F 278		9/20/17

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F 278	Continued From page 13 (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to ensure an accurate MDS/Rai assessment for three residents (#3, #2, and #6). 1. For Resident #3, the facility staff failed to accurately assess BIMS (Brief Interview of Mental Status) scores. 2. For Resident #2, the facility staff failed to accurately assess BIMS scores. 3. Resident #6's cognitive status was not	F 278	F278 1-. BIMS Interviews for Residents #3, #2 & #6 were completed on 8/10/17. 2-The MDSC will complete a 100% audit of current residents completed within the last quarter with noted changes in BIMS scores from assessment to assessment. 3-The Regional Data Analyst and Verification Specialist will educate the MDSC on requirements for completion of the BIMS interview. 4-The MDSC or designee will review and discuss residents with the Interdisciplinary	

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F 278	Continued From page 14 accurately coded. Findings included: 1. For Resident #3, the facility staff failed to accurately assess BIMS (Brief Interview of Mental Status) scores. Resident #3, an 80 year old male, was admitted to the facility on 9/10/2011 and readmitted on 8/3/2017. His diagnoses included cerebral palsy, hypertension, anemia, high cholesterol, depression, diabetes, dementia, and contractions. Resident #3's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/18/2017 was coded as an annual assessment. He was coded a BIMS score of 14/15 indicating no cognitive impairment. Resident #3 was coded as needing extensive assistance of one person for his activities of daily living and as being frequently incontinent of bowel and bladder. A review of the clinical record was conducted on 8/9/2017 at 11:00 AM. It revealed a previous MDS report with an ARD of 1/28/2017 that assessed Resident #3 as having a BIMS score of 3/15, indicating severe cognitive impairment. On 8/10/2017 at 10:20 AM an interview was conducted with Employee D and Employee E, facility MDS coordinators. They were questioned about the discrepancy between BIMS assessments of 4/18/2017 and 1/28/2017. They stated that an error was made with the BIMS assessment of 4/18/2017.	F 278	team on a weekly basis to determine any residents with a noted decline or improvement in their BIMS scores and complete significant change assessments as appropriate. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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Administration was informed of the findings on 8/10/2017 at 11:30 AM.

2. For Resident #2, the facility staff failed to accurately assess BIMS scores.

Resident #2, an 88 year old female, was admitted to the facility on 9/9/2015 and readmitted on 12/30/2016. Her diagnoses included dementia, osteoporosis, congestive heart failure, and deep vein thrombosis.

Resident #2's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/10/2017 was coded as a quarterly assessment. Resident #2 was coded a BIMS (Brief Interview of Mental Status) score of 1/15 indicating severe cognitive impairment. Resident #2 was coded as needing extensive assistance of one person for her activities of daily living and as being always incontinent of bowel and bladder.

A review of the clinical record was conducted on 8/9/2017 at 8:45 AM. It revealed a previous MDS assessment with an ARD 2/7/2017 that assessed Resident #2 as having had a BIMS score of 15/15, no cognitive impairment.

On 8/10/2017 at 10:20 AM an interview was conducted with Employee D and Employee E, facility MDS coordinators. They were questioned about the discrepancy between the BIMS assessments of 2/7/2017 and 5/10/2017. They stated that an error was made with the BIMS assessment of 2/7/2017.

Administration was informed of the findings on 8/10/2017 at 11:30 AM.

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3. Resident #6's cognitive status was not accurately coded.

Resident #6, was initially admitted to the facility 6/14/15. Diagnoses included: Dementia, chronic obstructive pulmonary disease, diabetes and glaucoma.

Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/13/17 was coded as a quarterly assessment. Resident #6 was coded as having short and long term memory deficits and required moderate assistance in making daily life decisions. Resident #6 was coded as needing extensive assistance in transferring with two staff members, required total assistance with eating, total care in toileting and hygiene and was incontinent of bowel and bladder.

Review of the quarterly assessment, dated with an ARD of 3/18/17, revealed the resident had been coded with a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment.

Review of the care plan dated 7/31/17 revealed: "The Resident has impaired thought processes related to dementia, intermittent confusion."

On 8/10/17 at 10:25 AM, an interview was conducted with the Corporate MDS coordinator (Administration D). She stated: "We had several different interviewers doing the assessments as the MDS position has been open."

On 8/10/17 at the end of the day exit, the DON (director of nursing) and the Administrator were

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F 278	Continued From page 17 notified of above findings.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (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 (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). (iii) Any specialized services or specialized	F 279		9/20/17

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F 279	Continued From page 18 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. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility record review, and clinical record review, the facility staff failed to devise, and implement a comprehensive care plan for the use of a knee splint to prevent falls and further decline in range of motion for one Resident (Resident #4) in a survey sample of 17 Residents. Resident #4 was observed on 8-8-17 during initial tour, and on 8-9-17 at 4:30 p.m., wearing a knee splint without a physician's order to do so, and no nursing care plan interventions for application of the device or care.	F 279	F279 1-An order was received on 8/9/17 for the splint and the care plan was revised on 8/9/17 to include the provisions for the knee splint for Resident #4. 2-The Unit Manager or designee will review all residents with splints and devices to ensure that the care plan includes provisions for the device and an order is in place as appropriate for the device. 3-The Staff Development Coordinator will educate all Licensed Nursing staff on the requirements for updating the care plan	

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F 279	Continued From page 19 The findings included: Resident #4 was initially admitted to the facility on 7-14-17 to receive rehab for weakness after a hospitalization for sepsis. The Resident was in a weakened state and needed strength training to return to ambulation and self sufficiency. Admission diagnoses included; E-Coli urinary tract infection with sepsis, Addison's disease, high cholesterol, infectious gastroenteritis, and osteoporosis. Resident #4's only MDS (minimum data set) with an ARD (assessment reference date) of 7-21-17 was coded as a full admission assessment. Resident #4 was coded as having no cognitive deficits and required limited assistance of one staff member to perform activities of daily living. Resident #4 was coded as being at risk for falls. Resident #4 was coded as having no limitation in range of motion for all extremities. Resident #4 was observed on 8-8-17 during initial tour, and on 8-9-17 at 4:30 p.m., wearing a left knee splint. The Resident during interview stated she had to have the splint to walk or her knee would buckle and she would fall. She stated the staff did not really know how to apply it properly. Resident #4's care plan review on 8-8-17 revealed no interventions for a knee brace. The Resident was admitted for therapy to strengthen ambulation and self care deficits. The Resident was care planned for falls, however, no splint was mentioned. No interventions for the application of the device, nor care for the Resident's skin under the device nor device maintenance were care planned.	F 279	for devices and obtaining an order for devices as appropriate. 4-The Unit Manager or designee will complete audits on a weekly basis of residents with devices in place to ensure that the care plan includes provisions in the care for the resident with a device and an order is in place as appropriate. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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F 279	Continued From page 20 Review of Resident #3's clinical record revealed a signed physician's order dated 8-9-17 that included: Apply brace to left knee every day shift. Remove at bedtime. When interviewed the Corporate Registered Nurse (RN), and the Director of Nursing (DON) stated they were aware that Resident #4 had a brace, but were unsure what type of brace it was. They were also unaware that no order nor care planning for the device had been completed. On 8-9-17 the DON stated new orders and care planning had been completed for the left knee brace that morning, and none existed for the 25 day stay for Resident #4 up until the time of survey. The administrator, DON, and Corporate RN were informed at the end of day debriefs on 8-8-17, and 8-9-17 of the failure of the staff to implement orders for, and care planning for, the use of the left knee brace to prevent falls and further decline in range of motion for Resident #4. No further information was submitted by the facility.	F 279		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		9/20/17

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F 281	Continued From page 21 Based on staff interview, facility documentation review, and clinical record review the facility staff failed to follow the standards of professional practice for medication and treatment administration for two residents (Resident #8 and #7). 1. For Resident #8, the facility staff failed to correctly transcribe physician orders onto the Medication Administration Record. 2. For Resident #7, the facility staff failed to document medications and treatments as having been administered. Findings included: 1. For Resident #8, the facility staff failed to correctly transcribe physician orders onto the Medication Administration Record. Resident #8, a 77 year old female, was admitted to the facility on 1/20/2017 and readmitted on 7/29/2017. Her diagnoses included spinal fracture, cerebral vascular accident, depression, anxiety, aphasia, hypothyroidism, high cholesterol, and coronary artery disease. Resident #8's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/13/2017 was coded as a quarterly assessment. Resident #8 was coded a BIMS (Brief Interview of Mental Status) score of 8/15, indicating moderate cognitive impairment. Resident #8 was coded as needing only supervision in her activities of daily living, and as being always continent of bowel and bladder. On 8/9/2017 at 1:30 PM a review of the clinical	F 281	F281 1-The order for Lantus SoloStar Solution Pen Injector was correctly transcribed for Resident #8 on 8/9/17. Resident #7 is receiving medications and treatments as ordered and is documented on the medication and treatment administration record. 2-The Unit Manager or designee will review the Medication and Treatment Administration records of all current residents to ensure that the medications and treatments are administered and documented correctly. 3-The Staff Development Coordinator will educate all Licensed Nursing Staff on documentation requirements of medications and treatments on the Medication and Treatment Administration record and the process to follow for transcribing orders. 4-The Unit Manager or designee will complete a weekly audit of the Medication and Treatment Administration records of all current residents to ensure that they medications and treatments are administered and documented correctly. The Unit Manager or designee will complete a weekly audit of any new Physician orders to ensure that the orders are transcribed correctly.	

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record was conducted. It revealed two medication orders that were incorrectly transcribed to the MAR (Medication Administration Record) as follows:

7/29/2017 "Lantus SoloStar Solution Pen Injector. Inject 56 units subcutaneously in the afternoon ...". This order was transcribed to the MAR to be given at 9:00 AM.

7/29/2017 "Miacalcin solution one spray in alternating nostrils one time a day. Upon transcription to the MAR, there was no provision for using alternating nostrils, thus it could not be certain that the physician order was followed exactly.

An interview was conducted on 8/10/2017 at 10:00 AM with Employee B, Director of Nursing who stated that these two orders were incorrectly transcribed to the MAR.

Administration was informed of the findings on 8/10/2017 at 11:30 AM.

2. For Resident #7, the facility staff failed to document medications and treatments as having been administered.

Resident #7 was originally admitted to the facility on 10-10-16. Diagnoses included: Stroke, dysphagia, type 2 diabetes, high cholesterol, hypertension, glaucoma, gout, and cardiac disease.

Resident #7's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of

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5-7-17. The Resident was coded with a Brief interview for mental status (BIMS), indicating severe cognitive impairment. The Resident was coded as requiring extensive to total dependence on staff for all activities of daily living with the exception of eating. The Resident was also coded as frequently incontinent of bladder, and always incontinent of bowel.

Review of the clinical record revealed the most recent recapitulated physician's orders signed by the physician which included the following medication and treatment orders. Review of the "Medication and Treatment Administration Records" (MAR's/TAR's) for July and August 2017, revealed that the medications and treatments denoted below were not documented as administered.

1. Diltiazem extended release capsules 180 mg (milligrams) one time per day at 9:00 a.m. No blood pressure or pulse taken prior to administration on 7-3-17, 7-7-17, 7-19-17, 7-23-17, 7-28-17, 7-29-17, 7-31-17, and on 7-30-17 no blood pressure was taken.

2. House supplement Gelatein Pulse 1 cup at 2:00 p.m. every day. Not given on 7-11-17.

3. Med Plus 2.0 supplement three times per day 120 ml (milliliters) at 9:00 a.m., 2:00 p.m., and 9:00 p.m. Not given on 7-11-17, 8-1-17, and 8-4-17, at 2:00 p.m.

4. No treatments on 8-1-17 were signed as completed.

The nursing progress notes did not document why these omissions occurred, however, there

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was a nursing note on 7-19-17 at 5:29 a.m., and 5:30 a.m., which stated "medication has not arrived from pharmacy will arrive on the noon run. RP (responsible party) and MD (doctor) aware. No new orders." The note did not included what specific medication, or how many medications this included.

On 8-9-17 at 10:30 a.m. an interview with the "Director of Nursing (DON), was conducted. She stated they would have to look into the concerns of treatment and medication administration for Resident #7, and return with further information. By the end of survey no further information was provided.

Review of the Resident's care plan revealed that the Resident's medications and treatments would be administered as ordered by a physician.

The facility policy on medication administration also stated that the Resident's medications and treatments would be administered as ordered by a physician.

The DON and Corporate Registered nurse (RN) consultant gave "Mosby's" as the facility standard reference for nursing practice. Guidance was provided for nursing, Fundamentals of Nursing, Mosby's, "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients.

On 8-10-17 at the end of the day debrief, the Administrator, Corporate RN Consultant, and DON (director of nursing) were notified of the above findings. The facility presented no further information.

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F 318 SS=D	INCREASE/PREVENT DECREASE IN RANGE OF MOTION CFR(s): 483.25(c)(2)(3) (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility record review, and clinical record review, the facility staff failed to obtain orders for the use of a knee splint to prevent falls and further decline in range of motion for one Resident (Resident #4) in a survey sample of 17 Residents. Resident #4 was observed on 8-8-17 during initial tour, and on 8-9-17 at 4:30 p.m., wearing a knee splint without a physician's order to do so. The findings included: Resident #4 was initially admitted to the facility on 7-14-17 to receive rehab for weakness after a hospitalization for sepsis. The Resident was in a weakened state and needed strength training to return to ambulation and self sufficiency. Admission diagnoses included; E-Coli urinary tract infection with sepsis, Addison's disease, high cholesterol, infectious gastroenteritis, and osteoporosis.	F 318	F318 1-An order for a knee splint for Resident #4 was received on 8/9/17. 2-The Unit Manager or designee will review all residents with splints and devices to ensure that an order is in place as appropriate. 3-The Staff Development Coordinator will educate all Licensed Nursing staff on the requirements for having orders in place as appropriate. 4-The Unit Manager or designee will complete audits on a weekly basis of residents with devices in place to ensure that an order is in place as appropriate. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	9/20/17

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F 318	Continued From page 26	F 318		

Resident #4's only MDS (minimum data set) with an ARD (assessment reference date) of 7-21-17 was coded as a full admission assessment. Resident #4 was coded as having no cognitive deficits and required limited assistance of one staff member to perform activities of daily living. Resident #4 was coded as being at risk for falls. Resident #4 was coded as having no limitation in range of motion for all extremities.

Resident #4 was observed on 8-8-17 during initial tour, and on 8-9-17 at 4:30 p.m., wearing a left knee splint. The Resident during interview stated she had to have the splint to walk or her knee would buckle and she would fall. She stated the staff did not really know how to apply it properly.

Resident #4's care plan review on 8-8-17 revealed no interventions for a knee brace. The Resident was admitted for therapy to strengthen ambulation and self care deficits. The Resident was care planned for falls, however, no splint was mentioned. No interventions for the application of the device, nor care for the Resident's skin under the device nor device maintenance were care planned.

Review of Resident #3's clinical record revealed a signed physician's order dated 8-9-17 that included: Apply brace to left knee every day shift. Remove at bedtime.

When interviewed the Corporate Registered Nurse (RN), and the Director of Nursing (DON) stated they were aware that Resident #4 had a brace, but were unsure what type of brace it was. They were also unaware that no order nor care planning for the device had been completed.

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F 318	Continued From page 27 On 8-9-17 the DON stated new orders and care planning had been completed for the left knee brace that morning, and none existed for the 25 day stay for Resident #4 up until the time of survey. The administrator, DON, and Corporate RN were informed at the end of day debriefs on 8-8-17, and 8-9-17 of the failure of the staff to implement orders for, and care planning for the use of the left knee brace to prevent falls and further decline in range of motion for Resident #4. No further information was submitted by the facility.	F 318		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		9/20/17

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F 329	Continued From page 28 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to ensure that Resident #8 was free from unnecessary medications. 1. The facility staff failed to follow physician ordered parameters for the administration of Toprol XL. Findings included: Resident #8, a 77 year old female, was admitted to the facility on 1/20/2017 and readmitted on 7/29/2017. Her diagnoses included spinal fracture, cerebral vascular accident, depression, anxiety, aphasia, hypothyroidism, high cholesterol, and coronary artery disease. Resident #8's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date)	F 329	F329 1- Resident #8 is receiving Toprol as ordered. 2- The Unit Manager or Designee will review the medication administration records for current residents receiving hypertension medications to ensure that they are administered and documented appropriately and as ordered. 3- The Staff Development Coordinator or Designee will educate all licensed nursing staff on following physician ordered parameters with the administration of hypertension medication and documenting the administration or findings appropriately on the medication administration record. 4- The Unit Manager or designee will review the medication administration records for current residents receiving	

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F 329	Continued From page 29 of 6/13/2017 was coded as a quarterly assessment. Resident #8 was coded a BIMS (Brief Interview of Mental Status) score of 8/15, indicating moderate cognitive impairment. Resident #8 was coded as needing only supervision in her activities of daily living, and as being always continent of bowel and bladder. On 8/9/2017 at 1:30 PM a review of the clinical record was conducted. It revealed the following physician order dated 8/4/2017: "Toprol XL Tablet Extended Release 25 mg (milligram). Give 0.5 tablet, 12.5 mg, daily. Hold for SBP (Systolic Blood Pressure) less than 110 and pulse less than 50." The MAR (Medication Administration Record) for August 2017 showed that Toprol XL was administered on 8/5-8/9/2017 without obtaining blood pressure and pulse readings. There was no record of blood pressure or pulse readings in the balance of the clinical record for this period. An interview was conducted with Employee B, Director of Nursing on 8/10/2017 at 10:00 AM. She stated that blood pressure and pulse readings should be obtained prior to the administration of Toprol XL and that the order was not correctly followed. Administration was informed of the findings on 8/10/2017 at 10:45 AM.	F 329	hypertension medications to ensure that they are administered and documented appropriately and as ordered on a weekly basis. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	
F 354 SS=D	WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON CFR(s): 483.35(b)(1)-(3) (1) Except when waived under paragraph (e) or	F 354		9/20/17

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F 354	Continued From page 30 (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility failed to ensure that a RN (registered nurse) was available for at least 8 hours a day. There were three days on which a RN was not scheduled to work. The findings included: Review of the actual worked staffing schedule for the prior two months was reviewed. For this 60 bed facility, there were generally 2-3 nurses on each shift, and 3-5 CNA's (certified nursing assistants) on each shift; this was consistent with other facilities of the same size. Further review revealed there were three days, 7-22-17, 8-5-17 and 8-6-17, which there was no RN (registered nurse) coverage of at least eight hours on these days. The days mentioned were weekend days. On 8/10/17 at 1:20 PM, the DON (director of nursing) was questioned about the RN coverage	F 354	F354 1-The facility is providing RN coverage at least 8 consecutive hours a day. 2-The DON or designee will review the current schedule to ensure that there is RN coverage for at least 8 consecutive hours a day. 3-The DON will educate all Licensed Nursing staff on the requirement for RN coverage. 4-The DON or designee will review the Nursing staff schedule on a weekly basis to ensure that there is RN coverage for at least 8 consecutive hours a day. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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F 354	Continued From page 31 for the days mentioned. She stated, "We didn't have an RN." There was no variance for lack of RN coverage. On 8/10/17 at the end of the day exit, the Administrator and DON were notified of the above findings. The above allegation was substantiated with a deficiency due to lack of RN coverage for at least eight hours a day.	F 354		