STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(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 SHDULD BE CRC[illegible] APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/6/18 through 3/9/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	Wayland Nursing and Rehabilitation center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provisions of quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Wayland Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Wayland Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018		

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LABORATORY DIRECTOR'S OR PRDVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T. Wayland
TITLE: Administrater
(X6) DATE: 4/12/18

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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E 018	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by:	E 018	E-018 The facility will develop and implement an emergency plan that includes a system to track the location of on-duty staff and sheltered patients that are relocated during an emergency. The Emergency Policies and procedures will be reviewed to incorporate the necessary components of a satisfactory overall plan. The Emergency Preparedness Plan will be reviewed and updated annually by the facility Safety Committee. The reviews and updates will be reported to and monitored by the facility's QA Committee on an annual basis.	4/21/18

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E 018	Continued From page 2 Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop a tracking system to document locations of patients and staff. The findings include: On 3/9/18 at 9:45 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to evidence a tracking system to document locations of patients and staff. ASM # 1 stated that the facility did not have it. ASM #1 was made aware of the findings at that time. No further information was obtained prior to exit.	E 018		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that	E 023		

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E 023	Continued From page 3 preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The findings include: On 3/9/18 at 9:45 a.m. a review and interview of	E 023	E-023 The facility will develop and implement an emergency plan that will include policies and procedures that will indicate how the patient information will be protected, preserved, kept confidential, and maintained to provide availability of records. The Emergency policy and procedures will be reviewed to ensure that components of a satisfactory plan are incorporated. The Emergency Preparedness Plan will be reviewed and updated annually by the facility Safety Committee. The reviews and updates will be reported to and monitored by the facility's QA Committee on an annual basis.	4/21/18

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E 023	Continued From page 4 the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. ASM # 1 stated that the resident's charts would go with them but that it had not been included into the facility plan yet. ASM #1 was made aware of the findings at that time. No further information was obtained prior to exit.	E 023	E-025 The facility will develop and implement contracts and Memorandums of Understanding with other entities to receive patients in the event the facility is unable to care for them during an emergency. The Emergency Policy and procedures plan will be reviewed and updated and revised, as applicable, to ensure that components of a satisfactory plan are incorporated. The Emergency Preparedness Plan will be reviewed and updated annually by the facility's Safety Committee. Reviews and updates will be reported to and monitored by the facility's QA Committee on an annual basis.	4/21/18
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at	E 025		

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E 025	Continued From page 5 §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. The findings include: On 3/9/18 at 9:45 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility	E 025		

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E 025	Continued From page 6 is not able to care for them during an emergency. OSM # 1 stated that the facility did not have it. ASM #1 was made aware of the findings at that time. No further information was obtained prior to exit.	E 025	E-030 The facility will develop and implement a procedure for sharing medical documentation for patients under the facility's care. The procedure will outline the means to ensure the continuity of care with other health care providers and the means to release necessary patient information. The Emergency Preparedness Plan will be reviewed and updated to ensure that the components of a satisfactory plan are incorporated. The Emergency preparedness Plan will be reviewed and updated annually by the Facility's Safety Committee. Reviews and updates will be reported to and monitored by the Facility's QA Committee.	4/21/18
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 7 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health	E 030		

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E 030	Continued From page 8 providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. The findings include: On 3/9/18 at 9:45 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to provide evidence of documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 030		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at	E 036		

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E 036	Continued From page 9 paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 036	E-036 The facility will adopt a written training and testing program that meets the requirements of the regulation and will document that the training and testing program has been reviewed and updated on an annual basis. The emergency preparedness Plan will be updated and reviewed by the administrator and facility consultant to ensure that the components of a satisfactory plan are incorporated. The Emergency preparedness Plan will be reviewed and updated annually by the facility's safety Committee. Reviews, updates and changes will be reported to and monitored by the Facility's QA Committee.	4/21/18

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E 036	Continued From page 10 The facility staff failed to provide evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis by asking for documentation of the annual review as well as any updates made. The findings include: On 3/9/18 at 9:45 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to provide evidence the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis by asking for documentation of the annual review as well as any updates made. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 11 expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.	E 037	E-037 The facility will conduct in-service training for employees on the Emergency preparedness Plan. In service training and education will be conducted annually thereafter. The Emergency preparedness plan will be reviewed and updated to ensure that that the components of a satisfactory plan are incorporated. The Emergency preparedness Plan will be reviewed and updated annually by the Facility's Safety Committee. Reviews and updates will be reported to and monitored by the Facility's QA Committee.	4/21/18

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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
E 037	Continued From page 12 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually.	E 037		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

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E 037	Continued From page 13 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least	E 037		

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E 037	Continued From page 14 annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. The findings include: On 3/9/18 at 9:45 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. ASM # 1 stated that the facility did not have it and that not all staff had been trained. No further information was obtained prior to exit.	E 037		4/21/18
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to	E 039		

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E 039	Continued From page 15 test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO]	E 039	E-039 The facility will conduct a tabletop exercise on an annual basis to review, update and individualize the Emergency preparedness plan. The Emergency preparedness Plan will be reviewed and updated to ensure that the components of a satisfactory plan are incorporated. The Emergency Preparedness Plan will be reviewed and updated at least annually by the Facility's Safety Committee. Any interim revisions, reviews and updates will be reported to and monitored by the facility's QA Committee.	4/21/18

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E 039	Continued From page 16 must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's exercise analysis and response evidencing how the facility updated its emergency program based on the exercise analysis. The findings include: On 3/8/18 at 9:45 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (other staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to provide evidence of documentation, of the facility's exercise analysis and response and evidence how the facility updated its emergency program based on the exercise analysis. ASM # 1 stated that the facility	E 039		

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E 039	Continued From page 17 did not have it. No further information was obtained prior to exit.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted from 3/06/18 through 3/09/18. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 90 certified bed facility was 53 at the time of the survey. The survey sample consisted of 25 current residents Residents # 10, 41, 34, 35, 44, 30, 18, 36, 39, 12, 14, 43, 13, 40, 42, 37, 23, 8, 9, 5, 24, 20, 25, 27, and 45 and three closed records, Residents # 51, 52, and 53.	F 000	F-580 The facility notified the Physician regarding the Blood Sugar levels for Resident #43. The facility notified the Physician and responsible representative that Resident #14 had refused the ordered protein supplement. The facility notified the Physician and responsible representative that resident #25 did not receive the ordered Symetrel for 3 and one half days. A review of resident charts that had orders for blood sugars, refusals of protein supplements and missed meds was conducted by the nursing staff and there was found to be no other affected residents.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		

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F 580	Continued From page 18 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to notify the MD (medical doctor) and RR (resident representative) of a change in condition for three of 28 residents in the survey sample, Resident #43, #14, and #25.	F 580	An in-service was conducted with licensed personnel to re-educate them on the proper procedures for notifications of physicians and responsible representatives. Procedures for abnormal blood sugars, refusals of meds, and missed medications were also included. The DON or her designee will conduct an audit weekly for 4 weeks then monthly of selected resident charts to determine that proper notifications are being provided to physicians and responsible representatives. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/21/18

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F 580	Continued From page 19 1. The facility staff failed to notify the medical doctor when the Resident #43's blood sugar levels [1] were over 400 on three occasions in March of 2018. 2. The facility staff failed to notify the physician and responsible representative that Resident #14 refused the physician ordered protein supplement to promote wound healing 18 out of 34 opportunities in February 2018. 3. The facility staff failed to notify the physician and responsible representative that Resident #25 did not receive the physician ordered Symetrel for three and a-half days in February 2018. The findings include: 1. The facility staff failed to notify the medical doctor when the Resident #43's blood sugar levels [1] were over 400 on three occasions in March of 2018. Resident #43 was admitted to the facility on 1/31/18 with diagnoses that included but were not limited to unspecified psychosis, type two diabetes, dementia, hypothyroidism and high blood pressure. Resident #43's most recent MDS (minimum data set) assessment was a 14-day scheduled assessment, with an ARD (assessment reference date) of 2/14/18. Resident #43 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #43 was coded as requiring extensive assistance from two or more staff with transfers, locomotion and toileting; extensive assistance from one staff member with	F 580		

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F 580	Continued From page 20 dressing and personal hygiene, and as being totally dependent on staff with bathing. Review of Resident #43's most recent POS (physician order summary) dated 2/2018 documented the following order: "Accucheck AC + HS (before meals and hours of sleep) with Humalog Insulin [2] BS (blood sugar): BS 201-250= 4 units BS 251-300= 6 units BS 301-350= 8 units BS 351-400= 10 units BS 401 or greater = 12 units Call MD." Review of Resident #43's March 2018 MAR (Medication Administration Record) revealed Resident #43 had BS readings over 400 on the following dates and times: 3/3/18 at 5:00 p.m., blood sugar was 560; 3/3/18 at 9:00 p.m., blood sugar was 423; 3/4/18 at 5:00 p.m., blood sugar was 520. Further review of the March 2018 MAR and the March nursing notes failed to evidence, the physician was notified of the elevated blood sugars. On 3/8/18 at 8:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3, a nurse who frequently works with Resident #43. When asked what the above physicians orders for insulin meant, LPN #3 stated she would administer the 12 units and then notify the doctor if the resident's blood sugar was over 400. When asked why the doctor would want to be notified, LPN #3 stated the doctor may want to order additional units of insulin or additional blood sugar checks. When asked if notification of the doctor	F 580		

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F 580	Continued From page 21 would be documented anywhere in the clinical record, LPN #3 stated it should be documented in a nursing note. When asked if nurses would notify the physician every time a blood sugar reading was over 400, LPN #3 stated, "They wouldn't necessarily." LPN #3 stated, "Most of the orders say to notify if 400 or over, but the physician has said in the past to not call them unless it's over 500." LPN #3 then consulted with RN (registered nurse) #2 and asked about an order clarification. LPN #3 was asked if the current physician order was being followed if there is no evidence of physician notification. LPN #3 stated, "No." LPN #3 stated that nurses did have a communication book with the physician that documented any concerns. LPN #3 presented this book for review and the blood sugars above 400 for Resident #43 were not documented in the book. LPN #3 stated there was a chance the MD (medical doctor)/NP (nurse practitioner) were made aware verbally but there was no documentation. LPN #3 stated, "There is usually someone in-house quite a bit." LPN #3 stated that Resident #43's blood sugars were always within normal limits for her. On 3/8/18 at 3:28 p.m., an interview was conducted with ASM (administrative staff member) #4, Resident #43's physician. ASM #4 could not recall being made aware of the above instances where Resident #43's blood sugars were elevated. ASM #4 stated that he would expect nursing staff to contact him or the NP. ASM #4 stated he would want to know when "things are out of control." ASM #4 could not recall telling staff to call him only if blood sugars are over 500. On 3/08/18 at 5:12 p.m., the above concerns	F 580		

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F 580	Continued From page 22 were addressed with ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing). The facility policy titled, Notification of "Physician for Change in Condition" documented the following: "It is the policy of the facility to notify the physician when a significant change in a resident's condition occurs with documentation contained within the medical record. No further information was presented prior to exit. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. [1] Blood Sugar levels are the sugars in the blood and the body's main source of energy. When the body's blood sugar rises, for instance after a meal, the pancreas secretes insulin. Insulin enters the blood stream and transports these sugars into the body's cells where it is transformed into energy. This then causes the blood sugar levels to fall. When the pancreas is not functioning properly, like a person with type one or two diabetes, blood sugar levels continue to rise in the blood stream. This is also known as	F 580		

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F 580	Continued From page 23	F 580		

Hyperglycemia. Medications (insulin) may be needed to control blood sugar levels. This information was obtained from The National Institutes of Health. https://medlineplus.gov/hyperglycemia.html.

Normal blood sugar levels for people who do not have diabetes are 70-130 before meals and less than 180 2 hours after meals. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024698/

[2] Humalog insulin is a fast acting insulin that helps turn sugar ingested from the food and drink we eat into energy used by the body. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010736/?report=details

2. The facility staff failed to notify the physician and responsible representative that Resident #14 refused the physician ordered protein supplement to promote wound healing for 18 out of 34 opportunities in February 2018.

Resident #14 was admitted to the facility on 8/24/16 with diagnoses that included but were not limited to: nutritional anemia, chronic pain, depression, dementia and elevated cholesterol.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/29/17. The resident was coded as having a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The

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F 580	Continued From page 24 resident was coded as requiring assistance from staff for all activities of daily living. The resident was not coded as having a wound. Review of the quarterly MDS dated 10/27/17 documented that the resident did not have a wound. Review of the dietitian's note dated 3/30/17 documented in part, "Pertinent med's (medications) include...beneprotein 1 scoop TID (three times a day). Resident with wound to right lower buttocks. Resident with a new wt (weight) of 123.4# (pounds) on 3/22(2017) indicating wt loss of ~ (approximately) 8# past month." Review of the resident's care plan initiated on 1/30/17 and revised on 8/11/17 documented, "Focus At Risk for skin breakdown related to: Cognitive impairment, immobility. Interventions. Supplements as ordered by the physician. Review of the physician's orders from November 2017 through March 2018 documented, "Beneprotein (a protein supplement) 1 (scoop) TID (three times a day) for wound healing." Review of the February 2018 MAR (medication administration record) documented, "Beneprotein 1 (scoop) TID (three times a day) for wound healing." On 18 occasions, the nurse's initials were circled indicating the supplement was not given on those occasions. On the backside of the MAR, there was documentation on three occasions that the resident refused the supplement. Review of the February 2018 nurse's notes did not evidence documentation that the physician or	F 580		

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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
F 580	Continued From page 25 responsible representative (RR) were notified that the resident did not receive the beneprotein as ordered. An interview was conducted on 3/8/18 at 1:40 p.m. with LPN (licensed practical nurse) #2. When asked when the physician or RR was notified, LPN #2 stated, "If they're short of breath, have a high heart rate, low blood pressure, any change in the resident's condition." When asked why the physician was notified, LPN #2 stated, "Because we have to follow the physician's orders. Physician orders are written to be followed." When asked if the physician and RR would be notified if the resident refused an ordered medication or a supplement, LPN #2 stated, "Yes. We would call the MD (medical doctor) to see if you can get another supplement and keep trying (to give it)." When asked if this would be documented, "LPN #2 stated, "Yes, ma'am, under the progresses notes for that specific reason." On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "NOTIFICATION OF PHYSICIAN FOR CHANGE IN RESIDENT'S CONDITION" documented, "It is the policy of the facility to notify the physician when a significant change in a resident's condition occurs with documentation contained within the medical record." No further information was provided prior to exit. 3. The facility staff failed to notify the physician	F 580		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

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F 580	Continued From page 26 and responsible representative that Resident #25 did not receive the physician ordered Symetrel for three and a-half days in February 2018. Resident #25 was admitted to the facility on 7/17/15 and readmitted on 12/19/17 with diagnoses that included but were not limited to: Parkinson's disease (1), heart failure, diabetes, psychotic disorders, depression, schizophrenia (2), anoxic brain injury (3) and seizures. The most recent complete MDS, a 30-day assessment, with an ARD of 1/17/18 coded the resident as having scored a (six) 6 out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of staff for all activities of daily living with the exception of eating which the resident could perform with supervision. Review of the care plan initiated on 7/24/15 and revised on 4/3/17 did not evidence documentation regarding medications. Review of the physician's orders for March 2018 documented, "Symetrel (4) Amantadine CAP (capsule) 100 MG (milligrams) BY MOUTH TWICE DAILY. 12/20/17 (order date)." A clarification order dated 1/14/18 documented, "Symetrel for Parkinson's disease." Review of the February 2018 MAR documented, "Symetrel (4) Amantadine CAP (capsule) 100 MG (milligrams) BY MOUTH TWICE DAILY. 12/20/17 (order date)." Review of the MAR documented that the medication was not given at 9:00 a.m. or 8:00 p.m. on 2/3, 2/4 and 2/5/18 and the medication was not given at 9:00 a.m. on 2/6/18 as evidenced by the nurse's circled initials.	F 580		

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F 580	Continued From page 27 Review of the backside of the MAR documented for each of these days and times, "Symetrel 100 mg PO (by mouth) out of stock." Review of the February nurse's notes did not evidence documentation that the physician or the responsible representative were notified that the Symetrel had not been administered on 2/3, 2/4, 2/5 and 2/6/18. An interview was conducted on 3/8/18 at 1:40 p.m. with LPN (licensed practical nurse) #2, regarding how staff obtain medications for residents'. LPN #2 stated, "I would have to call the pharmacy and see if they can call it over to the (name of local pharmacy), my backup pharmacy." When asked what staff would do if a medication was not available to for administration for four days, LPN #2 stated, "We would call the pharmacy and the doctor to see if we could get another medication." When asked if the RP (responsible party) would be notified, LPN #2 stated yes. When asked why, LPN #2 stated that the family was always notified of any change in the resident's condition. When asked if the physician would be notified, LPN #2 stated, "Yes because we have to follow physician orders. Physician orders are written to be followed." When asked if this would be documented, LPN #2 stated, "Yes ma'am under the progress notes for that specific reason." The nurses' who did not administer the medications were no longer employed by the facility and could not be interviewed. On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the	F 580		

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F 580	Continued From page 28 findings. No further information was provided prior to exit. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. 1. Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html 2. Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. This information was obtained from: https://medlineplus.gov/schizophrenia.html 3. Cerebral hypoxia refers to a condition in which there is a decrease of oxygen supply to the brain even though there is adequate blood flow. Drowning, strangling, choking, suffocation,	F 580		

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F 580	Continued From page 29 cardiac arrest, head trauma, carbon monoxide poisoning, and complications of general anesthesia can create conditions that can lead to cerebral hypoxia. Symptoms of mild cerebral hypoxia include inattentiveness, poor judgment, memory loss, and a decrease in motor coordination. Brain cells are extremely sensitive to oxygen deprivation and can begin to die within five minutes after oxygen supply has been cut off. This information was obtained from: https://www.ninds.nih.gov/Disorders/All-Disorders/Cerebral-Hypoxia-Information-Page 4. Amantadine is an antiviral that is used in the prophylactic or symptomatic treatment of influenza A. It is also used as an antiparkinsonian agent, to treat extrapyramidal reactions, and for postherpetic neuralgia. The mechanisms of its effects in movement disorders are not well understood but probably reflect an increase in synthesis and release of dopamine, with perhaps some inhibition of dopamine uptake. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/amantadine#section=Top	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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	F 609		

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F 609	Continued From page 30 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. §483.12(c)(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 corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that facility staff failed to report an allegation of abuse for two of 28 residents in the survey sample, Resident #9 and #41. 1. The facility staff failed to report Resident #9's allegation of sexual abuse to the appropriate state agencies in a timely manner. 2. The facility staff failed to notify the appropriate state agency of a 7/15/17 injury of unknown origin for Resident #41. The findings include: 1. Resident #9 was admitted to the facility on 6/14/17 and readmitted on 8/19/17 with diagnoses that included but were not limited to	F 609	F-609 The facility did fail to timely report the allegations of abuse for resident #9 and #41. The investigations were completed and reviewed at the time of the survey. 100 % audit of notification of reportable events was completed by the administrator on 3/12. There were no other instances found of failure to report or reporting late. An in-service and reeducation was conducted by the SDC with facility personnel regarding the abuse policy, and reporting requirements. Facility Reported Incidents will be reviewed monthly by the facility administrator for compliance with reporting requirements and adherence to abuse policy.	4/21/18

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F 609	Continued From page 31 dementia without behavioral disturbance, anxiety disorder, type two diabetes, major depressive disorder, high blood pressure, chronic ischemic heart disease, COPD (chronic obstructive pulmonary disease), and stroke. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/13/17. Resident #9 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as requiring extensive assistance with one staff member for most ADLS (activities of daily living). Review of Resident #9's clinical record revealed the following social worker notes dated 12/19/17 and 12/20/17: 12/19/18 at 1:57 p.m.: "CNA (certified nursing assistant) reported some concerns regarding the outing with resident's son (Name of son), Administrator, and DON (Director of Nursing), and this writer interviewed resident who did not verbalize any areas of concerns. Talked about shopping and going out to eat. Stated that her son treats he well and is kind to her. Resident has a history of confusion and hallucinations, she said at one point during interview, she was waiting for people on the plane to get here and that she went shopping to buy present for her mother. Will continue to monitor and follow up with resident regarding visits." 12/20/18 at 12:55 p.m.: "This writer and DON (Director of Nursing) called (Name of Social Services) and spoke with APS (adult protective services) worker, (Name of social worker). Advised (Name of social worker) of the report	F 609	Results of the reviews will be reported by the Administrator to the facility's QA Committee on a monthly basis for three months then quarterly thereafter. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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F 609	Continued From page 32 given by CNA regarding outing with son and the statement made by resident. (Name of social worker) was given all information and stated that she would be speaking with the team...FNP (Facility nurse practitioner) aware of above." 12/20/17 at 14:58 (2:58 p.m.): "This writer called DON and called resident's son advise of accusations resident made against son during outing with son, Son, (Name of son) stated that "he did not have sex with his mother" and that "this was stupid." (Name of son) was informed that he could not enter (Name of facility) until investigation has been completed. (Name of son) stated do what you got to do. (Son) concerned that he will not get to spend Christmas with mother..." 12/21/17 at 2:47 p.m.: "This writer called and spoke with (Name of Son), resident's RP (responsible party) and advised that the investigation was unfounded and that he could return to (Name of facility) to see mother. (Name of son) stated that he would pick up resident on Saturday at 4 p.m. to attend Christmas family event and to ask nursing to save resident's dinner tray for when she returns. Nursing made aware of above." A facility reported incident (FRI) was not submitted to the appropriate state agency until 12/20/17 (two days after the resident reported the abuse allegation to the CNA). The FRI documented the following: "On December 18th 2017 C.N.A. (certified nursing assistant) ask resident if she had a good time while out with her son over the weekend. Resident replied yes and began to discuss what they had done including that, he didn't use a rubber. When resident asked	F 609		

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F 609	Continued From page 33 what the rubber was used for, she stated, "sex." She then admitted that she has sex with her son." The investigation and follow up to the initial FRI was completed and submitted to the appropriate state agency on 12/21/17. On 3/7/18 at 1:44 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows if a resident were to report an allegation of abuse from a family or staff member, LPN #1 stated she would first ensure the resident's safety, and report the allegation immediately to the administrator and possibly the police department. LPN #1 stated the administrator would take over from there and initiate an investigation. On 3/8/18 at 10:28 a.m., an interview was conducted with OSM (other staff member) 1, the social worker. When asked her involvement with an abuse allegation from a resident, OSM #1 stated she was always notified if a resident reported an allegation of abuse. OSM #1 stated she would immediately talk with the resident and start an investigation. OSM #1 stated if the allegation were reported to her first, she would immediately notify the administrator who would then initiate an investigation. OSM #1 stated it is also her responsibility to notify APS (adult protective services) and the ombudsman immediately. OSM #1 stated she was not involved with creating the FRI. OSM #1 stated the DON (Director of Nursing) and Administrator completes the FRI. On 3/8/18 at 12:10 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the	F 609		

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F 609	Continued From page 34 DON (Director of Nursing). When asked about the process staff follows when a resident reports and allegation of abuse to the staff, ASM #2 stated the staff member would report the allegation to the nurse manager and the manager would report the allegation right to her (the DON). ASM #2 stated she would then report to the administrator immediately. When asked what immediately meant, ASM #2 stated within 24 hours. ASM #2 stated the administrator would then initiate the FRI. ASM #1 then stated that allegations of abuse would be reported to the appropriate state agencies within 2 hours maximum. ASM #1 stated the investigation would then start and he would follow up with the appropriate state agencies within 5 days or sooner. When asked when the allegation Resident #9 had made to the CNA had occurred, ASM #2 stated that it was reported to the CNA on December 18th but December 20th was when she believed she found out. ASM # 2 was not certain of the date she had found out. ASM #2 stated, "I am not sure what happened, the CNA may have reported the incident late." On 3/8/18 at 1:23 p.m., an interview was conducted with CNA (certified nursing assistant) #3, the nursing aide involved in the FRI. When asked about the events of 12/18/17, CNA #3 stated on December 18th, she was caring for Resident #9 and asked the resident how her visit with her son went. CNA #3 stated the resident had claimed she was upset that her son did not use a rubber when they had sex. CNA #3 stated she had asked Resident #9 to clarify that statement because Resident #9 had severe dementia. CNA #3 stated the Resident had repeated herself and confirmed she has had sex with her son. CNA #3 stated she reported this	F 609		

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F 609	Continued From page 35 allegation directly to the administrator as well as the social worker. CNA #3 stated the administrator at the time and who no longer works at the facility, told her and the social worker not to say anything, the resident has dementia and this was one of her behaviors. CNA #3 stated the DON was out of work that day so she and the social worker had reported this allegation to the DON the next day or when the DON came back to work. CNA #3 stated she and the social worker did not feel comfortable not reporting this allegation. On 3/08/18 at 1:23 p.m., further interview was conducted with OSM #1, the social worker. When asked if she could recall the allegation of abuse regarding Resident #9, OSM #1 stated she could recall when the CNA had reported this allegation to her and the Administrator, they were both told to keep quiet and that an allegation like this could "mess up this man's (son's) life". OSM #1 stated, "This is not the same administrator that is here now." OSM #1 stated she reported to this to the DON as soon as the DON came back. When asked when the DON arrived back to the facility, OSM #1 stated it was the next day. When asked if she could contact anyone else for assistance if the administrator was not willing to report an allegation of abuse, OSM #1 stated she could contact the ombudsman and she did contact the ombudsman. OSM #1 could not recall when she contacted the long-term care ombudsman. On 3/8/18 at 12:10 p.m., ASM #1, the administrator and ASM #2, the DON were made aware of the above concerns. The facility policy titled "Abuse, Neglect, and	F 609		

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F 609	Continued From page 36 Misappropriation" documents in part, the following: "It is every employees responsibility immediately report an incident of resident abuse or suspected abuse to his or her supervisor. The supervisor and/or employee must then report immediately to the Administrator. If the immediate supervisor is the alleged perpetrator, the report is to be made to the administrator or Director of Nursing, or as needed to the facility's Regional Vice President of Operations. Any employee who fails to immediately report suspected mistreatment, abuse including injuries of unknown sources, neglect, and/or misappropriation of property of a resident will face disciplinary action up to and including termination of employment...Reporting to the administrator: Any alleged or suspected abuse is immediately reported to the administrator or designee. Immediate reporting to the administrator ensures that abuse investigated, reported to the state authorities, and that the resident is free from further abuse." 2. The facility staff failed to notify the appropriate state agency of a 7/15/17 injury of unknown origin for Resident #41. Resident #41 was admitted to the facility on 6/21/16 with diagnoses that included but were not limited to Parkinson's disease, high blood pressure and fractured hip. Review of the most recent MDS (minimum data set) assessment dated 1/17/18, a 30 day assessment, with an ARD (assessment reference date) of 1/17/18 coded the resident as having scored a six 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	F 609		

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F 609	Continued From page 37 daily living except for eating which the resident could perform after the tray was set up. A request was made on 3/6/18 during the entrance conference at 7:00 a.m. for all facility reported investigations since the last survey. A green folder labeled with Resident #41's name was received. The folder contained information about a facial bruise of unknown origin that occurred on 7/15/17. Multiple staff interviews were conducted from 7/15/17 through 7/17/17. There was a notation in the folder that documented, "No evidence of abuse found." On 3/7/18 at 2:00 p.m. a request for a copy of the facility reported incident (FRI) for Resident #41's 7/15/17 facial bruise was made to ASM (administrative staff member) #1, the administrator. At 3:30 p.m., ASM #1 returned and stated they could not locate the FRI but would try to contact the previous administrator to ask where the report was. On 3/8/18 at 9:40 a.m. ASM #1 stated, "We have not found it (the FRI)." An interview was conducted on 3/8/18 at 12:01 p.m. with ASM #1, the administrator and ASM #2, the director of nursing. When asked about the process followed to report an injury of unknown origin, ASM #2 stated, "If a resident reports it to the staff member they report it to me and I report it to the administrator within 24 hours." When asked if a FRI would be sent in Resident #41's situation, ASM #2 stated, yes, it should have been but she was out on leave at the time of the incident. When asked who would submit the FRI, ASM #2 stated, "The previous administrator would initiate the FRI report and if he is not	F 609		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

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F 609	Continued From page 38 available it falls back on me." ASM # 1 stated, "On abuse we submit the report in 2 hours maximum. After we submit the FRI, then the investigation has to start. We send home the suspected staff, question the resident, other residents, and families." On 3/8/18 at 1:07 p.m., ASM #1 returned and stated, "I just talked to the last administrator. She said if it's in a green folder it was an internal investigation, and we determined that it was not an unknown (injury). I'm looking at the incident reports now." When asked if that was acceptable, ASM #1 stated it should have been reported. ASM #1 stated, "I report everything." Review of the nurse's notes dated 7/15/17 at 1:59 p.m. documented, "Housekeeping reported to writer that resident had a bruise on her face. Upon assessment large purplish colored bruise noted to resident Lower (sic) (R) jaw. R jaw appears slightly swollen compared to L (left). Resident states that she did not know it was there, that it did not hurt. States that she did not fall or hit on anything...MD (medical doctor) and RP (responsible party) made aware." Review of the incident report dated 7/15/17 and revised on 7/28/17 documented, "Housekeeping reported to writer that resident had a bruise on her face. Upon assessment, large purplish (sic) colored to (R) (right) lower jaw. States that she did not know it was there. States that she did not fall or hit it on anything. People Notified (name of responsible representative). Investigation completed, resident denies any accidents. She does have a long hx (history) of getting up without assistance. There is no evidence of any foul play. Resident likely was standing, loss balance and hit	F 609		

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F 609	Continued From page 39 face on sink." An interview was conducted on 3/9/18 at 11:15 p.m. with LPN (licensed practical nurse) #2, the nurse who cared for the resident on 7/15/17. When asked the process staff followed when a resident had an injury, LPN #2 stated, "They notify me. I notify my supervisor and there's an investigation we have to do." When asked about the bruise found on Resident #41 on 7/15/17, LPN #2 stated, "I remember I asked her if she fell but she denied it." No further information was provided prior to exit.	F 609	F-622 The record for Resident #25 was updated by the physician regarding transfer. The record for resident #39 was updated by the physician regarding the transfer to the hospital. The record for Resident #53 was updated by the physician regarding the reason for a facility initiated transfer. The record for Resident#5 was updated by the physician regarding transfer to the hospital. A review of resident transfers for the last 30 days was conducted by the IDT for compliance with regulations and updates were done as needed.	
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (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; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (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	F 622		

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F 622	Continued From page 40 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 (F) The facility ceases to operate. (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 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. §483.15(c)(2) Documentation. 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. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (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).	F 622	A review of resident discharge charts will be conducted by the IDT during its morning meetings to ensure compliance by the physician in documenting reasons for transfer. The Administrator will share with the Medical Director the results of the review weekly for 4 weeks then monthly thereafter. Results of the reviews will be reported by the Administrator to the facility's QA Committee on a monthly basis for three months then quarterly thereafter. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/21/18

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F 622	Continued From page 41 (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for 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, facility document review and clinical record review, it was determined that the facility staff failed to ensure documentation by the physician in the clinical record provide when two four of 28 residents in the survey sample, Residents # 25, 39, 5 and 53, were transferred to the hospital. 1. The facility staff failed to ensure, a note by the physician, for a facility initiated transfer for Resident #25 to the hospital on 12/14/17. 2. The facility staff failed to ensure, a note by the physician, for a facility initiated transfer for	F 622		

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F 622	Continued From page 42 Resident #39 to the hospital on 1/29/19. 3. Resident #53 was transferred to the hospital on 12/20/17. There were no physician notes documented in the clinical record regarding the reason for the facility-initiated transfer. 4. The facility staff failed to ensure the physician documented a note in the clinical record for Resident #5's facility initiated transfer to the hospital on 2/21/18. The findings include: 1. Resident #25 was admitted to the facility on 7/17/15 and readmitted on 12/19/17 with diagnoses that included but were not limited to: Parkinson's disease (1), heart failure, diabetes, psychotic disorders, depression, schizophrenia (2), anoxic brain injury (3) and seizures. The most recent complete MDS, a 30-day assessment, with an ARD (assessment reference date) of 1/17/18, coded the resident as having scored a 6 out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of staff for all activities of daily living with the exception of eating, which the resident could perform with supervision. Review of the physician's orders dated 12/14/17 documented, "Give one dose Albuterol 0.083% (4) via neb (nebulizer)/If no improvement send to ER (emergency room)." Review of the nurse's note on 12/14/17 at 6:05 a.m. documented, "At 04:30 (4:30 a.m.) CNA (certified nursing assistant) called to nurse's	F 622		

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F 622	Continued From page 43 station C to state resident was having difficulty breathing... Called (name of physician) received order to administer albuterol via nebulizer if ineffective send to the ER." Review of the nurse's note on 12/14/17 at 4:45 a.m. documented, "Administered resident breathing treatment...Resident still having auditory inspiration and expiration wheezing without the use of a stethoscope...Called Ems (sic) [emergency medical services] to transport at 05:00 (5:00 a.m.) to (name of emergency room)." Review of the physician's notes for December 2017 did not evidence documentation by the physician regarding the reason the resident could not be treated at the facility and required a transfer to the emergency room. An interview was conducted on 3/08/18 12:01 p.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. When asked about the process staff followed when a resident was transferred to the emergency room, ASM#2 stated, "What we do is we assess the resident, and call the doctor or the FNP (family nurse practitioner). We tell them what we have found and they tell us to send them to the ER or give us orders." When asked where this was documented, ASM #2 stated, "In the progress notes. Once we decide they are going to the ER or hospital we call the RR (resident representative), we talk to the resident and we get the papers together and call the ER with report and 911 for transport." When asked if the physician wrote a note documenting the reason the resident required an emergency room transfer, ASM #2, "I don't know. I'd have to check on that." ASM #1 and ASM #2 were made aware	F 622		

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F 622	Continued From page 44 of the findings at that time. An interview was conducted on 3/08/18 at 3:06 p.m. with ASM #4, the resident's physician. When asked what role he had in transferring a resident to the hospital, ASM #4 stated, "An acute transfer to the hospital opposed to routine. The process is that I'm to be called about the patient's circumstances and decide if they go to the hospital or is there something I can order to take care of it in the facility." When asked if he wrote a note regarding why a resident would be transferred to the hospital, ASM #4 stated, "No. I don't normally do that, as I am not there. I expect the nursing staff are doing that." When asked if he was aware of the new regulations regarding transfers, ASM #3 stated, "I am not aware of the new regulations. I'm not aware of the one that is specific to the transfer to the hospital." Review of the facility's policy titled "TRANSFER AND DISCHARGE" revised on 3/9/18 (the last day of the survey) documented, "The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; 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....d) The health of individuals of the facility would otherwise be endangered... The facility will have documentation in the resident's medical record that the above situations discussed in "a" or "b" have occurred. An physician may document the situation in "d" has occurred. The resident's attending physician will provide documentation	F 622		

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F 622	Continued From page 45 that situations discussed in "a" or "b" have occurred. Before a facility transfers or discharges a resident, the facility will: Notify the resident and, if known, a family member or legal representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand." No further information was provided prior to exit. 1. Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html 2. Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. This information was obtained from: https://medlineplus.gov/schizophrenia.html 3. Cerebral hypoxia refers to a condition in which there is a decrease of oxygen supply to the brain even though there is adequate blood flow. Drowning, strangling, choking, suffocation, cardiac arrest, head trauma, carbon monoxide poisoning, and complications of general anesthesia can create conditions that can lead to cerebral hypoxia. Symptoms of mild cerebral hypoxia include inattentiveness, poor judgment, memory loss, and a decrease in motor coordination. Brain cells are extremely sensitive to oxygen deprivation and can begin to die within	F 622		

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F 622	Continued From page 46 five minutes after oxygen supply has been cut off. This information was obtained from: https://www.ninds.nih.gov/Disorders/All-Disorders/Cerebral-Hypoxia-Information-Page 4. Albuterol sulfate inhalation solution is indicated for the relief of bronchospasm in patients 2 years of age and older with reversible obstructive airway disease and acute attacks of bronchospasm. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5329614f-ae0b-4854-bb6f-ea0b7dae87c0 2. The facility staff failed to ensure, a note by the physician, for a facility initiated transfer for Resident #39 to the hospital on 1/29/19. Resident #39 was admitted to the facility on 11/17/15 and readmitted on 2/6/18 with diagnoses that included but were not limited to: heart failure, chronic lung diseases and weakness. The most recent complete MDS, a quarterly assessment, with an ARD (assessment reference date) of 2/13/18 coded the resident as having scored a four out of ten on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the nurse's note dated 1/29/19 at 11:41 a.m. documented, "Patient noted with increased confusion by staff. I spoke to the patient who had difficulty communicating due to SOB (shortness of breath) and some increased confusion... (Name of physician) called (sic) agreed to send	F 622		

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F 622	Continued From page 47 out. 911 called and squad arrived at 11:42 (a.m.)." Review of the physician's orders dated 1/29/18 documented, "Send to ER (emergency room) for evaluation." Review of the January and February 2018 physician notes did not evidence documentation regarding the reason the resident required an emergency room transfer. An interview was conducted on 3/8/18 12:01 p.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. When asked about the process staff followed when a resident was transferred to the emergency room, ASM#2 stated, "What we do is we assess the resident, and call the doctor or the FNP (family nurse practitioner). We tell them what we have found and they tell us to send them to the ER or give us orders." When asked where this was documented, ASM #2 stated, "In the progress notes. Once we decide they are going to the ER or hospital we call the RR (resident representative), we talk to the resident and we get the papers together and call the ER with report and 911 for transport." When asked if the physician wrote a note when documenting the reason the resident required an emergency room transfer, ASM #2, "I don't know. I'd have to check on that." ASM #1 and ASM #2 were made aware of the findings at that time. An interview was conducted on 3/08/18 3:06 p.m. with ASM #4, the resident's physician. When asked what role he had in transferring a resident to the hospital, ASM #4 stated, "An acute transfer to the hospital opposed to routine. The process is that I'm to be called about the patient's	F 622		

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F 622	Continued From page 48 circumstances and decide if they go to the hospital or is there something I can order to take care of it in the facility." When asked if he wrote a note regarding why the resident was transferred, ASM #4 stated, "No. I don't normally do that, as I am not there. I expect the nursing staff are doing that." When asked if he was aware of the new regulations regarding transfers, ASM #3 stated, "I am not aware of the new regulations. I'm not aware of the one that is specific to the transfer to the hospital." No further information was provided prior to exit. 3. Resident #53 was transferred to the hospital on 12/20/17. There were no physician notes documented in the clinical record regarding the reason for the facility-initiated transfer. Resident #53 was admitted to the facility on 7/22/16 and readmitted on 8/30/17 with diagnoses that included but were not limited to high cholesterol, anxiety disorder, epilepsy, major depressive disorder, and COPD (chronic obstructive pulmonary disease). Resident #53's most recent assessment was a quarterly assessment with ARD (assessment reference date) of 12/6/18. Resident #53 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #53 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living). Resident #53 was discharged from the facility on 12/22/17. Review of Resident #53's clinical record revealed the following nursing note dated 12/20/17 at 5:35 a.m.: "Went to give resident his medication, resident was verbally unresponsive. Skin hot and dry to touch. Loose cough noted. When resident	F 622		

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F 622	Continued From page 49 name called, he tried to open his eyes. Vital signs: 100.8 (temperature), 93 (pulse), 28 (respirations), 110/60 (blood pressure), 02 sat (oxygen saturation [amount of oxygen in the blood]) 95 percent on room air." The next note dated 12/20/17 at 5:41 a.m. documented the following: "(Name of NP (nurse practitioner) notified of resident's condition. Order give to send the resident to the ER (emergency room) for an evaluation." Further review of the nursing notes revealed the following: 12/20/17 at 1:47 p.m. "Telephoned (Name of hospital) ER (emergency room) to follow up on resident's condition. Resident being admitted to room 332 with diagnosis of sepsis." 12/22/17 at 2:16 p.m. "residents (sic) RP (responsible party) in facility and obtained all of residents belongings. t.v (sic) also taken. staff (sic) assisted RP with items to van. she (sic) had to questions nor concerns while at facility." There were no physician notes regarding the reason for the facility-initiated transfer or a discharge summary for Resident #53 in the clinical record. On 3/8/18 at 3:28 p.m., an interview was conducted with ASM (administrative staff member) #4, the medical director. ASM #4 stated that he does not write notes for every facility-initiated transfer. ASM #4 stated that he was not aware of the new regulations. ASM #4 stated that he writes discharge summaries for residents who are discharged. He could not	F 622		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

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F 622	Continued From page 50 recall Resident #53 at that moment. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing were made aware of the above concerns. No further information was presented prior to exit. 4. The facility staff failed to ensure the physician documented a note in the clinical record for Resident #5's facility initiated transfer to the hospital on 2/21/18. Resident #5 was admitted to the facility on 5/21/15 with a recent readmission on 2/25/18, with diagnoses that included but were not limited to: cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. A significant change assessment was in progress at the time of survey. Review of the clinical record documented a nurse's note dated, 2/21/18 at 9:49 a.m., "Called NP (nurse practitioner), order received to send resident to ER (emergency room) - Farmville d/t (due to) resident being in chair and lend (sic) forward and unable to regain body control in	F 622		

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F 622	Continued From page 51 chair. Nurse and CNA (certified nursing assistant) laid resident back in bed and obtained vital signs." The nurse's note dated, 2/21/18 at 10:25 a.m. documented, "Resident lethargic but will answer simple questions. Resident voiced that he was weak and didn't feel well. VS (vital signs) 86/40 (blood pressure), 99.6 (temperature) 93 (pulse) 16 (respirations) 97% (oxygen saturation)." The nurse's note on 2/21/18 at 10:25 a.m. documented, "(Name of county) squad in to transport resident to (name of hospital) no distress noted." The physician order dated, 2/21/18 documented, "Transport to ER - (name of hospital and town) to treat and eval (evaluate), RP (responsible party) notified." Review of the clinical record did not reveal documentation by the physician regarding the reason for Resident #5's facility initiated transfer to the hospital on 2/21/18. There was no documentation regarding how the facility could not meet the resident's needs. An interview was conducted with LPN (licensed practical nurse) #1, on 3/8/18 at 9:58 a.m., regarding the process staff follow when a resident is transferred to the hospital. LPN #1 stated, "Usually we gather information and call the doctor to get an order. A lot of times, the NP (nurse practitioner) is in the building. They give a verbal order; we transfer it to a telephone order and fax it to the pharmacy." When asked if the physician writes when a resident has a facility initiated transfer to the hospital, LPN #1 stated, "I'm not aware of that." An interview was conducted with administrative	F 622		

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F 622	Continued From page 52 staff member (ASM) #1, the administrator and ASM #2, the director of nursing, on 3/8/18 at 12:01 p.m., regarding physician documentation for facility initiated transfers of residents to the hospital. ASM #2 stated, "I'll have to get back with you on that." An interview was conducted with ASM #4, the medical director, on 3/8/18 at 3:15 p.m. When asked what his role in transferring a resident to the hospital, ASM #4 stated, "I am supposed to be called and advised of the circumstances and I decide whether we transfer to the ER (emergency room) or give an order to treat here." When asked if he wrote a note for facility initiated transfers to the ER, ASM #4 stated, "Only if I am in the building when it occurs." When asked if he writes a note when he is not in the building, ASM #4 stated, "No, I don't usually." The administrator and director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (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.	F 623	F-623 Written Notification to the to the resident representative and to the long term care ombudsman was provided for	

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F 623	Continued From page 53 (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 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F 623	resident#34,#20,#53,#25,#39 and #5. A review by the Social Worker of transfers for last 30 days found no other incidents of non-compliance. An in-service will be conducted with the Social Worker by the Administrator to update her on the rules regarding notification of Resident representatives and the Ombudsman. The IDT will review discharges for proper notifications at its morning meetings to ensure compliance with the regulations. Results of the reviews will be reported by the Social Worker to the facility's QA Committee on a monthly basis for three months then quarterly thereafter. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/27/18

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F 623	Continued From page 54 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; (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	F 623		

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F 623	Continued From page 55 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: Based on staff interview and clinical record review, it was determined that facility staff failed to provide written notification to the resident representative and the long term care ombudsman of a facility initiated transfer to the hospital for six of 28 residents in the survey sample, Resident #34, #20, #53, #25, #39, and #5. 1. The facility staff failed to provide written notification to Resident #34, the resident representative and ombudsman for Resident #34's transfer to the hospital on 12/17/17. 2. The facility staff failed to provide written notification to Resident #20, the resident representative and ombudsman for Resident #20's transfer to the hospital on 12/17/17. 3. The facility staff failed to provide written notification to Resident #53, the resident representative and ombudsman for Resident #53's transfer to the hospital on 12/20/17. 4. The facility staff failed to provide written documentation to Resident #25's responsible representative and notify the ombudsman when the resident was transferred to the emergency room on 12/14/17. 5. The facility staff failed to provide written documentation to Resident #39's responsible	F 623		

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F 623	Continued From page 56 representative and notify the ombudsman when the resident was transferred to the emergency room on 1/29/18. 6. The facility staff failed to provide written documentation to Resident #5, the resident's representative and the ombudsman, when Resident #5 was transferred to the hospital on 2/21/18. The findings include: 1. Resident #34 was admitted to the facility on 6/19/15 and readmitted on 12/20/17 with diagnoses that included but were not limited to morbid obesity, unspecified dementia without behavioral disturbance, major depressive disorder, Alzheimer's disease, high blood pressure, chronic heart failure and muscle atrophy and wasting. Resident #34's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/2/18. Resident #34 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #34's nursing notes revealed that Resident #34 was sent out to the hospital on 12/17/17. The following note was documented: "Resident has vomited large amount of brown emesis. Smells like stool. VS (Vital signs: elevated). MD (medical doctor) made aware and order received to send to ER (emergency room) for evaluation and tx (treatment). 911 was called and RP (representative) and ER made aware. The next note dated 12/17/17 at 1:12 a.m., documented the following: "Resident has left the	F 623		

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F 623	Continued From page 57 facility on stretcher with (Name of ambulance) being transported to (Name of ER). She is alert and oriented and able to make needs known." Review of the clinical record revealed that Resident #34 was admitted to the hospital with a diagnosis of a bowel obstruction. Further review of Resident #34's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #34's transfer, and that the ombudsman received a copy of this written notification. On 3/8/18 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process followed when a resident is sent to the hospital, LPN #1 stated she would gather all information from her assessment such as vital signs etc, notify the physician and then she would get the verbal order to send the resident out to the emergency room if the physician agreed with her findings. When asked what she and other nurses would document about a facility-initiated transfer, LPN #1 stated she would document the timeframe of everything that had occurred such as the time the family and physician were notified. When asked if she would give the resident or family member anything in writing about their transfer, LPN #1 stated, "No, not generally." When asked if she would notify the ombudsman for every facility-initiated transfer to the hospital, LPN #1 stated, "No." On 3/8/18 at 10:20 a.m., an interview was conducted with OSM #1, the social worker. When asked her role with facility- initiated transfers to the hospital; OSM #1 stated that most of the time the nurses handled the transfers,	F 623		

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F 623	Continued From page 58 notifications and all that. OSM #1 stated that the nurses spoke to family members verbally. OSM #1 stated that she did not notify the ombudsman with every facility-initiated transfer to the hospital. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1 and ASM (administrative staff member) #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Transfer and Discharge" documents in part, the following: "Before a facility transfers or discharges a resident, the facility will: Notify the resident and, if known, a family member or legal representative of the transfer or discharge and the reasons for the move in writing and in a language manner they understand." 2. The facility staff failed to provide written notification to Resident #20, the resident representative and ombudsman for Resident #20's transfer to the hospital on 12/17/17. Resident #20 was admitted to the facility on 11/2/15 with diagnoses that included but were not limited to compression fracture of the first lumbar vertebra, difficulty in walking, muscle weakness, type two diabetes, dementia without behavioral disturbance, Alzheimer's disease, heart failure, altered mental status, and difficulty swallowing. Resident #20's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 1/2/18. Resident #20 was coded as being severely impaired in cognitive function scoring a three on the Staff Assessment for Mental Status exam. Resident #20 was coded as being totally dependent on staff for most ADLS (activities of	F 623		

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F 623	Continued From page 59 daily living). Review of Resident #20's nursing notes revealed that Resident #20 went out to the hospital on 12/17/17. The following was documented: "12/17/17 at 6:55 a.m., Resident has just projectile vomited brown coffee grounds-emesis. States her stomach hurts. ABD (abdomen) firm. Will send to (name of ER [emergency room]) for tx (treatment and evaluation)." The next note dated 12/17/17 at 7:13 a.m., documented the following: "RR (resident representative) has been made aware of need for transfer to (Name of ER)." Resident #20 returned back to the facility on 12/17/17 at 3:05 p.m. with no further episodes of hematemesis or any diagnosis from the ER (emergency room). Further review of Resident #20's clinical record failed to evidence the resident and RP (responsible party) were notified in writing of the reason for her transfer, and that the ombudsman received a copy of this written notification. On 3/8/18 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process followed when a resident is sent to the hospital, LPN #1 stated that she would gather all information from her assessment such as vital signs etc, notify the physician and then she would get the verbal order to send the resident out to the emergency room if the physician agreed with her findings. When asked what she and other nurses would document about a facility-initiated transfer, LPN #1 stated that she would document the timeframe	F 623		

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F 623	Continued From page 60 of everything that had occurred such as the time the family and physician were notified. When asked if she would give the resident or family member anything in writing about their transfer, LPN #1 stated, "No, not generally." When asked if she would notify the ombudsman for every facility-initiated transfer to the hospital, LPN #1 stated, "No." On 3/8/18 at 10:20 a.m., an interview was conducted with OSM #1, the social worker. When asked her role with facility- initiated transfers to the hospital; OSM #1 stated that most of the time the nurses handled the transfers, notifications and all that. OSM #1 stated that the nurses spoke to family members verbally. OSM #1 stated that she did not notify the ombudsman with every facility-initiated transfer to the hospital. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1 and ASM (administrative staff member) #2, the DON (Director of Nursing) were made aware of the above concerns. 3. The facility staff failed to provide written notification to Resident #53, the resident representative and ombudsman for Resident #53's transfer to the hospital on 12/20/17. Resident #53 was admitted to the facility on 7/22/16 and readmitted on 8/30/17 with diagnoses that included but were not limited to high cholesterol, anxiety disorder, epilepsy, major depressive disorder, and COPD (chronic obstructive pulmonary disease). Resident #53's most recent assessment was a quarterly assessment with ARD (assessment reference date) of 12/6/18. Resident #53 was coded as	F 623		

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F 623	Continued From page 61 being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #53 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living). Review of Resident #53's clinical record revealed the following nursing note dated 12/20/17 at 5:35 a.m.: "Went to give resident his medication, resident was verbally unresponsive. Skin hot and dry to touch. Loose cough noted. When resident named called he tried to open his eyes. Vital signs: 100.8 (temperature), 93 (pulse), 28 (respirations), 110/60 (blood pressure), 02 sat (oxygen saturation [amount of oxygen in the blood]) 95 percent on room air." The next note dated 12/20/17 at 5:41 a.m. documented the following: "(Name of NP) notified of resident's condition. Order give to send the resident to the ER (emergency room) for an evaluation." Further review of the nursing notes revealed the following notes: 12/20/17 at 1:47 p.m. "Telephoned (Name of hospital) ER to follow up on resident's condition. Resident being admitted to room 332 with diagnosis of sepsis." 12/22/17 at 2:16 p.m. "residents (sic) RP (responsible party) in facility and obtained all of residents belongings. t.v (sic) also taken. staff (sic) assisted RP with items to van. she (sic) had to questions nor concerns while at facility." Further review of Resident #53's clinical record	F 623		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

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F 623	Continued From page 62 failed to evidence the resident, and RP (responsible party) were notified in writing of the reason for her reason for transfer, and that the ombudsman received a copy of this written notification. On 3/8/18 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process followed when a resident is sent to the hospital, LPN #1 stated that she would gather all information from her assessment such as vital signs etc, notify the physician and then she would get the verbal order to send the resident out to the emergency room if the physician agreed with her findings. When asked what she and other nurses would document about a facility-initiated transfer, LPN #1 stated that she would document the timeframe of everything that had occurred such as the time the family and physician were notified. When asked if she would give the resident or family member anything in writing about their transfer, LPN #1 stated, "No, not generally." When asked if she would notify the ombudsman for every facility-initiated transfer to the hospital, LPN #1 stated, "No." On 3/8/18 at 10:20 a.m., an interview was conducted with OSM #1, the social worker. When asked her role with facility- initiated transfers to the hospital; OSM #1 stated that most of the time the nurses handled the transfers, notifications and all that. OSM #1 stated that the nurses spoke to family members verbally. OSM #1 stated that she did not notify the ombudsman with every facility-initiated transfer to the hospital. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1 and ASM (administrative staff	F 623		

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F 623	Continued From page 63 member) #2, the DON (Director of Nursing) were made aware of the above concerns. 4. The facility staff failed to provide written documentation to Resident #25's responsible representative and notify the ombudsman when the resident was transferred to the emergency room on 12/14/17. Resident #25 was admitted to the facility on 7/17/15 and readmitted on 12/19/17 with diagnoses that included but were not limited to: Parkinson's disease (1), heart failure, diabetes, psychotic disorders, depression, schizophrenia (2), anoxic brain injury (3) and seizures. The most recent complete MDS, a 30 day assessment, with an ARD (assessment reference date) of 1/17/18 coded the resident as having scored a 6 out of 15 on the BIMS indicating the resident was severely impaired cognitively. Review of the physician's orders dated 12/14/17 documented, "Give one dose Albuterol 0.083% (4) via neb (nebulizer)/If no improvement send to ER." Review of the nurse's note on 12/14/17 at 6:05 a.m. documented, "At 04:30 (4:30 a.m.) CNA (certified nursing assistant) called to nurses station C to state resident was having difficulty breathing...Called (name of physician) received order to administer albuterol via nebulizer if ineffective send to the ER (emergency room)." Review of the nurse's note on 12/14/17 at 4:45 a.m. documented, "Administered resident breathing treatment...Resident still having auditory inspiration and expiration wheezing without the use of a stethoscope...Called Ems	F 623		

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F 623	Continued From page 64 (sic) [emergency medical services] to transport at 05:00 (5:00 a.m.) to (name of emergency room)." Review of the clinical record did not evidence documentation that the resident representative (RR) and the ombudsman were notified in writing about the resident's emergency room transfer. An interview was conducted on 3/8/18 09:59 a.m. with LPN (licensed practical nurse) #1. When asked about the process staff follow for sending a resident to the hospital, LPN #1 stated, "Usually we gather all our information, notify the doctor, and get an order." When asked how the family was notified of the transfer, LPN #1 stated, "Through the telephone." When asked if the resident or family were given anything in writing about the transfer, LPN #1 stated, "No not generally." An interview was conducted on 3/8/18 at approximately 10:15 a.m. with OSM (other staff member) #1, the social worker. When asked about the process staff follows when the resident was transferred to the hospital, OSM #1 stated, "I try to let the family know but usually the nurses handle that." When asked if the resident or responsible representative were given anything in writing about the transfer, OSM #1 stated, "I'm not sure if they do or not." When asked if the ombudsman was notified when a resident was transferred to the hospital, OSM #1 stated, "No, not unless there was an issue." When asked what an issue was, OSM #1 stated, "If they were transferred and the family wasn't providing support. We notify the ombudsman for that." An interview was conducted on 3/08/18 12:01 p.m. with ASM (administrative staff member) #1,	F 623		

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F 623	Continued From page 65 the administrator and ASM #2, the director of nursing. When asked about the process staff follows when a resident was transferred to the emergency room, ASM#2 stated, "What we do is we assess the resident, and call the doctor or the FNP (family nurse practitioner). We tell them what we have found and they tell us to send them to the ER or give us orders." When asked where this was documented, ASM #2 stated, "In the progress notes. Once we decide they are going to the ER or hospital we call the RR (resident representative), we talk to the resident and we get the papers together and call the ER with report and 911 for transport." When asked if the family or RR was given any written documentation about the transfer, ASM #2 stated, "No, we just talk to the resident's family over the phone, because they usually don't come in. They usually meet them at the hospital." When asked who notified the ombudsman of the transfer and discharge, ASM #2 stated, "I'm not sure about that." ASM #1 stated, "I do know under the new regulations the ombudsman should be notified but I do not know what they have been doing here." ASM #1 began employment at the facility on 2/1/18. ASM #1 and ASM #2 were made aware of the findings at that time. Review of the facility's policy titled "TRANSFER AND DISCHARGE" revised on 3/9/18 (the last day of the survey) documented, "The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; b) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services	F 623		

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F 623	Continued From page 66 provided by the facility....d) The health of individuals of the facility would otherwise be endangered... The facility will have documentation in the resident's medical record that the above situations discussed in "a" or "b" have occurred. An physician may document the situation in "d" has occurred. The resident's attending physician will provide documentation that situations discussed in "a" or "b" have occurred. Before a facility transfers or discharges a resident, the facility will: Notify the resident and, if known, a family member or legal representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand." The policy did not document anything regarding written notification to the ombudsman for facility initiated transfers and discharges. No further information was provided prior to exit. 1. Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html 2. Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. This information was obtained from: https://medlineplus.gov/schizophrenia.html 3. Cerebral hypoxia refers to a condition in which	F 623		

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F 623	Continued From page 67 there is a decrease of oxygen supply to the brain even though there is adequate blood flow. Drowning, strangling, choking, suffocation, cardiac arrest, head trauma, carbon monoxide poisoning, and complications of general anesthesia can create conditions that can lead to cerebral hypoxia. Symptoms of mild cerebral hypoxia include inattentiveness, poor judgment, memory loss, and a decrease in motor coordination. Brain cells are extremely sensitive to oxygen deprivation and can begin to die within five minutes after oxygen supply has been cut off. This information was obtained from: https://www.ninds.nih.gov/Disorders/All-Disorders/Cerebral-Hypoxia-Information-Page 4. Albuterol sulfate inhalation solution is indicated for the relief of bronchospasm in patients 2 years of age and older with reversible obstructive airway disease and acute attacks of bronchospasm. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5329614f-ae0b-4854-bb6f-ea0b7dae87c0 5. The facility staff failed to provide written documentation to Resident #39's responsible representative (RR) and the ombudsman when the resident was transferred to the emergency room on 1/29/18. Resident #39 was admitted to the facility on 11/17/15 and readmitted on 2/6/18 with diagnoses that included but were not limited to: heart failure, chronic lung diseases and weakness. The most recent complete MDS, a quarterly	F 623		

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F 623	Continued From page 68 assessment, with an ARD of 2/13/18 coded the resident as having scored a four out of ten on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the nurse's note dated 1/29/19 at 11:41 a.m. documented, "Patient noted with increased confusion by staff. I spoke to the patient who had difficulty communicating due to SOB (shortness of breath) and some increased confusion... (Name of physician) called (sic) agreed to send out. 911 called and squad arrive at 11:42 (a.m.)." Review of the physician's orders dated 1/29/18 documented, "Send to ER (emergency room) for evaluation." Review of the clinical record did not evidence written documentation about the transfer had been provided to the RR (responsible representative) and the ombudsman. An interview was conducted on 3/8/18 09:59 a.m. with LPN (licensed practical nurse) #1. When asked about the process staff follow for sending a resident to the hospital, LPN #1 stated, "Usually we gather all our information, notify the doctor, and get an order." When asked how the family was notified of the transfer, LPN #1 stated, "Through the telephone." When asked if the resident or family were given anything in writing about the transfer, LPN #1 stated, "No not generally." An interview was conducted on 3/8/18 at approximately 10:15 a.m. with OSM (other staff member) #1, the social worker. When asked	F 623		

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F 623	Continued From page 69 about the process staff follows when the resident was transferred to the hospital, OSM #1 stated, "I try to let the family know but usually the nurses handle that." When asked if the resident or responsible representative were given anything in writing about the transfer, OSM #1 stated, "I'm not sure if they do or not." When asked if the ombudsman was notified when a resident was transferred to the hospital, OSM #1 stated, "No, not unless there was an issue." When asked what an issue was, OSM #1 stated, "If they were transferred and the family wasn't providing support. We notify the ombudsman for that." An interview was conducted on 3/08/18 12:01 p.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. When asked about the process staff follows when a resident was transferred to the emergency room, ASM#2 stated, "What we do is we assess the resident, and call the doctor or the FNP (family nurse practitioner). We tell them what we have found and they tell us to send them to the ER or give us orders." When asked where this was documented, ASM #2 stated, "In the progress notes. Once we decide they are going to the ER or hospital we call the RR (resident representative), we talk to the resident and we get the papers together and call the ER with report and 911 for transport." When asked if the family or RR was given any written documentation about the transfer, ASM #2 stated, "No, we just talk to the resident's family over the phone, because they usually don't come in. They usually meet them at the hospital." When asked who notified the ombudsman of the transfer and discharge, ASM #2 stated, "I'm not sure about that." ASM #1 stated, "I do know under the new regulations the ombudsman should be notified	F 623		

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*** TX REPORT ***
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Part 2 of 3

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Nursing Fax Skilled Care Wing- 434-736-2269

FAX

TO: Dept of Health / Va. FROM: Wayland Nursing

FAX: 804/527-4502 PAGES: 2/3

PHONE: DATE: 3/30/2018

RE: CC:

Comments (POC) Office of Licensure & Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 70 but I do not know what they have been doing here." ASM #1 began employment at the facility on 2/1/18. ASM #1 and ASM #2 were made aware of the findings at that time. No further information was provided prior to exit. 6. The facility staff failed to provide written documentation to Resident #5, the resident's representative and the ombudsman, when Resident #5 was transferred to the hospital on 2/21/18. Resident #5 was admitted to the facility on 5/21/15 with a recent readmission on 2/25/18, with diagnoses that included but were not limited to: cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. A significant change assessment was in progress at the time of survey. Review of the clinical record documented a nurse's note dated, 2/21/18 at 9:49 a.m., "Called NP (nurse practitioner), order received to send resident to ER (emergency room) - Farmville d/t (due to) resident being in chair and lend (sic) forward and unable to regain body control in chair. Nurse and CNA (certified nursing	F 623		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

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F 623	Continued From page 71 assistant) laid resident back in bed and obtained vital signs." The nurse's note dated, 2/21/18 at 10:25 a.m. documented, "Resident lethargic but will answer simple questions. Resident voiced that he was weak and didn't feel well. VS (vital signs) 86/40 (blood pressure), 99.6 (temperature) 93 (pulse) 16 (respirations) 97% (oxygen saturation)." The nurse's note on 2/21/18 at 10:25 a.m. documented, "(Name of county) squad in to transport resident to (name of hospital) no distress noted." The physician order dated, 2/21/18 documented, "Transport to ER - (name of hospital and town) to treat and eval (evaluate), RP (responsible party) notified." Further review of the clinical record for Resident #5, failed to evidence documentation that the resident or their representative were provided with written notification of Resident #5's transfer to the hospital on 2/21/18, and no documentation evidencing the ombudsman was notified of the transfer to the hospital. An interview was conducted with LPN (licensed practical nurse) #1, on 3/8/18 at 9:58 a.m., when asked about the process staff follows when a resident is transferred to the hospital, LPN #1 stated, "Usually we gather information and call the doctor to get an order. A lot of times, the NP (nurse practitioner) is in the building. They give a verbal order; we transfer it to a telephone order and fax it to the pharmacy." When asked if they notify anyone else other than the doctor, LPN #1 stated, "We call the family." When asked where that is documented, LPN #1 stated, "In the nurse's notes." When ask if the resident or resident representative is provided anything in	F 623		

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F 623	Continued From page 72 writing regarding the transfer to the hospital, LPN #1 stated, "No, we just call them." When asked if the nurse notifies the ombudsman, LPN #1 stated, "No." An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m. When asked about her role when a resident is transferred to the hospital, OSM #1 stated, "If they haven't left the building I would let the family know. The nurses handle the transfers." When asked how the staff notify the family, OSM #1 stated, "I think they call them." When asked where that is documented, OSM #1 stated, "A note in the nurse's notes that they spoke with the family." When asked if the facility gives the resident or resident representative anything in writing related to the transfer, OSM #1 stated, "I don't know about that. I don't believe they do." When asked how she notifies the ombudsman of transfers to the hospital, OSM #1 stated, "I email her with the discharges." When asked if she notifies the ombudsman when a resident is transferred to the hospital, OSM #1 stated, "No, only if there has been a problem with the family." An interview was conducted with administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, on 3/8/18 at 12:01 p.m. When asked about the process followed for transferring a resident to the hospital, ASM #2 stated, "The nurses assess the resident and call the doctor or nurse practitioner. We tell them what we've found and they decide to send to the ER or give us orders to treat in house." When asked where that is documented, ASM #2 stated, "In the progress note. Once the doctor or	F 623		

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F 623	Continued From page 73 nurse practitioner has given the order to transfer the resident, we notify the resident representative and resident. We talk to the resident, get papers together; we call the family and call the ER with report." When asked if the resident or resident representative is given any written documentation upon transfer, ASM #2 stated, "No, we talk to the resident' family on the phone and explain why. Many times they (the family) will meet the resident at the ER." When asked who notifies the ombudsman of the transfers and discharges, ASM #2 stated, "I'm not sure of that." ASM #1 stated, "I know under the new regulations they are to be notified. I just came 2/1/18 and I don't know what happens here at this facility." ASM #1 and ASM #2 were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.	F 623		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 645		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

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F 645	Continued From page 74	F 645		

State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

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F 645	Continued From page 75 (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to complete a Preadmission Screening and Resident Review (PASARR) for four of 28 residents in the survey sample, Residents # 5, # 10, # 8, and # 25. 1. The facility staff failed to complete a Level I pre-admission screening and resident review for Resident #5, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs. 2. The facility staff failed to complete the pre-admission screening and resident review for Resident #10, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to	F 645	F-645 PASARRs will be obtained for residents #5, #10, #8, and #25 since they should have been obtained prior to admission. The Social Worker and admissions personnel were trained by the Administrator on the need for a PASSARR prior to admission? New admits and referrals will be screened by the Social Worker for the proper PASSARR documentation prior to admission to the facility. The new admit will be reviewed by the IDT at its morning meeting to ensure compliance with the PASARR regulations. Results of the morning meeting reviews will be submitted to the Administrator	4/2/18

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F 645	Continued From page 76 admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs. 3. The facility staff failed to complete the pre-admission screening and resident review for Resident #8, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs. 4. The facility staff failed to complete the pre-admission screening and resident review for Resident #25, to ensure each resident in a nursing facility are screened for a mental disorder (MD) or intellectual disability (ID) prior to admission; and to ensure individuals identified with MD or ID, are evaluated and receive care and services setting appropriate to their needs. The findings include: 1. The facility staff failed to complete a Level I pre-admission screening and resident review for Resident #5, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs. Resident #5 was admitted to the facility on 5/21/15 with a recent readmission on 2/25/18, with diagnoses that included but were not limited	F 645		

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F 645	Continued From page 77 to cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. In Section A1500 - Preadmission Screening and Resident Review, it coded the resident as not currently being considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. A significant change assessment was in progress at the time of survey. Review of the clinical record failed to evidence a Level I Preadmission Screening and Resident Review as having been completed. An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m., regarding the PASARR assessments. OSM #1 stated, "I know it's for people who have mental retardation. I recently met with someone at the local hospital to ask about it and they said they'd get back with me." When asked when this conversation occurred, OSM #1 stated, "Last month, maybe." When asked if she was familiar with the regulations related to PASARR, OSM #1 stated, "No."	F 645		

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F 645	Continued From page 78 An interview was conducted with administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, on 3/8/18 at 12:01 p.m. When asked what a PASARR is, ASM #1 stated, "It's a preadmission screening for mental capabilities of the resident. We need one on every that comes in here." When asked who does the PASARR in this building, ASM #1 stated, "I'm not aware of anyone doing it, but it has to be. ASM #1 stated, "The hospital is not sending them either." The administrator and ASM #2 were made aware of the above findings on 3/8/18 at 5:10 p.m. The director of nursing informed this surveyor on 3/9/18 at 10:01 a.m., the facility did not have a policy for PASARR completion. 2. The facility staff failed to complete the pre-admission screening and resident review for Resident #10, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs. Resident #10 was admitted to the facility 12/3/13 with diagnoses that included but were not limited to: Huntington's chorea (abnormal hereditary condition characterized by progressive involuntary rapid, jerky motions and mental deterioration, leading to dementia) (1), depression, inflammation of the liver, lack of coordination, seizures, and unspecified mental disorder due to a known physiological condition.	F 645		

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F 645	Continued From page 79 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/17, coded the resident as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was coded as being dependent upon one or more staff members for all of his activities of daily living. Review of the clinical record failed to evidence a Level I Preadmission Screening and Resident Review as having been completed. A copy of Resident #10's PASARR was requested on 3/8/18 at approximately 9:00 a.m., ASM (administrative staff member) #2, the director of nursing. An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m., regarding the PASARR assessments. OSM #1 stated, "I know it's for people who have mental retardation. I recently met with someone at the local hospital to ask about it and they said they'd get back with me." When asked when this conversation occurred, OSM #1 stated, "Last month, maybe." When asked if she was familiar with the regulations related to PASARR, OSM #1 stated, "No." An interview was conducted with administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, on 3/8/18 at 12:01 p.m. When asked what a PASARR is, ASM #1 stated, "It's a preadmission screening for mental capabilities of the resident. We need one on every that comes in here." When asked who	F 645		

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F 645	Continued From page 80 does the PASARR in this building, ASM #1 stated, "I'm not aware of anyone doing it, but it has to be. ASM #1 stated, "The hospital is not sending them either." On 3/8/18 at 12:25 p.m., administrative staff member (ASM) #1 stated there was no PASARR for Resident #10. He stated the social worker should be able to complete these. The administrator and ASM #2 were made aware of the above findings on 3/8/18 at 5:10 p.m. The director of nursing, ASM #2 informed this surveyor on 3/9/18 at 10:01 a.m., the facility did not have a policy for PASARR completion. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 247. 3. The facility staff failed to complete the pre-admission screening and resident review for Resident #8, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs. Resident #8 was admitted to the facility on 12/11/12 with a recent readmission on 11/6/17, with diagnoses that included but were not limited to: Alzheimer's disease, mood disorder, anxiety disorder, diabetes, stroke, high blood pressure, and history of subdural hematoma (a collection	F 645		

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F 645	Continued From page 81 of blood beneath dura mater in the brain) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/7/17, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #8 was coded as being dependent upon one or more staff members for all of her activities of daily living. In Section K - Swallowing/Nutritional Status, the resident was coded as receiving all of her nutrition through a feeding tube. Review of the clinical record failed to evidence a Preadmission Screening and Resident Review as having been completed. On 3/8/18 at 8:44 a.m. administrative staff member (ASM) #2, the director of nursing, informed this surveyor that there was no PASARR for Resident #8. An interview was conducted with other staff member (OSM) #1, the social worker/admission/discharge coordinator, on 3/8/18 at 10:20 a.m., regarding the PASARR assessments. OSM #1 stated, "I know it's for people who have mental retardation. I recently met with someone at the local hospital to ask about it and they said they'd get back with me." When asked when this conversation occurred, OSM #1 stated, "Last month, maybe." When asked if she was familiar with the regulations related to PASARR, OSM #1 stated, "No." An interview was conducted with administrative staff member (ASM) #1, the administrator and	F 645		

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F 645	Continued From page 82 ASM #2, the director of nursing, on 3/8/18 at 12:01 p.m. When asked what a PASARR is, ASM #1 stated, "It's a preadmission screening for mental capabilities of the resident. We need one on every that comes in here." When asked who does the PASARR in this building, ASM #1 stated, "I'm not aware of anyone doing it, but it has to be. ASM #1 stated, "The hospital is not sending them either." The administrator and ASM #2 were made aware of the above findings on 3/8/18 at 5:10 p.m. The director of nursing informed this surveyor on 3/9/18 at 10:01 a.m., the facility did not have a policy for PASARR completion. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 265 and 549. 4. The facility staff failed to complete the pre-admission screening and resident review for Resident #25, to ensure each resident in a nursing facility are screened for a mental disorder (MD) or intellectual disability (ID) prior to admission; and to ensure individuals identified with MD or ID, are evaluated and receive care and services setting appropriate to their needs. Resident #25 was admitted to the facility on 7/17/15 and readmitted on 12/19/17 with diagnoses that included but were not limited to Parkinson's disease (1), heart failure, diabetes, psychotic disorders, depression, schizophrenia (2), anoxic brain injury (3) and seizures.	F 645		

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F 645	Continued From page 83 The most recent complete MDS, a 30-day assessment, with an ARD of 1/17/18 coded the resident as having scored a 6 out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of staff for all activities of daily living with the exception of eating which the resident could perform with supervision. Review of the clinical record did not evidence documentation that the pre-admission screening and resident review (PASARR) was completed. On 3/7/18 at 4:47 p.m., a request for a copy of the PASARR was made to ASM (administrative staff member) #2, the director of nursing. On 3/8/18 at 8:30 a.m., ASM #2 stated there was no PASARR for Resident #25. An interview was conducted on 3/8/18 at 10:15 a.m. with OSM (other staff member) #1, the social worker. When asked if she knew what a PASARR was, OSM #1 stated, "No. I know if a person has mental retardation they should have one. I met with someone from the hospital to ask about it. They said they'd have to get back to me." When asked when that had occurred, OSM #1 stated, "It's probably been maybe last month." An interview was conducted on 3/8/18 at 12:01 p.m. with ASM #1, the administrator and ASM #2, the director of nursing. When asked what a PASARR was, ASM #1 stated, "It's preadmission screening of the assessment of the resident to see if the SNF (skilled nursing facility) is a proper placement." When asked which residents had a PASARR completed, ASM #1 stated, "We need one for everyone who comes in here." When	F 645		

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F 645	Continued From page 84 asked if anyone was completing the PASARR's, ASM #1 stated, "Not to my knowledge. We asked for one from the hospital." ASM #2, the director of nursing, stated, "I don't think the hospital realizes what they are or what they are supposed to be doing." On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. A request for the facility's policy for PASARR was made at that time to ASM #2. On 3/9/18 at 8:37 a.m., ASM #2 stated they did not have a PASARR policy. No further information was provided prior to exit. 1. Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html 2. Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. This information was obtained from: https://medlineplus.gov/schizophrenia.html 3. Cerebral hypoxia refers to a condition in which there is a decrease of oxygen supply to the brain	F 645		

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F 645	Continued From page 85 even though there is adequate blood flow. Drowning, strangling, choking, suffocation, cardiac arrest, head trauma, carbon monoxide poisoning, and complications of general anesthesia can create conditions that can lead to cerebral hypoxia. Symptoms of mild cerebral hypoxia include inattentiveness, poor judgment, memory loss, and a decrease in motor coordination. Brain cells are extremely sensitive to oxygen deprivation and can begin to die within five minutes after oxygen supply has been cut off. This information was obtained from: https://www.ninds.nih.gov/Disorders/All-Disorders/Cerebral-Hypoxia-Information-Page	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial 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 656	F-656 The care plan was revised for resident #37's pain. The care plan was revised for resident #18's dental concerns. The care plan was revised for resident #5's wound care. The care plan was revised for resident #41's dental issues. The care plan was revised for resident #13's bed position, non-skid strips and correct arm blood pressure procedure. Care plans for residents with pain, hospice services, dental concerns, wounds, history of falls and limb restrictions for vital signs were reviewed by the IDT and revisions made if applicable.	4/21/18

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F 656	Continued From page 86 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 document review, and clinical record review, it was determined that facility staff failed to develop and implement the comprehensive care plan for five of 28 residents in the survey sample, Resident #37, #18, #5, #41 and #13. 1. The facility staff failed to develop a care plan to address Resident #37's pain on his comprehensive care plan dated 4/18/17 and failed to develop a care plan for hospice services when he was admitted to hospice on 8/11/17. 2. The facility staff failed to develop a comprehensive care plan to address Resident #18's dental concerns. 3. The facility staff failed to implement Resident	F 656	The IDT will review care plans at its morning meetings to ensure that care plans are updated timely and reflect proper changes in condition of the residents. Changes will be made during the meeting by the MDS Nurse as necessary. The QI nurse will perform a 10% audit of care plans monthly for 3 months to conclude continuous updates and revisions of care plans. The results of the audit will be submitted to the DON. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken	

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F 656	Continued From page 87 #5's comprehensive care plan for wound care. 4. The facility staff failed to develop a comprehensive care plan to address Resident #41's dental issues. 5a. The facility staff failed to implement Resident #13's comprehensive care plan to maintain the bed in the low position and to apply non-skid strips on the floor by the bed. 5b. The facility staff failed to implement Resident #13's comprehensive care plan and physician's order not to take blood pressures in the residents left arm. The findings include: 1. Resident #37 was admitted to the facility on 3/31/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes, high cholesterol, Alzheimer's disease, and dementia. Resident #37's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #37 was coded as being severely cognitively impaired scoring three out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #37 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living). Resident #37 was coded in Section J (pain) as not having any pain. Further review of his MDS revealed that he was receiving hospice services. Review of Resident #37's clinical record revealed he was receiving pain medications. Resident #37's most recent POS (physician order sheet)	F 656		

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F 656	Continued From page 88 dated 2/28/18, documented the following orders: "1) Morphine [1] Sul (sublingual) sol (solution) 100/5 ml (milliliters) under tongue every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. 2) Tylenol [2] 650 mg sup (suppository) 1 per rectum every four hours as needed for pain." This order was initiated on 9/21/17." Review of Resident #37's February and March 2018 MAR revealed Resident #37 had received Morphine 0.25 ML on 2/8/18, 2/11/18 and 3/5/18. Review of Resident #37's clinical record revealed an order for Hospice Services on 8/11/17. The following order was documented: "Admit to (Name of Hospice company) - hospice services. palliative care...Code status DNR (do not resuscitate) - Activity as tolerated." On 8/20/17, a significant change MDS (minimum data set) assessment was completed documenting that Resident #37 was receiving Hospice Services. Review of Resident #37's comprehensive care plan dated 4/18/17, failed to evidence a care plan to address Resident # 37's Pain or hospice care. On 3/8/18 at 8:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked what the care plan was used for, LPN #3 stated the care plan was used to determine the level of care of the patient. LPN #3 stated that if the resident has issues, such as falls, interventions would be updated on the care plan. LPN #3 stated the care plan had to reflect	F 656		

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F 656	Continued From page 89 the resident. When asked if it was important that the care plan was accurate, LPN #3 stated it was. When asked if a resident is receiving pain medication and is on hospice services should the resident have a care plan addressing pain, LPN #3 stated the resident should have a pain care plan in place. When asked how nursing would know how to coordinate hospice care and services if it is not on the resident's care plan, LPN #3 stated, "That would be really difficult." LPN #3 stated that nursing staff have direct communication with hospice and the hospice nurses themselves. LPN #3 stated that if staff needed clarification on hospice care or orders, a hospice RN (registered nurse) would be readily available. When asked if a resident receiving hospice services should have a hospice care plan in place, LPN #3 stated, "That seems like a good idea." LPN #3 stated that floor nurses do not develop or make changes to the care plan. LPN #3 stated changes to the care plans have to be put into place by the supervisors. On 3/8/18 at 9:03 a.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. When asked who was responsible for developing care plans, RN #1 stated she was ultimately responsible but that other staff members can also develop different sections. RN #1 stated it should be a collaborative effort. RN #1 stated care plans were also updated with quarterly assessments or for any significant change. RN #1 stated she would expect to see pain and hospice care plans for a resident receiving pain medications and on hospice. RN #1 also stated that pain is always an area addressed on the care plan for any resident. RN #1 confirmed that Resident #37 did not have pain or hospice care plans in place.	F 656		

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F 656	Continued From page 90 On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Resident Care Plan" documents in part, the following: "It is the policy of the facility to provide a written resident-centered care plan based upon physician's orders, assessments of the resident's needs and preferences, and pre-admissions screening and resident review. Development and implementation of the resident's care plan will occur by participating disciplines available in the facility at a team conference under the direction of the RN coordinator. The ICP (interdisciplinary care plan) team's composition will include but not be limited to: the resident and the resident's representative to the extent practicable, the attending physician, a registered nurse with responsibility for the resident, a nurse aide with the responsibility of the resident, a member of food and nutrition staff, and other appropriate staff or professionals as determined by the resident's need or as requested by the resident. Development of the comprehensive care plan with occur within 7 days after the completion of a comprehensive assessment by each discipline. Review of Modification of the plan will occur after each assessment, including the comprehensive and quarterly review assessments, under the direction of the RN coordinator. The resident care plan will be an ongoing process and will include current problems and/or needs identified from a complete assessment including the MDS and Care Area Assessments relevant to the resident's response to aging, illness, and his/her general health status. Any new problem or need	F 656		

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F 656	Continued From page 91 of the resident which is identified between his/her scheduled care plan review, will be addressed on the care plan by the appropriate disciplines..." [1] Morphine is indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3f3a870e-f325-475b-8453-fe3d1bb8f54. [2] Tylenol Tablet 325 mg (Acetaminophen) treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details. 2. The facility staff failed to develop a care plan to address Resident #18's dental concerns and issues. Resident #18 was admitted to the facility on 9/29/14 with diagnoses that included but were not limited to stroke, contractures, depression, elevated cholesterol and high blood pressure. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/28/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he is capable of making daily cognitive decisions. The resident was coded as requiring supervision to limited assistance for his activities of daily living. In Section K - Swallowing/Nutritional Status the resident was coded as not having any dental concerns.	F 656		

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F 656	Continued From page 92 An interview was conducted with Resident #18 on 3/6/18 at 9:13 a.m. Resident stated, "Something happened I never got my dentures. They pulled all of my teeth with a promise to get me dentures." The review of the comprehensive care plan updated on 4/28/17, failed to evidence any care plan addressing Resident #18's dental care and issues. The documentation from the Mobile Dental Unit dated 4/21/17, documented in part, "TX: Exam, Full mouth extractions." The documentation from the Mobile Dental Unit dated 6/28/17, documented in part, "TX: (treatment) Post - Op (operative) Possible impressions F/F (full set of dentures)." An interview was conducted with LPN (licensed practical nurse) #1 on 3/8/18 at 9:58 a.m. When asked why resident have care plans, LPN #1 stated, "It so you know what they (residents) can and cannot do and how to care for them." When asked who uses the care plan, LPN #1 stated, "We have the care guide for the CNAs and the nurses use the care plan." An interview was conducted with LPN #2 on 3/8/18 at 3:00 p.m. When asked the purpose of the care plan, LPN #2 stated, "It's how to care for the resident." When asked who has access to the care plan, LPN #2 stated, "CNAs, everyone." When asked why is would not be followed, LPN #2 stated, "It should always be followed." An interview was conducted with registered nurse	F 656		

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F 656	Continued From page 93 (RN) #1, the MDS nurse, on 3/8/18 at 3:25 p.m. When asked if a resident is having dental concerns, should that be care planned, RN #2 stated, "Yes." RN #1 was asked to review Resident #18's care plan and the Mobile Dental Unit notes. When asked if she saw dental on the care plan, RN #1 stated, "I added a care plan for dental on 3/7/18." When asked why dental concerns should be on the care plan, RN #1 stated, "If the resident is having difficulty with eating, chewing or swallowing, these need to be addressed on the care plan." The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. 3. The facility staff failed to implement Resident #5's comprehensive care plan for wound care. Resident #5 was admitted to the facility on 5/21/15 with a recent readmission on 2/25/18, with diagnoses that included but were not limited to: cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he	F 656		

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F 656	Continued From page 94 was severely impaired to make daily cognitive decisions. In Section M - Skin Conditions, the resident was not coded as having a pressure ulcer. A significant change MDS assessment was in progress at the time of survey. The comprehensive care plan dated, 2/15/18, documented in part, "Focus: Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: nutritional deficit, non-compliant (left foot) and left buttock." The "Interventions" documented in part, "Treatment as ordered by physician." Observation was made on 3/7/18 at 2:04 p.m. of LPN (licensed practical nurse) #4 performing the wound care for Resident #5. LPN #4 proceeded to gather her supplies. She went to the resident's left foot. The dressing on the left foot was dated 3/5/18. The date of the dressing was verified with LPN #4 and she stated she was off yesterday and didn't know who was doing treatments for the day. The physician order dated 2/12/18, documented, "Clean wound L (left) foot with Hibiclens*, apply Santyl ointment, cover w/ (with) NAD (non-adhesive dressing) daily until healed." *Hibiclens is an antiseptic antibacterial agent used in cleansing of the skin (2). The TAR (treatment administration record for March 2018 documented, "Hibiclens Liq (liquid) - clean wound left foot w/ Hibiclens. Apply Santyl oint (ointment), cover w/ NAD daily until healed." The TAR documented the wound care was not signed off as completed on 3/2/18 and 3/6/18.	F 656		

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F 656	Continued From page 95 An interview was conducted with LPN #2 on 3/8/18 at 3:00 p.m. When asked the purpose of the care plan, LPN #2 stated, "It's how to care for the resident." When asked who has access to the care plan, LPN #2 stated, "CNAs, everyone." When asked why is would not be followed, LPN #2 stated, "It should always be followed." The facility policy, "Resident Care Plan" documented in part, "Any new problems or need of the resident, which is identified between her/her scheduled care plan review, will be addressed on the care plan by the appropriate disciplines and brought to the next scheduled care plan meeting to inform the ICP (interdisciplinary care plan) team of it's addition." The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. 4. The facility staff failed to develop a comprehensive care plan to address Resident #41's dental issues. Resident #41 was admitted to the facility on 6/21/16 with diagnoses that included but were not limited to Parkinson's disease, high blood pressure and fractured hip. Review of the most recent MDS (minimum data set), a 30 day assessment, with an ARD	F 656		

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F 656	Continued From page 96 (assessment reference date) of 1/17/18 coded the resident as having scored a six 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 except for eating which the resident could perform after the tray was set up. During an interview conducted on 3/6/18 at 11:12 a.m. with Resident #41, Resident #41 stated, "They ordered dentures over a year ago and I have not received them yet." When asked if she had difficulty eating, Resident #41 stated, "Well sometimes the turkey's a little tough." Review of the resident's comprehensive care plan initiated on 3/6/18, the day the survey begun documented, "Focus. Care deficit pertaining to the teeth or oral cavity characterized by; altered oral mucous membrane; problems with dentures/teeth/gums or other oral dental health problems related to: edentulous. Interventions. Coordinate arrangements for dental care as needed." The care plan failed to address/document the resident had been waiting and or was in need of dentures. An interview was conducted on 3/7/18 at 12:53 p.m. with OSM (other staff member) #1, the social worker. When asked how obtaining dentures was handled at the facility, OSM #1 stated, "We go through (name of dental company). They come out to see the patients." When asked if the dental company fits the residents for dentures, OSM #1 stated they did. OSM #1 was asked the date of the last time the dental company was at the facility. OSM #1 stated, "Before I came. I came in the end of May	F 656		

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F 656	Continued From page 97 2017. They're coming on March 22, 2018. I just found out today that I am handling the dental part. I have not been handling that before. I have two residents that have told us that they removed teeth last year and nothing has been done to get them dentures." An interview was conducted on 3/7/18 at 1:01 p.m. with ASM #2, the director of nursing. When asked how dental concerns were managed, ASM #2 stated, "We have just signed a new contract with a new dental provider that comes to the facility, in their own mobile unit." When asked when was the last time the facility had dental services available to residents, ASM #2 stated, "I don't know, I would have to check to see when they were last here. With our last provider supposedly she bought this company out, they came with a mobile unit and saw some residents, supposedly there was some conflict, some dentures had been made and she was holding them hostage. We contacted our regional and they were contracted with a new provider. They are coming soon with some new dentures." ASM #2 was asked to provide any documentation that relates to the dentist coming to see Resident #41. On 3/7/18 at 1:53 p.m., a copy of dental progress note for Resident #41 was received. Review of the note documented, "6/28/17. Treatment Notes: Pt (patient) presents today for post op (operative) exam and possible impressions F/F (full dentures). Will deliver next visit. Treatment Plan Notes: Deliver F/F." An interview was conducted on 3/8/18 at 1:45 p.m. with LPN (licensed practical nurse) #2. When asked why residents had care plans, LPN #2 stated, "It's based on individual care." When	F 656		

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F 656	Continued From page 98 asked who used the care plan, LPN #2 stated, "MDS (minimum data set staff) all the nurses." When asked if staff were expected to follow the care plan, LPN #2 stated, "Yes." An interview was conducted on 3/8/18 at 3:23 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked why Resident #41's dental issues were not care planned until 3/6/18, RN #1 stated, "Someone told me that there was something missing from her care plan." When asked who that was RN #1 did not reply. When asked why a care plan would be developed for a resident who did not have any teeth and was waiting for dentures, RN #1 stated, "If there were any kind of difficulty with their eating, chewing or swallowing." On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 5a. The facility staff failed to implement Resident #13's comprehensive care plan to maintain the bed in the low position and to apply non-skid strips on the floor by the bed. Resident #13 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to: left mastectomy, difficulty swallowing, depression, anemia and Alzheimer's disease. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment	F 656		

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F 656	Continued From page 99	F 656		

reference date) of 12/20/17 coded the resident as having scored a three 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.

Review of the resident's care plan initiated on 12/3/14 and revised on 7/19/17 documented, "Focus. (Name of resident) has hx (history) of falls and (sic) at risk for further falls related to impaired mobility and cognitive impairments. Interventions. Bed in lowest position. Non-skid strips on floor by bed."

An observation was made on 3/6/18 at 7:30 a.m. of Resident #13. The resident was lying in bed; the bed height was at approximately 43 inches. There were no non-skid strips on the floor by the bed.

An observation was made on 3/7/18 at 2:40 p.m. of Resident #13's wound care. The resident was lying in the bed. After the wound care was completed, the bed was lowered to approximately 43 inches. There were no non-skid strips on the floor by the bed.

An observation was made on 3/8/18 at 1:40 p.m. of Resident #13 with LPN (licensed practical nurse) #2, the resident's nurse. The resident was lying in the bed. The height of the bed was at approximately 43 inches. There were no non-skid strips on the floor by the bed. When asked if the bed was in the lowest position, LPN #2 stated, "No ma'am it is not." LPN #12 then lowered the bed to the lowest position, which was approximately 14 inches in height. When asked if there were non-skid strips on the floor next to the

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F 656	Continued From page 100 resident's bed, LPN #2 stated, "No. She had them in her old room. There's no excuse for the non-skid strips to not be on the floor." An interview was conducted on 3/8/18 at 1:45 p.m. with LPN #2. When asked why residents had care plans, LPN #2 stated, "It's based on individual care." When asked who used the care plan, LPN #2 stated, "MDS (minimum data set staff) all the nurses." When asked if staff were expected to implement/follow the care plan, LPN #2 stated, "Yes." When asked why Resident #13 had a care plan that directed staff to maintain the bed in the lowest position, LPN #2 stated, "To prevent her from hurting herself." An interview was conducted on 3/8/18 at 3:23 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who developed the care plans, RN #1 stated, "I do. Other people can add to it as well, the DON (director of nursing), ADON (assistant director of nursing, social worker, activities." When asked why residents had care plans, RN #1 stated, "So we can individualize care for the residents. To make sure they get the care they need. When asked who used the care plans, RN #1 stated, "I would imagine everyone here. All the nurses, all the staff." When asked what things were included on the care plan, RN #1 stated, "When they first come in I do a baseline (care plan) that has to do with their falls, skin integrity, pain and any kind of diagnosis that triggers." When asked if staff were expected to follow the care plan RN #1 stated they were. On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.	F 656		

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F 656	Continued From page 101 No further information was provided prior to exit. 5b. The facility staff failed to implement Resident #13's comprehensive care plan and physician's order not to take blood pressures in the residents left arm. Review of the resident's care plan guide initiated on 11/28/14 documented, "No BP (blood pressure)/VP (venipuncture) in LEFT arm. Review of the March 2018 physician's orders documented, "No B/P in Left arm." Review of the weights and vitals summary sheet from September 2017 to March 2018 documented that the resident's blood pressure had been taken on her left arm on 30 occasions. An interview was conducted on 3/8/18 at 9:57 a.m. with LPN #1. When asked what the resident care guide was used for, LPN #1 stated, "It's for the aide or the nurse, caring for the resident." An interview was conducted on 3/8/18 at 1:45 p.m. with LPN #2. When asked why residents had care plans, LPN #2 stated, "It's based on individual care." When asked who used the care plan, LPN #2 stated, "MDS (minimum data set staff) all the nurses." When asked if staff were expected to follow the care plan, LPN #2 stated, "Yes." When asked why Resident #13 had a physician's order and a care plan not to obtain blood pressures in the left arm, LPN #2 stated because the resident had had a left mastectomy.	F 656		

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F 656	Continued From page 102 An interview was conducted on 3/8/18 at 3:23 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who developed the care plans, RN #1 stated, "I do. Other people can add to it as well, the DON (director of nursing), ADON (assistant director of nursing), social worker, activities." When asked why residents had care plans, RN #1 stated, "So we can individualize care for the residents. To make sure they get the care they need." When asked who used the care plans, RN #1 stated, "I would imagine everyone here. All the nurses, all the staff." When asked what things were included on the care plan, RN #1 stated, "When they first come in I do a baseline (care plan) that has to do with their falls, skin integrity, pain and any kind of diagnosis that triggers." When asked if staff were expected to follow the care plan RN #1 stated they were. On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657	F-657 The fall care plan for Resident #41 was revised to include current interventions. A review of resident's Care Plans with incidents in the past 30 -45 days was completed by the IDT Care	

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F 657	Continued From page 103 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review and clinical record review, it was determined the facility staff failed to review and revise the care plan for one of 28 residents in the survey sample, Resident #41. The facility staff failed to review and revise the care plan after Resident #4's fall on 10/26/17. The findings include: Resident #41 was admitted to the facility on 6/21/16 with diagnoses that included but were not limited to: Parkinson's disease, high blood pressure and fractured hip. Review of the most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 1/17/18 coded the resident as having a six out of 15 on the BIMS	F 657	Plans were updated as necessary. The IDT will review any resident with a fall at its morning meeting and the care Plan will be updated during the meeting. Fall interventions and referrals to therapy will be documented. The QI nurse will perform a 10% audit of care plans monthly for 3 months to conclude continuous updates and revisions of care plans. The results of the audit will be submitted to the DON. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/21/18

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F 657	Continued From page 104 (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 except for eating which the resident could perform after the tray was set up. Review of the nurse's notes documented that the resident had frequent falls. On 3/7/18 at 9:00 a.m. a request for all of Resident #41's fall investigations from ASM (administrative staff member) #2, the director of nursing. A review of the fall investigations documented, "10/26/18. CNA (certified nursing assistant) reported to nurse that (name of resident) was found sitting on the floor next to her bed." There was no documentation regarding the care plan review or revision. Review of the care plan initiated on 10/1/16 and revised on 8/28/17 did not evidence documentation that the care plan had been reviewed or revised regarding the resident's fall on 10/26/17. An interview was conducted on 3/8/18 at 3:23 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who developed the care plans, RN #1 stated, "I do. Other people can add to it as well, the DON (director of nursing), ADON (assistant director of nursing), social worker, activities." When asked why residents had care plans, RN #1 stated, "So we can individualize care for the residents. To make sure they get the care they need." When asked who used the care plans, RN #1 stated, "I would imagine everyone here. All the nurses, all the staff." When asked	F 657		

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F 657	Continued From page 105 what things were included on the care plan, RN #1 stated, "When they first come in I do a baseline (care plan) that has to do with their falls, skin integrity, pain and any kind of diagnosis that triggers." When asked how often the care plan was reviewed and revised, RN #1 stated, "Quarterly unless something comes up." When asked if the care plan would be reviewed and revised following a fall, RN #1 stated, "That would be the SDC (staff development coordinator). She reviews things and puts interventions into place." An interview was conducted on 3/8/18 3:37 p.m. with RN #2, the staff development coordinator. When asked if she did care plan updates, RN #2 stated, "Um, not all the time. I do if I see something." When asked if the care planned would be updated after a fall, RN #2 stated it would. On 3/8/18 at 5:15 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "RESIDENT CARE PLAN" documented, "It is the policy of the facility to provide a written resident-centered care plan based upon physician's orders, the assessment of the resident needs and preferences...The resident's care plan will be (sic) ongoing process and will include current problems and/or needs identified from a complete assessment...Any new problem or need of the resident, which is identified between his/her scheduled care plan review, will be addressed on the care plan by the appropriate disciplines..." No further information was obtained prior to exit.	F 657		

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F 657	Continued From page 106 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 with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.	F 657	F-658 The care plan regarding Pain was updated for resident #37. The physician was contacted and an order clarifying the proper pain medication for the resident's level of pain was obtained. The Care plans for any other Resident who had triggered for Pain were reviewed and updated as necessary. MDSs will be reviewed at the morning meeting to ensure that any resident that has triggered for pain has the proper non-pharmacological interventions noted and that the care plan has been updated. The QI nurse will perform a 10% audit of care plans monthly for 3 months to conclude continuous updates and revisions of care plans. The results of the audit will be submitted to the DON.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 28 residents in the survey sample, Resident #37. The facility staff failed to clarify two prn (as needed) pain medication orders for Resident #37. The findings include:	F 658		

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F 658	Continued From page 107 Resident #37 was admitted to the facility on 3/31/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes, high cholesterol, Alzheimer's Disease, and dementia Resident #37's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #37 was coded as being severely cognitively impaired scoring three out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #37 was coded as requiring extensive assistance from one staff member with most ADLS. Review of Resident #37's clinical record revealed that he was placed on Hospice Services on 8/11/17. Review of Resident #37's most recent POS (physician order sheet) dated 2/28/18, documented the following orders: 1) "Morphine [1] Sul (sublingual) sol (solution) 100/5 ml (milliliters) under tongue every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. 2) Tylenol [2] 650 mg sup (suppository) 1 per rectum every four hours as needed for pain." This order was initiated on 9/21/17. Review of Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37 received Morphine on the following dates and times: 2/8/17 at 12:30. AM or PM could not be identified. The following was documented on the	F 658	To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/21/18

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F 658	Continued From page 108 back of the MAR: "Morphine 0.25 ml; Reason: restlessness and discomfort." A pain level was not documented. 2/11/18 at 06:00. AM or PM could not be identified. The following was documented on the back of the MAR: "Morphine 0.25 ml; Reason: Pain/Anxiety." A pain level was not documented. 2/11/18 at 2:30. AM or PM could not be identified. The following was documented on the back of the MAR. "Morphine 0.25 ml; Reason: Back pain." A pain level was not documented. 3/5/18 at 7:00 p.m. No reason was documented on the back of the MAR to indicate why Morphine was administered. The back of the MAR was blank. There were no nursing notes regarding the administration of Morphine on the above dates. Review of Resident #37's comprehensive care plan dated 4/18/17, failed to evidence a care plan for Pain or Hospice. On 3/6/18 at 2 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 asked about the process followed if a resident had two prn (as needed) pain medication orders (Tylenol and Morphine), but there was no indication on when to use each medication. LPN #1 stated she would try Tylenol and alternate methods of pain relief first, and then try the stronger medication if the Tylenol or alternate method (non-pharmacological interventions) were ineffective. LPN #1 stated it would also depend on her assessment. LPN #1 stated she wasn't going to administer Tylenol first to a resident who	F 658		

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F 658	Continued From page 109	F 658		

has a pain of 10. When asked at what point (on a scale from 1-10) would she administer the Morphine over the Tylenol, LPN #1 stated, "That is a tough call." LPN #1 stated pain tolerance was different from person to person. When asked if nurses can administer pain medication at their discretion, LPN #1 stated she would probably have to call the physician to clarify the order.

On 3/8/18 at 8:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #37's nurse. LPN #3 was asked about the process followed if a resident had two prn (as needed) pain medication orders (Tylenol and Morphine), but there was no indication on when to use each medication. LPN #3 stated she would usually give the Tylenol first and then go to the Morphine if the Tylenol was not effective. When asked if nurses were able to determine what medication to administer at their discretion, LPN #3 stated that she would think so.

03/8/18 at 12:35 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated nursing was able to make a nursing judgment based on their pain assessment and determine which pain medication to use for relief. ASM #2 stated her staff have never had to clarify pain medication orders before.

On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2 the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that they use Lippincott as a professional standard of practice.

[1] Morphine is indicated for the management of

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F 658	Continued From page 110 acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3f3a870e-f325-475b-8453-fe3d1bb8f54. [2] Tylenol Tablet 325 mg (Acetaminophen)- Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.	F 658		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure only qualified staff administered tube feedings for one of 28 residents in the survey sample, Resident #8. The facility staff failed to ensure a trained staff member disconnected a feeding from the feeding tube for Resident #8. The findings include:	F 659	F-659 The C.N.A who removed resident #8's feeding tube was Re-educated on the CNA responsibilities related to residents with a feeding tube. No other residents were found to be affected by this deficient practice.	

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F 659	Continued From page 111 Resident #8 was admitted to the facility on 12/11/12 with a recent readmission on 11/6/17, with diagnoses that included but were not limited to: Alzheimer's disease, mood disorder, anxiety disorder, diabetes, stroke, high blood pressure, and history of subdural hematoma (a collection of blood beneath dura mater in the brain) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/7/17, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #8 was coded as being dependent upon one or more staff members for all of her activities of daily living. In Section K - Swallowing/Nutritional Status, the resident was coded as receiving all of her nutrition through a feeding tube. The physician order dated, 11/7/18, documented, "Diabetisource (nutritional replacement for food specific for diabetic residents) (2) @ (at) 40 ml/hr (milliliters per hour) via Peg tube (a feeding tube inserted through the abdominal wall). Observation was made of Resident #8's room on 3/8/18 at 8:45 a.m. The resident was not in the room. The tube feeding was observed hanging on the pole next to the bed. The end of the tubing, the tip that is connected to the resident, was not visible to this surveyor. An interview was conducted with CNA (certified nursing assistant) #3 on 3/8/18 at 8:49 a.m. When asked where Resident #8 was, CNA #3 stated she had just put her up by the nurse's station. When asked who disconnected the tube	F 659	Nursing staff were RE-educated regarding the proper procedure for the removal and insertion of feeding tubes and the proper scope of their practice – including responsibilities of licensed vs. non-licensed personnel. Residents who have feeding tubes will be monitored on a 5 days for 1 week then weekly for 4 weeks by the DON or her designee to determine proper placement and removal of feeding tubes. The results of the monitoring will be documented and submitted to the DON. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/21/18

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F 659	Continued From page 112 feeding from the resident, CNA #3 stated, "I did." CNA #3 stated, "The nurses show us how to do it." When asked if she had been trained in school to take care of a feeding tube, CNA #3 stated, "No, Ma'am." CNA #3 was asked where the end of the tubing with the tip was located; CNA #3 pulled the tubing out from under the covers. When asked why it is not good to have the tubing uncovered in the bed, CNA #3 stated, "It's an infection control issue." An interview was conducted with LPN (licensed practical nurse) #2 on 3/8/18 at 8:52 a.m. When asked if a CNA is allowed to disconnect a tube feeding, LPN #2 stated, "Never. They are never to touch a tube feeding." The above observation was shared with LPN #2, who then proceeded to change the entire set up of tube feeding. The comprehensive care plan dated, 10/30/16 and revised on 12/19/17, documented in part, "Focus: At risk for state of nourishment: less than body requirement characterized by inadequate intake, decreased appetite related to: being on a therapeutic diets, cognitive impairment depression." The "Interventions" documented in part, "Diet as ordered (Diabetisource) @ 40cc per hour via peg tube." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/18 at 12:35 p.m. When asked if a CNA can disconnect a resident from a tube feeding, ASM #2 stated, "No." Review of the job description for a CNA did not evidence any documentation regarding the administration of an enteral feeding.	F 659		

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F 659	Continued From page 113 The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 265 and 549. (2) This information was obtained from the following website: https://www.allegromedical.com/dietary-supplements-c522/enteral-feeding-diabetisource-xff8081812f688a20012f6abe767b4d0c$4050.html	F 659		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure residents received treatment and services in accordance with professional standards of practice and the comprehensive care plan for three of 28 residents in the survey sample, Resident #43, #13 and #40. 1. The facility staff failed to notify the MD (medical doctor) per physician's order when Resident #43's blood sugar levels [1] were over 400 on	F 684	F-684 The physician was notified regarding Resident #43's blood sugar levels. Blood Pressures were taken in the correct arm for Resident #13. The facility obtained the weight for Resident #13. The facility obtained the laboratory specimen as ordered by the Physician for Resident #40. An 100% audit of residents with orders for blood sugars, blood pressures with limb restrictions, weights and lab orders for the past 30 days was conducted by the IDT No other residents were found to be affected by the deficient practice.	

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F 684	Continued From page 114 three occasions in March. 2a. The facility staff failed to follow the physician's order and comprehensive care plan to not to obtain Resident #13's blood pressure in the left arm. 2b. The facility staff failed to obtain Resident #13's weight every two weeks as ordered by the physician. 3. The facility staff failed to obtain weekly laboratory specimens as ordered by the physician for Resident #40. The findings include: 1. The facility staff failed to notify the medical doctor when the Resident #43's blood sugar levels [1] were over 400 on three occasions in March of 2018. Resident #43 was admitted to the facility on 1/31/18 with diagnoses that included but were not limited to unspecified psychosis, type two diabetes, dementia, hypothyroidism and high blood pressure. Resident #43's most recent MDS (minimum data set) assessment was a 14-day scheduled assessment, with an ARD (assessment reference date) of 2/14/18. Resident #43 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #43 was coded as requiring extensive assistance from two or more staff with transfers, locomotion and toileting; extensive assistance from one staff member with dressing and personal hygiene, and as being totally dependent on staff with bathing.	F 684	Physician orders will be reviewed at the morning meetings by the IDT and charts will be updated at that time in PCC to ensure that orders are followed properly. Order changes and Physician notifications will be documented and all parties notified. Copies of updates and minutes of the meetings will be kept by the administrator. The results of the minutes and compliance will be submitted to the Facility's QA Committee monthly for three months then quarterly for review and guidance.	4/21/18

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F 684	Continued From page 115 Review of Resident #43's most recent POS (physician order summary) dated 2/2018 documented the following order: "Accucheck AC + HS (before meals and hours of sleep) with Humalog Insulin [2] BS (blood sugar): BS 201-250= 4 units BS 251-300= 6 units BS 301-350= 8 units BS 351-400= 10 units BS 401 or greater = 12 units Call MD." Review of Resident #43's March 2018 MAR (Medication Administration Record) revealed Resident #43 had BS readings over 400 on the following dates and times: 3/3/18 at 5:00 p.m., blood sugar was 560; 3/3/18 at 9:00 p.m., blood sugar was 423; 3/4/18 at 5:00 p.m., blood sugar was 520. Further review of the March 2018 MAR and the March nursing notes failed to evidence, the physician was notified of the elevated blood sugars. On 3/8/18 at 8:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3, a nurse who frequently works with Resident #43. When asked what the above physicians orders for insulin meant, LPN #3 stated she would administer the 12 units and then notify the doctor if the resident's blood sugar was over 400. When asked why the doctor would want to be notified, LPN #3 stated the doctor may want to order additional units of insulin or additional blood sugar checks. When asked if notification of the doctor would be documented anywhere in the clinical record, LPN #3 stated it should be documented in	F 684		

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F 684	Continued From page 116	F 684		

a nursing note. When asked if nurses would notify the physician every time a blood sugar reading was over 400, LPN #3 stated, "They wouldn't necessarily." LPN #3 stated, "Most of the orders say to notify if 400 or over, but the physician has said in the past to not call them unless it's over 500." LPN #3 then consulted with RN (registered nurse) #2 and asked about an order clarification. LPN #3 was asked if the current physician order was being followed if there is no evidence of physician notification. LPN #3 stated, "No." LPN #3 stated that nurses did have a communication book with the physician that documented any concerns. LPN #3 presented this book for review and the blood sugars above 400 for Resident #43 were not documented in the book. LPN #3 stated there was a chance the MD (medical doctor)/NP (nurse practitioner) were made aware verbally but there was no documentation. LPN #3 stated, "There is usually someone in-house quite a bit." LPN #3 stated that Resident #43's blood sugars were always within normal limits for her.

On 3/8/18 at 3:28 p.m., an interview was conducted with ASM (administrative staff member) #4, Resident #43's physician. ASM #4 could not recall being made aware of the above instances where Resident #43's blood sugars were elevated. ASM #4 stated that he would expect nursing staff to contact him or the NP. ASM #4 stated he would want to know when "things are out of control." ASM #4 could not recall telling staff to call him only if blood sugars are over 500.

On 3/08/18 at 5:12 p.m., the above concerns were addressed with ASM (administrative staff member) #1, the administrator and ASM #2, the

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F 684	Continued From page 117 DON (Director of Nursing). The facility policy did not address the above concerns. No further information was presented prior to exit. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary." [1] Blood Sugar levels are the sugars in the blood and the body's main source of energy. When the body's blood sugar rises, for instance after a meal, the pancreas secretes insulin. Insulin enters the blood stream and transports these sugars into the body's cells where it is transformed into energy. This then causes the blood sugar levels to fall. When the pancreas is not functioning properly, like a person with type one or two diabetes, blood sugar levels continue to rise in the blood stream. This is also known as Hyperglycemia. Medications (insulin) may be needed to control blood sugar levels. This information was obtained from The National Institutes of Health. https://medlineplus.gov/hyperglycemia.html. Normal blood sugar levels for people who do not have diabetes are 70-130 before meals and less than 180 2 hours after meals. This information was obtained from The National Institutes of	F 684		

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F 684	Continued From page 118 Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024698/ [2] Humalog insulin is a fast acting insulin that helps turn sugar ingested from the food and drink we eat into energy used by the body. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010736/?report=details 2a. The facility staff failed to follow the physician's order and comprehensive care plan to not to obtain Resident #13's blood pressure in the left arm. Resident #41 was admitted to the facility on 6/21/16 with diagnoses that included but were not limited to: Parkinson's disease, high blood pressure and fractured hip. Review of the most recent MDS (minimum data set) dated 1/17/18, a 30 day assessment, with an ARD (assessment reference date) of 1/17/18 coded the resident as having scored a six 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 except for eating which the resident could perform after the tray was set up. Review of the resident's care plan guide initiated on 11/28/14 documented, "No BP (blood pressure)/VP (venipuncture) in LEFT arm. Review of the March 2018 physician's orders documented, "No B/P in Left arm."	F 684		

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F 684	Continued From page 119 Review of the March 2018 medication administration record (MAR) documented, "No BP in Left arm. FYI." Review of the weights and vitals summary sheet from September 2017 to March 2018 documented that the resident's blood pressure had been taken on her left arm on 30 occasions. An interview was conducted on 3/8/18 at 1:45 p.m. with (licensed practical nurse) LPN #2. When asked why Resident #13 had a physician's order and a care plan not to take blood pressures in the left arm, LPN #2 stated because the resident had had a left mastectomy. LPN #2 reviewed the weights and vital summary sheet and stated, "Oh." When asked who took the resident's vital signs, LPN #2 stated, "I always do my own." When asked if staff were following the physician's orders, LPN #2 stated they were not. On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 2b. The facility staff failed to obtain Resident #13's weight every two weeks as ordered by the physician. Review of the resident's care plan did not evidence documentation addressing the weights.	F 684		

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F 684	Continued From page 120 Review of the September 2017 through March 2018 physician's orders documented, "WEIGHT EVERY 2 WEEKS." There was no original start date for the order documented. Review of the March 2018 MAR (medication administration record) documented, "WEIGHT EVERY 2 WEEKS." There were no weights documented on the MAR. Review of the weights and vitals summary report from 9/25/17 to 2/1/18 (the last recorded weight) documented that the resident's weight had been taken on 9/25/17, 10/16/17, 12/8/17, and 2/1/17. An interview was conducted on 3/08/18 at 9:59 a.m. with LPN #1. When asked if staff were expected to follow the physician's orders, LPN #1 stated, "Yes." When asked about process staff followed if they were not able to follow the physician's order, "If we can't follow it we notify the MD (medical doctor)." LPN #1 was asked to review Resident #13's weight and vitals summary sheet for the resident's weights, LPN #1 stated, "It doesn't look like (it's been done [the residents weights]) every two weeks." When asked who obtained the weights, LPN #1 stated, "Usually the aide." When asked who entered the weight, LPN #1 stated the nurses did. When asked if the physician's order had been followed, LPN #1 stated it had not. On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. 3. The facility staff failed to obtain weekly	F 684		

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F 684	Continued From page 121 laboratory specimens as ordered by the physician for Resident #40. Resident #40 was admitted to the facility on 3/16/17 with diagnoses that included but were not limited to: leukemia, Alzheimer's disease, dementia, irregular heart beat and high blood pressure. The most recent MDS, an annual assessment, with an ARD of 2/21/18 coded the resident as having scored a two out of 15 on the BIMS indicating the resident was severely cognitively impaired. The resident was coded as requiring assistance for all activities of daily living. Review of the care plan did not address the laboratory specimens. Review of the March 2018 physician's orders documented, "LAB (laboratory tests): CBC (complete blood count) [1] WKLY (weekly) & FAX RESULTS TO (Name of hospital) HEMATOLOGY." There was no original start date documented. On 3/8/18 at 3:00 p.m. a request was made for the original dated CBC laboratory order from OSM (other staff member) #5, medical records staff. On 3/8/18 at 3:33 p.m., OSM #5 returned and stated she could not locate the original order. Review of the January 2018 and February 2018 physician's orders documented, "LAB: CBC (complete blood count) [1] WKLY (weekly) & FAX RESULTS TO (Name of hospital) HEMATOLOGY."	F 684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(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 OATE
F 684	Continued From page 122 A request was made on 3/8/18 at 5:15 p.m. of ASM #2, the director of nursing, for a copy of the resident's CBC laboratory results. On 3/9/18 at 8:50 a.m., ASM#2 provided three CBC laboratory reports dated, 12/14/17, 1/15/18 and 2/12/18 to this writer. When asked why the laboratory specimens were not collected weekly, ASM #2 stated, "There wasn't an order for it." ASM #2 was shown the order from the March 2018 physician's orders. ASM #2 stated, "I didn't know about that." ASM #2 was made aware of the findings at that time. An interview was conducted on 3/9/18 at 11:15 a.m. with LPN #4. When asked about the process staff followed to obtain laboratory specimens, LPN #4 stated, "If it's a routine lab (laboratory specimen) we write it up on a lab slip." When asked how weekly laboratory specimens were obtained, LPN #4 stated, "We used to be able to do it on the computer, but we can't do that now." When asked who entered the laboratory orders since then, LPN #4 stated, "At one point the ADON (assistant director of nursing) was doing it." When asked how staff would know if a laboratory specimen had not been done as ordered, LPN #4 stated, "Hard to know." When asked to review Resident #40's order for the weekly CBC, LPN #4 stated, she was getting those because she was on an oral chemotherapy medication. No further information was provided prior to exit. 1. CBC - Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests measure the number and types	F 684		

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F 684	Continued From page 123 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. Specific types include tests for ·RBC - the numbers, size, and types of RBC in the blood ·WBC - the numbers and types of WBC in the blood ·Platelets - the numbers and size of the platelets · Hemoglobin - an iron-rich protein in red blood cells that carries oxygen · Hematocrit - how much space red blood cells take up in your blood · Reticulocyte count - how many young red blood cells are in your blood Mean corpuscular volume (MCV) - the average size of your red blood cells. The complete blood count (CBC) includes most or all of these. The CBC is one of the most common blood tests. This information was obtained from https://medlineplus.gov/bloodcounttests.html	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686	F-686 Residents with wound treatment orders have the potential to be affected by the alleged deficient practice. An audit was completed by the DON to assess current status of wounds, any wounds with negative findings were addressed immediately and corrective action was taken. The nurses providing treatment were in-serviced on proper bandage change and infection control procedures by the Director of Nurses.	

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F 686	Continued From page 124 by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide wound care in a manner to promote healing of a pressure wound for three of 28 residents in the survey sample, Residents #5, # 45 and #13. 1. a. The facility staff failed to change the dressing on a pressure wound every day as ordered by the physician for Resident #5. 1. b. The facility staff failed to administer the treatment for a pressure ulcer in a manner to promote healing for Resident #5. 2. The facility staff failed to provide Resident #45's wound care in a manner to promote healing and prevent infection. ASM (administrative staff member) #3, the ADON (Assistant Director of Nursing) was observed touching gauze used for cleaning and dressing Resident #45's wound with his bare hands and also used gloves to perform wound care that he took from the glove box and stuffed into his coat pocket. 3. The facility staff failed to administer a wound treatment in a manner to promote healing and prevent infection for Resident #13. LPN (licensed practical nurse) #4, failed to change gloves before providing wound care to Resident #13 after touch multiple items, the bed controls, side rail, sheets and the resident with her gloved hands. The findings include: 1. a. Resident #5 was admitted to the facility on 5/21/15 with a recent readmission on 2/25/18,	F 686	The Director of Nursing or her designee will observe wound Care weekly for 4 weeks then monthly thereafter on residents being provided care to ensure that proper procedures and infection control procedures are being followed. The results of the observations will be shared with the Administrator weekly. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/31/18

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F 686	Continued From page 125	F 686		

with diagnoses that included but were not limited to: cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. In Section M - Skin Conditions, the resident was not coded as having a pressure ulcer. A significant change assessment was in progress at the time of survey.

Observation was made on 3/7/18 at 2:04 p.m. of LPN (licensed practical nurse) #4 performing the wound care for Resident #5. LPN #4 proceeded to gather her supplies. She went to the resident's left foot. The dressing on the left foot was observed dated 3/5/18. The date of the dressing was verified with LPN #4 and she stated that she was off yesterday and didn't know who was doing treatments for the day.

The physician order dated 2/12/18, documented, "Clean wound L (left) foot with Hibiclens*, apply Santyl ointment, cover w/ (with) NAD (non-adhesive dressing) daily until healed."

*Hibiclens is an antiseptic antibacterial agent used in cleansing of the skin (2).

The TAR (treatment administration record) for March 2018 documented, "Hibiclens Liq (liquid) -

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F 686	Continued From page 126 clean wound left foot w/ hibiclens. Apply Santyl oint (ointment), cover w/ NAD (non-adhesive dressing) daily until healed." The TAR documented the wound was not signed off as completed on 3/2/18 and 3/6/18. The "Norton Scale for Predicting Risk of Pressure Ulcer" dated 2/25/18; documented in part, based on the scale was deemed to be at "High Risk" for developing pressure ulcers. The comprehensive care plan dated, 2/15/18, documented in part, "Focus: Ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: nutritional deficit, non-compliant (left foot) and left buttock." The "Interventions" documented in part, "Treatment as ordered by physician." The "Wound Ulcer Flowsheet" dated, 2/28/18, documented in part, "Left lateral foot. Length - 1.5; width - 1.5; depth - 0.2." All measurements were in centimeters. The wound was staged at "Unstageable*." *Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (3) An interview was conducted with LPN #4 on 3/7/18 at 2:28 p.m. When asked if a dressing is ordered every day, should it be done every day,	F 686		

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F 686	Continued From page 127 LPN #1 stated, "Absolutely." When asked what can happen to a wound if the treatments are not done as ordered, LPN #4 stated, "It can become infected and cause it to breakdown faster." An interview was conducted with LPN #1, on 3/8/18 at 9:58 a.m. When asked who does the treatments, LPN #1 stated, "Recently it's been (Name of LPN #4), then it's the nurse who is extra." When asked what staff do when there is an order for daily dressing changes, LPN #1 stated, "Change it daily." LPN #1 stated, "If I can't get to it, then I should ask the next shift or ADON (assistant director of nursing) for help." When asked if the nurses are supposed to follow the physician orders, LPN #1 stated, "Yes." When asked about the process staff follow when they cannot follow an order, LPN #1 stated, "You notify the doctor." An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing, on 3/8/18 at 1:38 p.m. When asked who does treatments, ASM #3 stated the treatment nurse does them. When asked who does them if there is no treatment nurse available, ASM #3 stated, "Then I should be doing it." When asked if he was on the medication cart on 3/6/18 for day shift, ASM #3 stated, "Yes, I was." When asked if staff do if they can't complete treatments, ASM #3 stated, "You should let the next nurse know." When asked if he told the next shift nurse he didn't complete the resident treatments on 3/6/18, ASM #3 stated, "No, I didn't." When asked why the nurse should do the dressings as ordered, ASM #3 stated, "In order to keep them as healthy as possible and by not doing the dressing it can cause the wound to deteriorate."	F 686		

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F 686	Continued From page 128 The facility policies, "Dressings - Clean" and "Wound/Ulcer Treatment" did not address following the physician orders for wound care. The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009564/?report=details. (3) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 1. b. The facility staff failed to administer the treatment for a pressure ulcer in a manner to promote healing for Resident #5. Observation was made of LPN #4 performing the wound care for Resident #5's left foot on 3/7/18 at 2:04 p.m. LPN #4 gathered her supplies. She pulled her scissors out of her pocket and put them on her clean field. She cut the bandage that was on Resident #5's left foot wound off with her scissors and removed the old dressing, which was dated 3/5/18. LPN #4 proceeded to wipe the wound with the Hibiclens liquid. She wiped from the inside out and then went down the sides of the wound and back to the center of the wound. The second time she wiped the wound she went from the center out and discarded her gauze pad.	F 686		

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F 686	Continued From page 129 LPN #4 proceeded to administer the treatment to the wound. She then went on to administer the treatment to the resident's left buttock. She had taken off the dressing left buttock wound and cleaned the wound per the physician order. LPN #4 proceeded to measure the wound, 1.0 x .7 cm (centimeters). She stated that the wound was a stage 3 pressure ulcer*. When asked why it was a stage three LPN #4 stated there was now slough in the wound. She then washed her hands, put on new gloves. She took the pen, which was clipped to the neck opening of her scrubs, and wrote down the measurements. LPN #4 then proceeded to apply the physician prescribed dressing. LPN #4 proceeded to wash her hands and her scissors with soap and water. When asked the preferred method of cleaning scissors used for a dressing change, LPN #4 stated, "I guess it really should be alcohol." When asked if she was trained to be the treatment nurse, LPN #4 stated, "A while back, I oriented with the previous treatment nurse but then they hired another nurse but she's now doing MDS assessments." *Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (1) An interview was conducted with LPN #4 on	F 686		

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F 686	Continued From page 130 3/7/18 at 2:28 p.m. When asked how a nurse should clean a wound, LPN #4 stated, "You start from the inside out, then you discard the dirty gauze." The above observation of her cleansing the wound was shared with LPN #4. When asked when scissors should be cleaned, LPN #4 stated, "After we use them." When asked what was in her pocket, LPN #4 stated, "Pens." She paused and then stated, "I should wash them before the treatment." When asked what is preferred, soap and water versus alcohol, LPN #4 stated, "It's probably be alcohol." The facility policy, "DRESSINGS - CLEAN" documented in part, "8. Cleanse wound. When cleaning an area, clean from the inside out." If cleaning is needed again, then use another clean 4 x 4 (gauze pad). NEVER reuse the same one." "When cleaning, be sure to move from the least-contaminated area to the most-contaminated area. For a linear shaped wound, such as an incision, gently wipe from top to bottom in one motion, starting directly over the wound and moving outward. For an open wound, such as a pressure ulcer, gently wipe in concentric circles, again starting directly over the wound and moving outward. Us a separate gauze pad each time the wound is cleaned. Discard the gauze pad for each wiping motion; repeat the procedure until you've cleaned the entire wound. Dry the wound with 4" X 4" gauze pads, using the same procedure as for cleaning. Discard the used gauze pads in the plastic bag." (2) In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000	F 686		

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F 686	Continued From page 131 showed that ordinary items can make your patients sick. In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol. (3) The administrator and director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Fundamentals of Nursing Made Incredibly Easy, Lippincott, Williams & Wilkins, 2007, page 428. (3) Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000. 2. The facility staff failed to provide Resident	F 686		

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F 686	Continued From page 132 #45's wound care in a manner to promote healing and prevent infection. ASM (administrative staff member) #3, the ADON (Assistant Director of Nursing) was observed touching gauze used for cleaning and dressing Resident #45's wound with his bare hands and also used gloves to perform wound care that he took from the glove box and stuffed into his coat pocket. Resident #45 was admitted to the facility on 2/5/18 with diagnoses that included but were not limited to Stage 4 pressure ulcer [1], sepsis, high blood pressure, muscle weakness and retention of urine. Resident #45's most recent MDS (minimum data set) assessment was a 14-day scheduled assessment with an ARD (assessment reference date) of 2/18/18. Resident #45 was coded as being moderately impaired in cognitive function scoring a 9 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #45 was coded as requiring extensive assistance from two staff members with transfers and bed mobility; extensive assistance from one staff member with dressing, and personal hygiene and total dependence on staff with bathing. Resident #45 was coded in section M (Skin Conditions) of the MDS assessment, as having a Stage 4 pressure ulcer that was present upon admission. Review of Resident #45's most recent wound care orders documented the following order dated 2/5/18: "Cleanse Wound to sacral decubitus twice daily with sterile saline. Apply santyl ointment [2] in the wound twice daily after cleanse. Then apply wet to dry dressing packing saline with saline gauze. Then cover with ABD (abdominal) pads."	F 686		

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F 686	Continued From page 133 On 3/8/18 at 10:58 a.m., a wound care observation was conducted with ASM #3 the ADON (Assistant Director of Nursing). ASM #3 first took a wad of gloves from the glove box and stuffed them in his coat pocket. ASM #3 then with his bare hands, reached into the gauze package, taking out a stack of gauze. ASM #3 then placed the gauze onto the medication cart directly on top of the opened TAR (treatment administration record). On 3/8/18 at 11:05 a.m., ASM #3 carried the stack of gauze and santyl with his bare hands and placed them onto the clean field in the resident's room. On 3/08/18 at 11:11 a.m., ASM #3 put on gloves (from his pocket) and cleaned his scissors with an alcohol swap. On 03/08/18 at 11:15 a.m., ASM #3 took all the gloves from his pocket and put them on the clean field. He then placed gloves on and began to remove the old dressing. ASM #3 then washed his hands and put on gloves that were part of his wad of gloves. At 11:16 a.m., ASM #3 used the gauze that he had touched with his bare hands to clean the wound along with normal saline. ASM #3 then washed his hands and placed on gloves. ASM #3 then took a Q-tip of santyl and rubbed it on an excoriated area around the wound first; and then moved into the center of the wound bed using the same Q-tip. ASM #3 then threw out the Q-tip and removed his gloves, washed his hands, and went out of the resident's room to grab additional gloves. On 3/8/18 at 11:20 a.m., ASM #3 put on clean gloves and then packed Resident #45's wound with the saline-soaked gauze. This gauze was part of the stack that ASM #3 had touched with his bare hands. ASM #3 then placed the ABD (abdominal pad) over the wound and secured the dressing.	F 686		

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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
F 686	Continued From page 134 On 3/8/18 at 1:33 p.m., an interview was conducted with ASM #3. When asked how to maintain infection control during wound care, ASM #3 stated that he would wash hands and remove gloves after he removed the old dressing and started to clean the wound. ASM #3 stated he would wash his hands again and put on new gloves before applying the clean (new) dressing. When asked if he currently has any items in his pocket, ASM #3 stated no. When asked if gloves he was going to use for a dressing change should ever be placed in his pocket; ASM #3 stated that his pocket was clean because he washed his coat the night before. ASM #3 then stated he was wearing a new jacket. ASM #3 did state he made a mistake grabbing the gauze from the package with his bare hands and putting it on the TAR. When asked if it was ok to apply santyl to the outside of the wound and then move into the wound bed using the same Q tip; ASM #3 stated it wouldn't matter because the santyl was not used to clean the wound. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled "Dressing-Clean" documented in part the following: "Equipment and Supplies: Clean dressing instruments, clean gloves." [1] A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually	F 686		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

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F 686	Continued From page 135 from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. Stage IV Pressure Ulcer Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. [2] *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>) 3. The facility staff failed to administer a wound treatment in a manner to promote healing and prevent infection for Resident #13. LPN (licensed	F 686		

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F 686	Continued From page 136 practical nurse) #4, failed to change gloves before providing wound care to Resident #13 after touch multiple items, the bed controls, side rail, sheets and the resident with her gloved hands. Resident #13 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to: left mastectomy, difficulty swallowing, depression, anemia and Alzheimer's disease. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/20/17 coded the resident as having scored a three 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. Review of the care plan initiated on 1/24/18 documented, "Focus. At Risk for skin breakdown or development of further pressure ulcers related to: High risk for pressure ulcer immobility (Stage II to coccyx) [1]." Review of the March 2018 physician's orders documented, "TX (treatment): CLEANSE COCCYX W/NS (with normal saline). APPLY AQUACEL (2) AND ALLEVYN FOAM (3) DRSG (dressing) QD (everyday) and PRN (as needed)." Review of the March 2018 medication administration record documented, "TX (treatment): CLEANSE COCCYX W/NS (with normal saline). APPLY AQUACEL (2) AND ALLEVYN FOAM (3) DRSG (dressing) QD (everyday) and PRN (as needed)."	F 686		

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F 686	Continued From page 137 A wound care observation was conducted on 3/7/18 at 10:20 a.m. with LPN (licensed practical nurse) #4, the treatment nurse. LPN #4 put a protective cover on the resident's bedside table and placed the wound care supplies on it, opened the dressing and labeled it and then washed her hands. LPN #4 then put on a pair of gloves. She raised the height of the bed and lowered the resident's head using the bed controller. LPN #4 lowered the bed railing pulled the resident's sheet down. She turned the resident onto her left side, removed the resident's brief and washed the wound with normal saline soaked gauzes that she took from her wound supplies on the resident's overbed table. LPN #4 did not wash her hands or change gloves after touching the resident's bed controls, sheets and resident prior to providing care to the pressure ulcer. The pressure ulcer was 4.5 cm (centimeters) by 1.5 cm and was partially covered with slough (4). An interview was conducted on 3/7/18 at 2:32 p.m. with LPN #4. When asked when staff changed gloves during wound care, LPN #4 stated, "After you take the dirty dressing off." The above wound care observation was reviewed with LPN #4. LPN #4 stated, "I should have changed the gloves." When asked why the gloves should be changed, LPN #4 stated, "Because I touched all those things. Because they probably had all those little microorganisms all over them." On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, WOUND	F 686		

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F 686	Continued From page 138 CARE/ULCER TREATMENT" did not evidence documentation regarding handwashing during wound care. No further information was provided prior to exit. 1. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 2. Aquacel - A textile fiber dressing composed of sodium carboxymethylcellulose with potential wound-healing activity. Sodium carboxymethylcellulose dressing protects the wound site from external factors that may cause pain, promote infection, or slow the natural wound healing process. Sodium carboxymethylcellulose is a non-toxic, non-allergenic, anionic water-soluble polymer derived from cellulose. Check for active clinical trials using this agent. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-drug/def/sodium-carboxymethylcellulose-dr	F 686		

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F 686	Continued From page 139 essing 3. Allevyn - a hydrocellular foam dressing which is able to absorb 10 times its weight in exudate, providing a cost-effective treatment option for exuding, granulating wounds. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/7703644 4. Slough -1. Necrotic tissue in the process of separating from viable portions of the body. This information was obtained from: http://medical-dictionary.thefreedictionary.com/slough	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §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	F 693	F-693 The C.N.A. who removed the feeding tube from Resident #8 was Re-educated by the Director of Nursing regarding the removal of the feeding tube on the day of survey. No other residents were found to be affected by this deficient practice. Nursing staff were in-serviced on the proper policy and procedure for care and removal of feeding tubes. Residents who have feeding tubes will be monitored by the Director of Nursing or her designee on a weekly basis to ensure compliance with policy, procedure, and proper scope of practice. Reports of these observations will be submitted to the Facility's QA committee for guidance and review.	4/21/18

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F 693	Continued From page 140 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 the facility staff failed to provide care and services for a tube feeding per the physician order for one of 28 residents in the survey sample, Resident #8. The facility staff failed to ensure Resident #8's tube feeding was administered, continuously, per the physician order. The findings include: Resident #8 was admitted to the facility on 12/11/12 with a recent readmission on 11/6/17, with diagnoses that included but were not limited to: Alzheimer's disease, mood disorder, anxiety disorder, diabetes, stroke, high blood pressure, and history of subdural hematoma (a collection of blood beneath dura mater in the brain) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/7/17, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #8 was coded as being dependent upon one or more staff members for all of her activities of daily living. In Section K - Swallowing/Nutritional Status, the resident was coded as receiving all of her nutrition through a feeding tube. The physician order dated, 11/7/18, documented, "Diabetisource (nutritional replacement for food	F 693		

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F 693	Continued From page 141 specific for diabetic residents) (2) @ (at) 40 ml/hr (milliliters per hour) via Peg tube (a feeding tube inserted through the abdominal wall). Observation was made of Resident #8's room on 3/8/18 at 8:45 a.m. The resident was not in the room. The tube feeding was hanging on the pole next to the bed. An interview was conducted with CNA (certified nursing assistant) #3 on 3/8/18 at 8:49 a.m. When asked where Resident #8 was, CNA #3 stated she had just put her up by the nurse's station. When asked who disconnected the tube feeding from the resident, CNA #3 stated, "I did." When asked why she did this, CNA #3 stated, "The nurses show us how to do it." When asked if she had been trained in school to take care of a feeding tube, CNA #3 stated, "No, Ma'am." An interview was conducted with LPN (licensed practical nurse) #2 on 3/8/18 at 8:52 a.m. When asked if a CNA is allowed to disconnect a tube feeding, LPN #2 stated, "Never. They are never to touch a tube feeding." The above observation and interview was shared with LPN #2 who then proceeded to change the entire set up of tube feeding. The comprehensive care plan dated, 10/30/16 and revised on 12/19/17, documented in part, "Focus: At risk for state of nourishment: less than body requirement characterized by inadequate intake, decreased appetite related to: being on a therapeutic diets, cognitive impairment depression." The "Interventions" documented in part, "Diet as ordered (Diabetisource @ 40cc per hour via peg tube."	F 693		

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F 693	Continued From page 142 An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/18 at 12:35 p.m. When asked if a CNA can disconnect a resident from a tube feeding, ASM #2 stated, "No." The facility policy, "Enteral Feeding" documented in part, "Licensed practical nurses, registered nurses or designated staff members technically trained may administer the tube feedings as ordered." In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 265 and 549. (2) This information was obtained from the following website: https://www.allegromedical.com/dietary-supplements-c522/enteral-feeding-diabetisource-xff8081812f688a20012f6abe767b4d0c$4050.html	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		

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F 695	Continued From page 143 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. 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 appropriate respiratory care services for two of 28 residents in the survey sample; Residents #9 and #12. 1. The facility staff failed to maintain Resident #9's oxygen equipment in a sanitary manner. 2. The facility staff failed to maintain Resident #12's a nebulizer in a sanitary manner. The findings include: 1. Resident #9 was admitted to the facility on 6/14/17 and readmitted on 8/19/17 with diagnoses that included but were not limited to dementia without behavioral disturbance, anxiety disorder, type two diabetes, major depressive disorder, high blood pressure, chronic ischemic heart disease, COPD (chronic obstructive pulmonary disease), and stroke. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/13/17. Resident #9 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as requiring extensive assistance with one staff member for most ADLS	F 695	F-695 The Oxygen tubing for Resident #8s equipment was discarded and new tubing secured immediately on 3/6/18. The nebulizer mask for Resident #12 was discarded and replaced immediately on 3/6/18 with a mask in a plastic bag for storage purposes. A 100% observation audit was completed on 3/9/2018 by the DON of residents with orders for oxygen therapy and nebulizer treatments. No other residents were found to be affected by this alleged deficient practice. Nursing staff were in-serviced on proper changing of Oxygen tubing and nebulizers and the Infection Control procedures required for proper storage by the SDC	4/21/18

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F 695	Continued From page 144 (activities of daily living). Review of Resident #9's most recent POS (physician order sheet) dated 2/28/18 revealed the following order: "02 (oxygen) @ 3 L (liters)/min (minute) via N/C (nasal cannula) continuous." On 3/6/18 at 7:23 a.m., an observation was made of Resident #9's room. Resident #9's 02 concentrator was sitting in the doorway of her room. Her oxygen tubing dated 3-5, was hanging from the concentrator. Most of the tubing was touching the floor. At 7:24 a.m., a nursing aide (CNA) #2 was coming down the hallway. CNA #2 stated she was putting soiled linen away from Resident #9's room and was coming back to bring the concentrator to the dining room where Resident #9 was sitting. This writer followed the CNA into the dining room where the resident was sitting. The aide placed the concentrator next to the resident, placed the nasal cannula back on the resident and turned the oxygen on. The oxygen went to up to 3 liters automatically. On 3/7/18 at 3:13 p.m., an interview was conducted with CNA #2. When asked about the process followed if she were to see a resident's oxygen tubing on the floor, CNA #2 stated she could ask central supply for a new tubing or she could get a wipe and wipe it off. When asked if she could recall Resident #9's oxygen tubing on the floor on 3/6/18, CNA #2 stated, "I was not aware of that." When asked why she would change oxygen tubing if it had touched the floor, CNA #2 stated she would change the tubing because of the germs on the floor. On 3/8/18 at 5:12 p.m., ASM (administrative staff	F 695	The Director of Nursing or her designee will perform observation audits to verify proper placement and storage of Oxygen equipment, tubing and nebulizers on a weekly basis for 4 weeks then monthly thereafter. The results of the observation audits will be communicated to the IDT during am meetings. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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F 695	Continued From page 145 member) #1, the administrator and ASM #2 the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled "Oxygen therapy" documents in part, the following: "Discard masks, cannulas, and tubing, if disposable, between residents, or whenever it has become visibly soiled." No further information was presented prior to exit. 2. The facility staff failed to maintain Resident #12's a nebulizer in a sanitary manner Resident #12 was admitted to the facility on 12/6/14 and readmitted on 11/10/17 with diagnoses that included but were not limited to major depressive disorder, anxiety disorder, COPD (chronic obstructive pulmonary disease), and urinary retention. Resident #12's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 12/18/17. Resident #12 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with bed mobility, and dressing; and total dependence on staff with toileting, personal hygiene, and bathing. Review of Resident #12's most recent POS (physician order sheet) revealed the following order: "Pulmicort [1] 0.5 mg/2 ml; premixed unit via nebulizer every night at bedtime for COPD. (Chronic Obstructive Pulmonary Disease)."	F 695		

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F 695	Continued From page 146 On 3/6/18 at 9:08 a.m., 11:56 a.m., and 2:11 p.m., observations of Resident #12's nebulizer were conducted. His nebulizer mask dated 3/5, was observed lying on top of the nebulizer machine. It was not contained in a plastic bag. On 3/6/18 at approximately 2:11 p.m., an interview was conducted with Resident #12. When asked if he could take the mask off himself and place it on his bedside table, Resident #12 stated he needed help with everything and could not reach that far. Resident #12 stated the staff take off his mask at night when the treatment is finished. On 3/7/18 at 8:47 a.m., an observation of Resident #12's nebulizer was conducted. The nebulizer mask was dated 3/7, indicating that it had just been changed that morning. The mask was sitting on top of the nebulizer machine not in a plastic bag. On 3/7/18 at 8:53 a.m., an interview was conducted with LPN (licensed practical nurse) #1, Resident #12's nurse. When asked how a nebulizer mask should be stored when not in use, LPN #1 stated a nebulizer mask should be stored in a plastic bag to maintain infection control. LPN #1 followed this writer to Resident #12's room. When asked what she observed about Resident #12's nebulizer, LPN #1 stated it was not in a plastic bag. LPN #1 took the mask and placed it in the plastic bag next to the mask. When asked if Resident #12 takes off his nebulizer mask himself, LPN #1 stated that he could not do that. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2 the	F 695		

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	495226	A. BUILDING _____ B. WING _____	03/09/2018

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F 695	Continued From page 147 DON (Director of Nursing) were made aware of the above concerns. [1] Pulmicort nebulizer is an inhaled corticosteroid used for the management of asthma. This information was obtained from The National Institutes of Health.	F 695	F-697 A pain assessment was completed immediately on Resident #37 for pain that included non-pharmacological interventions and the effectiveness of the prn medication by the ADON. An audit was completed for 100% of residents with prn Morphine ordered for pain relief by the DON to establish that non-pharmacological interventions are available and effectiveness of medication is documented. No other resident was found to be affected by this deficient practice. Residents who trigger for pain and who are on pain medication will be monitored weekly by the IDT in its morning meeting to ensure that proper non-pharmacological interventions are documented and the effectiveness of the medication noted.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff failed to ensure pain management was provided to residents consistent with professional standards of practice and the comprehensive centered care plan for one of 28 residents in the survey sample, Resident #37. The facility staff failed to accurately assess Resident #37's pain and failed to attempt non-pharmacological interventions, prior to the administration of prn (as needed) Morphine. The facility staff also failed to monitor the effectiveness of prn (as needed) Morphine after administration. The findings include: Resident #37 was admitted to the facility on	F 697		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 697	Continued From page 148 3/31/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes, high cholesterol, Alzheimer's Disease, and dementia Resident #37's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #37 was coded as being severely cognitively impaired scoring three out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #37 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living). Review of Resident #37's clinical record revealed that he was placed on Hospice Services on 8/11/17. Review of Resident #37's most recent POS (physician order sheet) dated 2/28/18, documented the following order: "Morphine [1] Sul (sublingual) sol (solution) 100/5 ml (milliliters) under tongue every four hours as needed for pain/shortness of breath." This order was initiated on 9/21/17. Review of Resident #37's February and March 2018 MARS (Medication Administration Records) revealed that Resident #37 received Morphine on the following dates and times: 1) 2/8/17 at 12:30. AM or PM could not be identified. The following was documented on the back of the MAR: "Morphine 0.25 ml; Reason: restlessness and discomfort." A pain level was not documented. There was no evidence that non-pharmacological interventions were attempted prior to administering Morphine. There was no evidence of a follow up pain assessment	F 697	To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	4/21/18

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F 697	Continued From page 149 after the Morphine was administered. 2) 2/11/18 at 06:00. AM or PM could not be identified. The following was documented on the back of the MAR: "Morphine 0.25 ml; Reason: Pain/Anxiety." A pain level was not documented. There was no evidence that non-pharmacological interventions were attempted prior to administering Morphine. A follow up pain assessment was conducted and documented the Morphine as being "effective." 3) 2/11/18 at 02:30. AM or PM could not be identified. The following was documented on the back of the MAR. "Morphine 0.25 ml; Reason: Back pain." A pain level was not documented. There was no evidence that non-pharmacological interventions were attempted prior to administering Morphine. There was no evidence of a follow up pain assessment after the Morphine was administered. 4) 3/5/18 at 7:00 p.m. No reason could be found on the back of the MAR indicating why Morphine was administered. The back of the MAR was blank. There were no nursing notes regarding the administration of Morphine on the above dates. Review of Resident #37's comprehensive care plan dated 4/18/17, failed to evidence a care plan for Pain or Hospice. On 3/8/18 at 8:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about the process followed prior to administering a prn pain medication, LPN #3 stated she would have the CNA first reposition	F 697		

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F 697	Continued From page 150	F 697		

the resident or try other non-pharmacological interventions. LPN #3 stated if that didn't work, she would administer the pain medication after a pain assessment. When asked what the pain assessment would include, LPN #3 stated she would look for non-verbal indications of pain as well as verbal, would assess to determine the location and the level of pain. LPN #3 stated after she administers the medication, she would then do a follow up pain assessment. When asked if the initial and follow up pain assessment should be documented in the clinical record, LPN #3 stated the pain assessment is usually documented on the back of the MAR. When asked where the pain assessment would be documented if it is not in the MAR or in the nursing notes, LPN #3 stated, "I wouldn't think it was done if there is no documentation." When asked where non-pharmacological pain relief interventions were written, LPN #3 stated that she doesn't usually document what non-pharmacological interventions were attempted or offered. When asked if they should be documented, LPN #3 stated they probably should be documented. When asked how she would know if nursing staff were offering non-pharmacological pain relief interventions if they are not documented, LPN #3 stated that she probably wouldn't know.

On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled "Nursing Guidelines Pain Management" documents in part the following: "Choose the appropriate analgesic when more than one is ordered. When documenting the

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F 697	Continued From page 151 degree of pain relief on the pain management log, reassess the resident and document the degree of pain relief 30 minutes after parenteral analgesic and 60 minutes after oral analgesic administration." The facility policy did not address the additional concerns addressed above. Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management.	F 697		

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F 697	Continued From page 152 [1] Morphine is indicated for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=3f3a870e-f325-475b-8453-fe3d1bb8f54.	F 697	F-745 The PASSARR will be obtained for resident #25. The Dentures for Resident #18 have been obtained. The dentures for resident#30 were obtained. Residents with orders for dental consults and new admissions have the potential to be affected by the alleged deficient practice. A review of other residents was conducted by the Social Worker to determine if all dental consults had occurred and or appointments were pending. The Social worker has been in-serviced on the requirements for admission, including the need for a PASARR prior to admission by the Administrator. The facility has secured a contract for Dental services and residents have received dental services as ordered.	4/27/18
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review and clinical record review, it was determined facility staff failed to provide medically related social services for three of 28 residents in the survey sample, Residents #25, #18, and #30. 1. The facility staff failed to complete ensure medically related social services were provided in regards to the preadmission screening and resident review (PASAAR) for Resident #25. 2. The facility staff failed to provide medically related social services in regards to assisting and obtaining dentures for Resident #18. 3. The facility staff failed to provide medically related social services in regards to assisting and obtaining dentures for Resident #30. The findings include:	F 745		

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F 745	Continued From page 153 1. Resident #25 was admitted to the facility on 7/17/15 and readmitted on 12/19/17 with diagnoses that included but were not limited to: Parkinson's disease (1), heart failure, diabetes, psychotic disorders, depression, schizophrenia (2), anoxic brain injury (3) and seizures. The most recent complete MDS, a 30-day assessment, with an ARD of 1/17/18 coded the resident as having scored a 6 out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of staff for all activities of daily living with the exception of eating which the resident could perform with supervision. Review of the clinical record did not evidence documentation that the pre-admission screening and resident review (PASARR) was completed. On 3/7/18 at 4:47 p.m., a request for a copy of the PASARR was made to ASM (administrative staff member) #2, the director of nursing. On 3/8/18 at 8:30 a.m., ASM #2 stated there was no PASARR for Resident #25. An interview was conducted on 3/8/18 at 10:15 a.m. with OSM (other staff member) #1, the social worker. When asked if she knew what a PASARR was, OSM #1 stated, "No. I know if a person has mental retardation they should have one. I met with someone from the hospital to ask about it. They said they'd have to get back to me." When asked when that had occurred, OSM #1 stated, "It's probably been maybe last month." An interview was conducted on 3/8/18 at 12:01	F 745	Admissions will be reviewed by the IDT to determine PASARR compliance. Dental Services will be provided as contracted and notations made in Social progress notes. A list of Dental consults will be maintained by the Social worker. The medical records staff member or QI nurse will complete an audit of 10 % admissions each month for 3 months then quarterly thereafter to determine procurement of the PASARR and availability of the PASARR in the medical records. The results of the audit will be shared with the administrator.	

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F 745	Continued From page 154 p.m. with ASM #1, the administrator and ASM #2, the director of nursing. When asked what a PASARR was, ASM #1 stated, "It's preadmission screening of the assessment of the resident to see if the SNF (skilled nursing facility) is a proper placement." When asked which residents had a PASARR completed, ASM #1 stated, "We need one for everyone who comes in here" When asked if anyone was completing the PASARR's, ASM #1 stated, "Not to my knowledge. We asked for one from the hospital." ASM #2, the director of nursing, stated, "I don't think the hospital realizes what they are or what they are supposed to be doing." The findings were reviewed at that time. Review of the facility's job description titled, "Social Worker" documented, "PURPOSE OF YOUR JOB POSITION: The primary purpose of your job position is to plan, develop, organize, implement, evaluate and direct the Social Work Department in accordance with current existing federal, state, and local standards, as well as our established polices and procedures, to assure that the medically related emotional and social needs of the residents are met/maintained on an individual basis. The responsibilities my include a combination of admissions, documentation, and service delivery duties. MAJOR DUTIES AND RESPONSIBILITIES: Listed below is an outline of the duties and responsibilities that you will be required to perform. AS SOCIAL WORKER, you are delegated the authority, responsibility, and accountability to carry out your assigned duties. ..1) Plan, develop, organize, implement, evaluate, and direct the social service programs of this facility 3) Develop and maintain a good working rapport with interdepartmental personnel and outside community health, welfare, and social agencies to assure that social service programs	F 745	To maintain continued compliance the Medical Records staff member or QI nurse will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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F 745	Continued From page 155 can be properly maintained to meet the needs of the residents 4) Keep abreast of current federal and state regulations as well as professional standards and make recommendations on changes in policy and procedures to the corporate consultant 21) Coordinate social service activities with other departments in the formulation of resident's individual interdisciplinary resident care plan. 22) Work with the facility's consultants as necessary and implement recommended change as required." No further information was provided prior to exit. 2. The facility staff failed to provide medically related social services in regards to assisting and obtaining dentures for Resident #18. Resident #18 was admitted to the facility on 9/29/14 with diagnoses that included but were not limited to: stroke, contractures, depression, elevated cholesterol and high blood pressure. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/28/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he is capable of making daily cognitive decisions. The resident was coded as requiring supervision to limited assistance for his activities of daily living. In Section K - Swallowing/Nutritional Status the resident was coded as not having any dental concerns. An interview was conducted with Resident #18 on 3/6/18 at 9:13 a.m. Resident #18 stated, "Something happened I never got my dentures. They pulled all of my teeth with a promise to get me dentures."	F 745		

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F 745	Continued From page 156 The documentation from the Mobile Dental Unit dated 4/21/17, documented in part, "TX (treatment): Exam, Full mouth extractions." The documentation from the Mobile Dental Unit dated 6/28/17, documented in part, "TX: (treatment) Post - Op (operative) Possible impressions F/F (full set of dentures)." The review of the comprehensive care plan updated on 4/28/17, failed to evidence any care plan addressing dental care or the need for obtaining dentures for Resident #18. An interview was conducted with other staff member (OSM) #1, the social worker/ admission/discharge planner, on 3/7/18 at 12:53 p.m., regarding how residents obtain dentures while at the facility, OSM #1 stated, "We go through (name of mobile dental company). They come out and see the residents." When asked if they fit the residents' for dentures, OSM #1 stated, "Yes." When asked the last time the dental unit was at the facility, OSM #1 stated, "I came the end of May 2017 and they are scheduled to come on 3/22/18. I just found out today that I am handling the dental part. I have not been handling that before. " An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/7/18 at 1:01 p.m. When asked how dental concerns are handled in the facility, ASM #2 stated, "We have just signed a new contract with a new dental provider that comes to the facility." When asked when the last time dental services were provided at the facility, ASM #2 stated, "I don't know, I would have to check to see when	F 745		

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F 745	Continued From page 157 they were last here. Our last provider supposedly bought out the company and came out and they saw some residents. There was a conflict and some resident's dentures are being held hostage." An interview was conducted with other staff member (OSM) #2, the account receivable staff member, on 3/8/18 at 1:38 p.m. When asked if she had any invoices for Resident #18 to receive dentures, OSM #2 stated she had no invoices for Resident #18 to have dentures. The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. 3. The facility staff failed to provide medically related social services in regards to assisting and obtaining dentures for Resident #30. Resident #30 was admitted to the facility on 3/28/12 with diagnoses that included but were not limited to: dementia, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), anxiety disorder, and dysphasia (a condition in which swallowing is difficult or painful) (2). The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 1/31/18, coded the resident as scoring a 15 on the BIMS (brief	F 745		

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F 745	Continued From page 158 interview for mental status) score, indicating he was capable of making daily cognitive decisions. The documentation from the Mobile Dental Unit, dated 6/28/17, documented in part, "Needs extraction of teeth as charted. After extractions, pt (Patient) is a candidate for F/P (fitting for partial dentures)." The comprehensive care plan dated, 6/5/17 documented in part, "Focus: (Resident #30) has broken and missing teeth related to poor PO (mouth) hygiene. Denies any dental pain at this time." The "Interventions" documented in part, "Monitor and notify physician or any s/sx (signs and symptoms) of dental pain. Refer to dentist for evaluation when resident feels able." An interview was conducted with Resident #30 on 3/6/18 at 10:20 a.m. The resident stated, "They came last year and cleaned my teeth but were supposed to come back and pull teeth and fit me for dentures. I want to eat pork chops and corn. They never came back." An interview was conducted with other staff member (OSM) #1, the social worker/ admission/discharge planner, on 3/7/18 at 12:53 p.m. When asked how residents obtain dentures while at the facility, OSM #1 stated, "We go through (name of mobile dental company). They come out and see the residents." When asked if they fit the residents' for dentures, OSM #1 stated, "Yes." When asked the last time the dental unit was at the facility, OSM #1 stated, "I came the end of May 2017 and they are scheduled to come on 3/22/18. I just found out today that I am handling the dental part. I have not been handling that before. "	F 745		

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F 745	Continued From page 159 An interview was conducted with other staff member (OSM) #2, the account receivable staff member, on 3/8/18 at 1:38 p.m. When asked if she had any invoices for Resident #30 to receive dentures, OSM #2 stated she had no invoices for Resident #30 to have dentures. The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, 178.	F 745		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 777	F-777 The ordered CBC was obtained for Resident #40. The Physician was notified of the results and new orders received or no new orders were received. A 100 % audit was completed by Nursing Personnel for current results for ordered CBC's No other issues were found. Physician orders are reviewed in the morning IDT meeting.	4/21/18

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F 777	Continued From page 160 review, it was determined the facility staff failed to obtain physician ordered laboratory specimens for one of 28 residents in the survey sample, Resident #40. The facility staff failed to obtain weekly laboratory specimens as ordered by the physician for Resident #40. The Findings Include: Resident #40 was admitted to the facility on 3/16/17 with diagnoses that included but were not limited to: leukemia, Alzheimer's disease, dementia, irregular heartbeat and high blood pressure. The most recent MDS, an annual assessment, with an ARD of 2/21/18 coded the resident as having scored a two out of 15 on the BIMS indicating the resident was severely cognitively impaired. The resident was coded as requiring assistance for all activities of daily living. Review of the care plan did not address the laboratory specimens. Review of the March 2018 physician's orders documented, "LAB (laboratory tests): CBC (complete blood count) [1] WKLY (weekly) & FAX RESULTS TO (Name of hospital) HEMATOLOGY." There was no original start date documented. On 3/8/18 at 3:00 p.m. a request was made for the original dated CBC laboratory order from OSM (other staff member) #5, medical records staff.	F 777	Any new orders will be noted and the documentation will be placed in the residents chart. Follow-up will be completed and documented in the afternoon meeting to ensure that specimens and cultures are obtained timely. Documentation of follow-up to lab orders will be kept in the IDT meeting minutes and reviewed by the director of Nursing or her designee. The ADON/QI nurse will perform weekly audits for 4 weeks then monthly thereafter for obtaining lab results. The results of the audit will be reviewed by the DON. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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F 777	Continued From page 161 On 3/8/18 at 3:33 p.m., OSM #5 returned and stated she could not locate the original order. Review of the January 2018 and February 2018 physician's orders documented, "LAB: CBC (complete blood count) [1] WKLY (weekly) & FAX RESULTS TO (Name of hospital) HEMATOLOGY." A request was made on 3/8/18 at 5:15 p.m. of ASM #2, the director of nursing, for a copy of the resident's CBC laboratory results. On 3/9/18 at 8:50 a.m., ASM#2 provided three CBC laboratory reports dated, 12/14/17, 1/15/18 and 2/12/18 to this writer. When asked why the laboratory specimens were not collected weekly, ASM #2 stated, "There wasn't an order for it." ASM #2 was shown the order from the March 2018 physician's orders. ASM #2 stated, "I didn't know about that." ASM #2 was made aware of the findings at that time. An interview was conducted on 3/9/18 at 11:15 a.m. with LPN #4. When asked about the process staff followed to obtain laboratory specimens, LPN #4 stated, "If it's a routine lab (laboratory specimen) we write it up on a lab slip." When asked how weekly laboratory specimens were obtained, LPN #4 stated, "We used to be able to do it on the computer, but we can't do that now." When asked who entered the laboratory orders since then, LPN #4 stated, "At one point the ADON (assistant director of nursing) was doing it." When asked how staff would know if a laboratory specimen had not been done as ordered, LPN #4 stated, "Hard to know." When asked to review Resident #40's order for the weekly CBC, LPN #4 stated, she was getting	F 777		

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F 777	Continued From page 162 those because she was on an oral chemotherapy medication. No further information was provided prior to exit. 1. CBC - Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests measure the number and types of cells in your blood. This helps doctors 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. Specific types include tests for · RBC - the numbers, size, and types of RBC in the blood · WBC - the numbers and types of WBC in the blood · Platelets - the numbers and size of the platelets · Hemoglobin - an iron-rich protein in red blood cells that carries oxygen · Hematocrit - how much space red blood cells take up in your blood · Reticulocyte count - how many young red blood cells are in your blood· Mean corpuscular volume (MCV) - the average size of your red blood cells The complete blood count (CBC) includes most or all of these. The CBC is one of the most common blood tests. This information was obtained from: https://medlineplus.gov/bloodcounttests.html	F 777	F-791 The facility obtained Dental services for Resident #18, #30, and #41. Other residents requiring Dental services were identified and services provided. A new Dental services Contract was negotiated and signed by the administrator. Dental services were on site at the facility on March 22 and provided dentures and partials as needed. Referrals for Dental services will be scheduled by Social services and maintained on a log in the Social services office.	4/24/18
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		

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F 791	Continued From page 163 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review it was determined the facility staff failed to provide	F 791	To maintain continued compliance Social Services will share the results of the dental compliance audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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F 791	Continued From page 164 routine dental services for three of 28 residents in the survey sample, Residents #18, #30, and #41. 1. The facility staff failed to arrange and ensure dental services were provided to Resident #18. 2. The facility staff failed to arrange for and ensure dental services were provided to Resident #30. 3. The facility staff failed to arrange for and ensure dental services were provided to Resident #41. The findings include: 1. Resident #18 was admitted to the facility on 9/29/14 with diagnoses that included but were not limited to: stroke, contractures, depression, elevated cholesterol and high blood pressure. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/28/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he is capable of making daily cognitive decisions. The resident was coded as requiring supervision to limited assistance for his activities of daily living. In Section K - Swallowing/Nutritional Status the resident was coded as not having any dental concerns. An interview was conducted with Resident #18 on 3/6/18 at 9:13 a.m. Resident #18 stated, "Something happened I never got my dentures. They pulled all of my teeth with a promise to get me dentures."	F 791		

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F 791	Continued From page 165 The documentation from the Mobile Dental Unit dated 4/21/17, documented in part, "TX (treatment): Exam, Full mouth extractions." The documentation from the Mobile Dental Unit dated 6/28/17, documented in part, "TX: (treatment) Post - Op (operative) Possible impressions F/F (full set of dentures)." The review of the comprehensive care plan updated on 4/28/17, failed to evidence any care plan addressing dental care or the need for obtaining dentures for Resident #18. An interview was conducted with other staff member (OSM) #1, the social worker/ admission/discharge planner, on 3/7/18 at 12:53 p.m., regarding how residents obtain dentures while at the facility, OSM #1 stated, "We go through (name of mobile dental company). They come out and see the residents." When asked if they fit the residents' for dentures, OSM #1 stated, "Yes." When asked the last time the dental unit was at the facility, OSM #1 stated, "I came the end of May 2017 and they are scheduled to come on 3/22/18. I just found out today that I am handling the dental part. I have not been handling that before. " An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/7/18 at 1:01 p.m. When asked how dental concerns are handled in the facility, ASM #2 stated, "We have just signed a new contract with a new dental provider that comes to the facility." When asked when the last time dental services were provided at the facility, ASM #2 stated, "I don't know, I would have to check to see when they were last here. Our last provider supposedly	F 791		

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F 791	Continued From page 166 bought out the company and came out and they saw some residents. There was a conflict and some resident's dentures are being held hostage." An interview was conducted with other staff member (OSM) #2, the account receivable staff member, on 3/8/18 at 1:38 p.m. When asked if she had any invoices for Resident #18 to receive dentures, OSM #2 stated she had no invoices for Resident #18 to have dentures. The facility policy, "Dental Services" documented in part, "Arrangements are made with the resident's personal dentist for the provision of routine and emergency dental care. If the resident does not have a personal dentist, then an agreement is obtained for care to be provided by a dentist with whom the facility has a contract. This dentist will provide dental care on a routine basis and a needed....If financial assistance is necessary, the Social Worker will help the resident or his/her representative and to see if there arrangements can be made. The Social Worker will assist resident who are eligible and wish to participate, to apply for reimbursement of dental services as an incurred medical expense, under the State plan." The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. 2. The facility staff failed to arrange for dental services for Resident #30.	F 791		

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F 791	Continued From page 167 Resident #30 was admitted to the facility on 3/28/12 with diagnoses that included but were not limited to: dementia, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), anxiety disorder, and dysphasia (a condition in which swallowing is difficult or painful) (2). The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 1/31/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The documentation from the Mobile Dental Unit, dated 6/28/17, documented in part, "Needs extraction of teeth as charted. After extractions, pt (Patient) is a candidate for F/P (fitting for partial dentures)." The comprehensive care plan dated, 6/5/17 documented in part, "Focus: (Resident #30) has broken and missing teeth related to poor PO (mouth) hygiene. Denies any dental pain at this time." The "Interventions" documented in part, "Monitor and notify physician or any s/sx (signs and symptoms) of dental pain. Refer to dentist for evaluation when resident feels able." An interview was conducted with Resident #30 on 3/6/18 at 10:20 a.m. The resident stated, "They came last year and cleaned my teeth but were supposed to come back and pull teeth and fit me for dentures. I want to eat pork chops and corn. They never came back." An interview was conducted with other staff	F 791		

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F 791	Continued From page 168 member (OSM) #1, the social worker/ admission/discharge planner, on 3/7/18 at 12:53 p.m. When asked how residents obtain dentures while at the facility, OSM #1 stated, "We go through (name of mobile dental company). They come out and see the residents." When asked if they fit the residents' for dentures, OSM #1 stated, "Yes." When asked the last time the dental unit was at the facility, OSM #1 stated, "I came the end of May 2017 and they are scheduled to come on 3/22/18. I just found out today that I am handling the dental part. I have not been handling that before. " An interview was conducted with other staff member (OSM) #2, the account receivable staff member, on 3/8/18 at 1:38 p.m. When asked if she had any invoices for Resident #30 to receive dentures, OSM #2 stated she had no invoices for Resident #30 to have dentures. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, 178. 3. The facility staff failed to arrange for and ensure dental services were provided to Resident #41. Resident #41 was admitted to the facility on 6/21/16 with diagnoses that included but were not limited to Parkinson's disease, high blood pressure and fractured hip. Review of the most recent MDS (minimum data	F 791		

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F 791	Continued From page 169 set), a 30 day assessment, with an ARD (assessment reference date) of 1/17/18 coded the resident as having scored a six 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 except for eating which the resident could perform after the tray was set up. During an interview conducted on 3/6/18 at 11:12 a.m. with Resident #41, Resident #41 stated, "They ordered dentures over a year ago and I have not received them yet." When asked if she had difficulty eating, Resident #41 stated, "Well sometimes the turkey's a little tough." Review of the resident's comprehensive care plan initiated on 3/6/18, the day the survey begun documented, "Focus. Care deficit pertaining to the teeth or oral cavity characterized by; altered oral mucous membrane; problems with dentures/teeth/gums or other oral dental health problems related to: edentulous. Interventions. Coordinate arrangements for dental care as needed." The care plan failed to address/document the resident had been waiting and or was in need of dentures. An interview was conducted on 3/7/18 at 12:53 p.m. with OSM (other staff member) #1, the social worker. When asked how obtaining dentures was handled at the facility, OSM #1 stated, "We go through (name of dental company). They come out to see the patients." When asked if the dental company fits the residents for dentures, OSM #1 stated they did. OSM #1 was asked the date of the last time the dental company was at the facility. OSM #1	F 791		

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F 791	Continued From page 170	F 791		

stated, "Before I came. I came in the end of May 2017. They're coming on March 22, 2018. I just found out today that I am handling the dental part. I have not been handling that before. I have two residents that have told us that they removed teeth last year and nothing has been done to get them dentures."

An interview was conducted on 3/7/18 at 1:01 p.m. with ASM #2, the director of nursing. When asked how dental concerns were managed, ASM #2 stated, "We have just signed a new contract with a new dental provider that comes to the facility, in their own mobile unit." When asked when was the last time the facility had dental services available to residents, ASM #2 stated, "I don't know, I would have to check to see when they were last here. With our last provider supposedly she bought this company out, they came with a mobile unit and saw some residents, supposedly there was some conflict, some dentures had been made and she was holding them hostage. We contacted our regional and they were contracted with a new provider. They are coming soon with some new dentures." ASM #2 was asked to provide any documentation that relates to the dentist coming to see Resident #41.

On 3/7/18 at 1:53 p.m., a copy of dental progress note for Resident #41 was received. Review of the note documented, "6/28/17. Treatment Notes: Pt (patient) presents today for post op (operative) exam and possible impressions F/F (full dentures). Will deliver next visit. Treatment Plan Notes: Deliver F/F."

On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the

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WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(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 791	Continued From page 171 findings.No further information was provided prior to exit.	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to store food in a sanitary manner for one of one kitchens and failed to serve food in a sanitary manner for two of three dining rooms. 1. The facility staff failed to discard leftover pureed pot roast when expired. 2. The facility staff failed to serve food in a sanitary manner in the Peach Haven dining room. While taking plates from the tray, to serve to	F 812	F-812 The out of date, leftover, pureed pot roast was thrown away. C.N.A #1 was re-educated regarding the proper handling and delivery of food to residents in the dining room. C.N.A #2 was re-educated regarding the proper and sanitary assisting of Resident #9's breakfast tray and juice cup. An observation audit was completed by the FSM No other observations / instances of outdated food or inappropriate food delivery were Observed. Dietary staff were in-serviced by the Food Service Manager regarding the policy for dating and discarding leftovers. Nursing personnel were in-serviced by the SDC regarding proper technique for delivery of trays and liquids.	4/21/18

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F 812	Continued From page 172 residents' CNA (certified nursing assistant) #1 was observed placing her thumb directly on the top surface of the plate around the rim of the plate. 3. The facility staff failed to assist Resident #9 with her breakfast in a sanitary manner during the dining observation in the Paradise dining room. CNA (certified nursing assistant) #2 was observed grabbing Resident #9's cup of juice by placing her bare fingers along the top of the cup. CNA #2 then brought the cup to the resident's mouth, and Resident #9 took a sip. The findings include: 1. Observation was made of the kitchen on 3/6/18 at 7:00 a.m. The refrigerator was observed. There was a bowl with a label that documented it was ground puree pot roast. The label contained a date of 2/27/18. A second observation was made on 3/6/18 at 7:30 a.m. accompanied by other staff member (OSM) #6, the dietary manager. When shown the puree pot roast dated 2/27/18, OSM #6 stated, "That should have been tossed." When asked what day it should have been disposed of, OSM #6 stated, "It should have been thrown away on 3/4/18." The facility policy, "Use and Storage of Leftovers" documented in part, "The maximum length of time a food may be kept is shown on the following chart." The chart documented, "Food Category: Meats, salads, or any food containing vegetables, soups containing potentially hazardous foods - 5 days if maintained at 41 degrees or below."	F 812	The Dietary manager or her designee will observe examine the kitchen for outdated food items and discard items properly. Administrative staff will observe meal service at least three times per week to ensure compliance with proper food delivery and sanitation practices. A record of observation will be kept in the Director of nurses Office and reviewed by the facility's QA Committee on a monthly basis.	

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F 812	Continued From page 173	F 812		

The administrator and the director of nursing were made aware of the above findings on3/7/18 at 4:58 p.m.

No further information was obtained prior to exit.

2. The facility staff failed to serve food in a sanitary manner in the Peach Haven dining room. While taking plates from the tray, to serve to residents' CNA (certified nursing assistant) #1 was observed placing her thumb directly on the top surface of the plate around the rim of the plate.

Observation was made of the Peach Haven dining room on 3/6/18 at 8:05 a.m. CNA (certified nursing assistant) #1 was observed serving several residents their breakfast. CNA #1 took the plates off the trays to place them in front of the resident. While taking plates from the tray, CNA #1 placed her thumb on the top surface of the plate around the rim of the plate.

An interview was conducted with CNA #1 on 3/7/18 at 3:01 p.m. CNA #1 was asked to demonstrate how she holds a plate when serving a resident. CNA #1 demonstrated holding a plate with both of her thumbs on the top surface of the plate. When asked if she should be touching the surface of the plate where the resident's food is, CNA #1 stated, "Probably not."

The facility policy, "Food, Serving" does not address how to hold a plate when serving residents.

The administrator and the director of nursing were made aware of the above findings on 3/7/18

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F 812	Continued From page 174 at 4:58 p.m. No further information was obtained prior to exit. 3. The facility staff failed to assist Resident #9 with her breakfast in a sanitary manner during the dining observation in the Paradise dining room. CNA (certified nursing assistant) #2 was observed grabbing Resident #9's cup of juice by placing her bare fingers along the top of the cup. CNA #2 then brought the cup to the resident's mouth, and Resident #9 took a sip. Resident #9 was admitted to the facility on 6/14/17 and readmitted on 8/19/17 with diagnoses that included but were not limited to dementia without behavioral disturbance, anxiety disorder, type two diabetes, major depressive disorder, high blood pressure, chronic ischemic heart disease, COPD (chronic obstructive pulmonary disease), and stroke. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/13/17. Resident #9 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as requiring extensive assistance with one staff member for most ADLS (activities of daily living). On 3/6/18 at 8:23 a.m., observation of the Paradise dining room (feeding assistance dining) was conducted. On 3/6/18 at 8:25 a.m., CNA (certified nursing assistant) #2 was observed assisting Resident #9 with her breakfast. CNA #2 was observed grabbing Resident #9's cup of juice by placing her bare fingers along the top of the cup. CNA #2 then brought the cup to the resident's mouth, and Resident #9 took a sip.	F 812		

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F 812	Continued From page 175 On 3/7/18 at 3:13 p.m., an interview was conducted with CNA #2. When asked how CNA #2 should grab a resident's cup who needs feeding assistance, CNA #2 stated that she would wash her hands prior to assisting the resident. CNA #2 stated that she would hold around the bottom of the cup and help the resident bring the cup up to her mouth. When asked why she would not touch the top rim of the cup, CNA #2 stated, "That is germs." When CNA #2 was informed of the above observation made in dining by this writer, CNA #2 stated, "Did, I do that? I'm sorry." On 3/7/18 at 4:58 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.	F 812	F-838 The Facility Assessment will be updated to maintain compliance with the regulation. The IDT will collaborate on the facility Assessment to include all required facets of a comprehensive and acceptable plan and will conduct a review of the plan at least annually. After completion and adoption the Facility assessment will be reviewed with staff and current copies will be placed in different locations throughout the building. The facility assessment will be approved by the facility's QA Committee on an annual basis	4/21/18
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to,	F 838		

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F 838	Continued From page 176 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.	F 838		

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F 838	Continued From page 177 §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that facility staff failed to have a complete facility assessment. The facility staff failed to conduct a facility-wide assessment utilizing an "all hazards approach" to determine resources necessary to care for its residents during day-to day operations and emergencies. The findings include: On 3/8/18 at 12:00 p.m., review of the facility's assessment was conducted. The facility assessment failed to address all elements of the facility's resident population, more specifically any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility including but not limited to, activities and food and nutrition services. The facility assessment also failed to address all of the facility's resources including all equipment (medical and non-medical), all buildings and other structures; and failed to address contracts, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. On 3/8/18 at 12:40 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that he presented what the facility had before he	F 838		

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F 838	Continued From page 178 arrived in the building in February. ASM #1 stated that the facility assessment was not complete. ASM #1 stated that he needed to put a team together to work on the facility assessment. No further information was presented prior to exit.	F 838		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a contract for dental services for three of 28 residents in the survey sample. 1. The facility staff failed to maintain a contract to	F 840	F-840 The facility has obtained a contract to provide Dental services for Resident #18, #30, and #41. Other residents requiring Dental Services were identified and services were provided as needed. The facility administrator negotiated a dental Services contract and services were provided to residents on or about March 22, 2018. The Contract for Dental services will be reviewed and renewed on an annual basis.	4/21/18

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F 840	Continued From page 179 ensure dental services were provided for Resident #18. Resident #18 has been waiting since June 2017 for his set of dentures. 2. The facility staff failed to maintain a contract to ensure dental services were provided for Resident #30. Resident #30 has been waiting since June 2017 to have his teeth removed and measured for dentures. 3. The facility staff failed to maintain a contract to ensure dental services were provided for Resident #41. Resident #41 has been waiting since June 2017 to receive her dentures that were already made and not delivered. The findings include: 1. The facility staff failed to maintain a contract to ensure dental services were provided for Resident #18. Resident #18 has been waiting since June 2017 for his set of dentures. Resident #18 was admitted to the facility on 9/29/14 with diagnoses that included but were not limited to: stroke, contractures, depression, elevated cholesterol and high blood pressure. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/28/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he is capable of making daily cognitive decisions. The resident was coded as requiring supervision to limited assistance for his activities of daily living. In Section K - Swallowing/Nutritional Status the resident was coded as not having any dental	F 840		

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F 840	Continued From page 180 concerns. The documentation from the Mobile Dental Unit dated 4/21/17, documented in part, "TX (treatment): Exam, Full mouth extractions." The documentation from the Mobile Dental Unit dated 6/28/17, documented in part, "TX: (treatment) Post - Op (operative) Possible impressions F/F (full set of dentures)." An interview was conducted with Resident #18 on 3/6/18 at 9:13 a.m. Resident stated, "Something happened I never got my dentures. They pulled all of his teeth with a promise to get me dentures." 2. The facility staff failed to maintain a contract for dental services for Resident #30. Resident #30 has been waiting since June 2017 to have his teeth removed and measured for dentures. Resident #30 was admitted to the facility on 3/28/12 with diagnoses that included but were not limited to: dementia, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), anxiety disorder, and dysphasia (a condition in which swallowing is difficult or painful) (2). The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 1/31/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The documentation from the Mobile Dental Unit,	F 840		

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F 840	Continued From page 181 dated 6/28/17, documented in part, "Needs extraction of teeth as charted. After extractions, pt (Patient) is a candidate for F/P (fitting for partial dentures)." An interview was conducted with Resident #30 on 3/6/18 at 10:20 a.m. The resident stated, "They came last year and cleaned my teeth but were supposed to come back and pull teeth and fit me for dentures. I want to eat pork chops and corn. They never came back." (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, 178. 3. The facility staff failed to maintain a contract for dental services for Resident #41. Resident #41 has been waiting since June to receive her dentures that were already made and not delivered. Resident #41 was admitted to the facility on 6/21/16 with diagnoses that included but were not limited to: Parkinson's disease, high blood pressure and fractured hip. Review of the most recent MDS (minimum data set) dated 1/17/18, a 30 day assessment, with an ARD (assessment reference date) of 1/17/18 coded the resident as having a six 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 except for eating which the resident could perform after the tray was set up.	F 840		

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F 840	Continued From page 182 The documentation from the Mobile Dental Unit, dated 4/21/17, documented, "TX (treatment): Exam, Extraction." The documentation from the Mobile Dental Unit, dated, 6/28/18, documented, "TX: Post-Op (operative), Possible F/F (full set of dentures) impressions." An interview was conducted with other staff member (OSM) #1, the social worker/ admission/discharge planner, on 3/7/18 at 12:53 p.m. When asked how a resident obtains dentures while at the facility, OSM #1 stated, "We go through (name of mobile dental company). They come out and see the residents." When asked if they fit residents' for dentures, OSM #1 stated, "Yes." When asked the last time the dental unit was at the facility, OSM #1 stated, "I came the end of May 2017 and they are scheduled to come on 3/22/18. I just found out today that I am handling the dental part. I have not been handling that before. " An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/7/18 at 1:01 p.m. When asked how dental concerns are handled in the facility, ASM #2 stated, "We have just signed a new contract with a new dental provider that comes to the facility." When asked when the last time dental services were provided to residents at the facility, ASM #2 stated, "I don't know, I would have to check to see when they were last here. Our last provider supposedly bought out the company and came out and they saw some residents. There was a conflict and some resident's dentures are being held hostage."	F 840		

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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 OATE
F 840	Continued From page 183 An interview was conducted with OSM #2, the accounts receivable, on 3/8/18 at 3:39 p.m. When asked how long the facility has been without a dental contract, OSM #2 stated, "I really don't want to say. The last visit they made was on 6/28/17. I'm not sure that's when the contract ended but services have not been provided since then and the new contract was signed 2/22/18." A request for a policy was made of ASM #2 on 3/9/18 at approximately 10:00 a.m. ASM #2 returned to this surveyor at 11:00 a.m. and stated they did not have a policy on obtaining outside resources contracts. The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit.	F 840	F-880 The Facility's Infection Control policy and procedure has been Reviewed and Accepted. The program for Legionella has been implemented. Residents #9, #12, #20, #45, #5, #8, and #13 have been assessed and have been found to be unaffected by the deficient practice. Every resident has the possibility of being affected by failure to follow the infection control policy and procedure as well as the legionella Program.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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,	F 880		

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F 880	Continued From page 184 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	In-services for facility personnel have been conducted to re-inforce the tenets of the Infection Control program. Education on the legionella program will be conducted for staff. New employees will receive education on both programs as part of their orientation. The infection Control program will be monitored by the Infection Control Nurse. The Legionella Program will be monitored by the Maintenance Director. Reports of compliance and education will be submitted to and monitored by the Facility's QA Committee.	4/21/18

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F 880	Continued From page 185 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to have a complete legionella program; and failed to follow infection control practices for seven of 28 residents in the survey sample, Resident #9, #12, #20, #45, #5, #8, and #13. 1. The facility failed to have a complete Legionella program. 2. The facility staff failed to maintain infection control practices and ensure Resident #9's oxygen tubing was not in contact with the floor. Resident #9's oxygen tubing dated 3-5, was observed hanging from the concentrator with most of the tubing touching the floor. At 7:24 a.m., a nursing aide (CNA [certified nursing assistant]) #2 was observed placing the nasal cannula and tubing that had been on the floor back on the resident. 3. The facility staff failed to maintain infection control practices and store Resident #12's nebulizer mask in a plastic bag when not in use. 4. The facility staff failed to assist Resident #20	F 880		

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F 880	Continued From page 186 with meals in a sanitary manner while in the resident's room. 5. The facility staff failed to maintain infection control practices during Resident #45's stage four wound dressing change. ASM (administrative staff member) #3, the ADON (Assistant Director of Nursing) was observed touching gauze used for cleaning and dressing Resident #45's wound with his bare hands and also used gloves to perform wound care that he took from the glove box and stuffed into his coat pocket. 6. The facility staff failed to follow infection control practices during the administration of a treatment for Resident #5 7. The facility staff failed to follow infection control practices in the administration of a tube feeding for Resident #8. 8. The facility staff failed to follow infection control practices during the wound care observation on Resident #13. LPN (licensed practical nurse) #4, failed to change gloves before providing wound care to Resident #13 after touch multiple items, the bed controls, side rail, sheets and the resident with her gloved hands. The findings include: 1. The facility failed to have a complete Legionella program. On 3/7/18 at approximately 11:00 a.m., review of the Legionella program was conducted with ASM (administrative staff member) #1, the administrator. Water temperature sheets dated	F 880		

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F 880	Continued From page 187 11-30-17, 12-7-17, 1-3-18 and 2-12-18 were presented documenting water temperatures of the facility kitchen's sinks on the cold and hot side, temperature of the water heater, holding tank, and chlorine level. Rooms on units A, B, and C were also tested for water temperature. Rooms numbers were not identified. On 3/7/18 at 11:14 a.m., an interview was conducted with ASM #1. ASM #1 stated that all he could find was some water temperature sheets. ASM #1 stated they did not have a program (for Legionella) and that he will get on it. On 3/7/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. 2. The facility staff failed to maintain infection control practices and ensure Resident #9's oxygen tubing was not in contact with the floor. Resident #9's oxygen tubing dated 3-5, was observed hanging from the concentrator with most of the tubing touching the floor. At 7:24 a.m., a nursing aide (CNA [certified nursing assistant]) #2 was observed placing the nasal cannula and tubing that had been on the floor back on the resident. Resident #9 was admitted to the facility on 6/14/17 and readmitted on 8/19/17 with diagnoses that included but were not limited to dementia without behavioral disturbance, anxiety disorder, type two diabetes, major depressive disorder, high blood pressure, chronic ischemic heart disease, COPD (chronic obstructive pulmonary disease), and stroke. Resident #9's	F 880		

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F 880	Continued From page 188	F 880		

most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/13/17. Resident #9 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as requiring extensive assistance with one staff member for most ADLS (activities of daily living).

Review of Resident #9's most recent POS (physician order sheet) dated 2/28/18 revealed the following order: "02 (oxygen) @ 3 L (liters)/min (minute) via N/C (nasal cannula) continuous."

On 3/6/18 at 7:23 a.m., an observation was made of Resident #9's room. Resident #9's 02 (oxygen) concentrator was sitting in the doorway of her room. Her oxygen tubing dated 3-5, was hanging from the concentrator. Most of the tubing was touching the floor. At 7:24 a.m., a nursing aide (CNA) #2 was coming down the hallway. CNA #2 stated she was putting soiled linen away from Resident #9's room and was coming back to bring the concentrator to the dining room where Resident #9 was sitting. This writer followed the CNA into the dining room where the resident was sitting. The aide placed the concentrator next to the resident, placed the nasal cannula back on the resident and turned the oxygen on. The oxygen went to up to 3 liters automatically.

On 3/7/18 at 3:13 p.m., an interview was conducted with CNA #2. When asked about the process followed if she were to see a resident's oxygen tubing on the floor, CNA #2 stated she could ask central supply for a new tubing or she

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F 880	Continued From page 189 could get a wipe and wipe it off. When asked if she could recall Resident #9's oxygen tubing on the floor on 3/6/18, CNA #2 stated, "I was not aware of that." When asked why she would change oxygen tubing if it had touched the floor, CNA #2 stated she would change the tubing because of the germs on the floor. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2 the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled "Oxygen therapy" documents in part, the following: "Discard masks, cannulas, and tubing, if disposable, between residents, or whenever it has become visibly soiled." No further information was presented prior to exit. 3. The facility staff failed to maintain infection control practices and store Resident #12's nebulizer mask in a plastic bag when not in use. Resident #12 was admitted to the facility on 12/6/14 and readmitted on 11/10/17 with diagnoses that included but were not limited to major depressive disorder, anxiety disorder, COPD (chronic obstructive pulmonary disease), and urinary retention. Resident #12's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 12/18/17. Resident #12 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring	F 880		

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F 880	Continued From page 190 extensive assistance from one staff member with bed mobility, and dressing; and total dependence on staff with toileting, personal hygiene, and bathing. Review of Resident #12's most recent POS (physician order sheet) revealed the following order: "Pulmicort [1] 0.5 mg/2 ml; premixed unit via nebulizer every night at bedtime for COPD. (Chronic Obstructive Pulmonary Disease)." On 3/6/18 at 9:08 a.m., 11:56 a.m., and 2:11 p.m., observations of Resident #12's nebulizer were conducted. His nebulizer mask dated 3/5, was observed lying on top of the nebulizer machine. It was not contained in a plastic bag. On 3/6/18 at approximately 2:11 p.m., an interview was conducted with Resident #12. When asked if he could take the mask off himself and place it on his bedside table, Resident #12 stated he needed help with everything and could not reach that far. Resident #12 stated the staff take off his mask at night when the treatment is finished. On 3/7/18 at 8:47 a.m., an observation of Resident #12's nebulizer was conducted. The nebulizer mask was dated 3/7, indicating that it had just been changed that morning. The mask was sitting on top of the nebulizer machine not in a plastic bag. On 3/7/18 at 8:53 a.m., an interview was conducted with LPN (licensed practical nurse) #1, Resident #12's nurse. When asked how a nebulizer mask should be stored when not in use, LPN #1 stated a nebulizer mask should be stored in a plastic bag to maintain infection control. LPN	F 880		

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F 880	Continued From page 191 #1 followed this writer to Resident #12's room. When asked what she observed about Resident #12's nebulizer, LPN #1 stated it was not in a plastic bag. LPN #1 took the mask and placed it in the plastic bag next to the mask. When asked if Resident #12 takes off his nebulizer mask himself, LPN #1 stated that he could not do that. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2 the DON (Director of Nursing) were made aware of the above concerns. [1] Pulmicort nebulizer is an inhaled corticosteroid used for the management of asthma. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4f339e84-33be-44d1-bbae-e0579da12c7f. 4. For Resident #20, facility staff failed to assist with meals in a sanitary manner while in the resident's room. Resident #20 was admitted to the facility on 11/2/15 with diagnoses that included but were not limited to compression fracture of the first lumbar vertebra, difficulty in walking, muscle weakness, type two diabetes, dementia without behavioral disturbance, Alzheimer's disease, heart failure, altered mental status, and difficulty swallowing. Resident #20's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 1/2/18. Resident #20 was coded as being severely impaired in cognitive function scoring a three on	F 880		

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F 880	Continued From page 192 the Staff Assessment for Mental Status exam. Resident #20 was coded as being totally dependent on staff for most ADLS (activities of daily living). On 3/6/18 at 8:56 a.m., an observation was conducted of Resident #20. A nursing aide (CNA (certified nursing assistant) #4 was observed assisting Resident #20 with her breakfast. CNA #4 was observed holding toast with her bare hands and feeding it to Resident #20. On 3/7/18 at approximately 3:00 p.m., an interview was conducted with CNA #4. When asked how she would maintain infection control while feeding a resident, CNA #4 stated she would first wash her hands before she assists with the meals. When asked how she would handle toast that needs to be fed to a resident, CNA #4 stated she would break the toast into pieces using a fork and then use the fork to give to the toast to the resident. When asked if this is what she did with Resident #20 on 3/6/18, CNA #4 stated she had made a mistake that morning. When asked why it was important for staff not to touch resident's food with their bare hands, CNA #4 stated that germs from her hands would go to the resident's mouth. On 3/7/18 at 4:58 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. A policy could not be provide regarding the above concerns.	F 880		

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F 880	Continued From page 193 5. The facility staff failed to maintain infection control practices during Resident #45's stage four wound dressing change. ASM (administrative staff member) #3, the ADON (Assistant Director of Nursing) was observed touching gauze used for cleaning and dressing Resident #45's wound with his bare hands and also used gloves to perform wound care that he took from the glove box and stuffed into his coat pocket. Resident #45 was admitted to the facility on 2/5/18 with diagnoses that included but were not limited to Stage 4 pressure ulcer [1], sepsis, high blood pressure, muscle weakness and retention of urine. Resident #45's most recent MDS (minimum data set) assessment was a 14-day scheduled assessment with an ARD (assessment reference date) of 2/18/18. Resident #45 was coded as being moderately impaired in cognitive function scoring a 9 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #45 was coded as requiring extensive assistance from two staff members with transfers and bed mobility; extensive assistance from one staff member with dressing, and personal hygiene and total dependence on staff with bathing. Resident #45 was coded in section M (Skin Conditions) of the MDS assessment, as having a Stage 4 pressure ulcer that was present upon admission. Review of Resident #45's most recent wound care orders documented the following order dated 2/5/18: "Cleanse Wound to sacral decubitus twice daily with sterile saline. Apply santyl ointment [2] in the wound twice daily after cleanse. Then apply wet to dry dressing packing saline with saline gauze. Then cover with ABD (abdominal)	F 880		

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F 880	Continued From page 194 pads." On 3/8/18 at 10:58 a.m., a wound care observation was conducted with ASM #3 the ADON (Assistant Director of Nursing). ASM #3 first took a wad of gloves from the glove box and stuffed them in his coat pocket. ASM #3 then with his bare hands, reached into the gauze package, taking out a stack of gauze. ASM #3 then placed the gauze onto the medication cart directly on top of the opened TAR (treatment administration record). On 3/8/18 at 11:05 a.m., ASM #3 carried the stack of gauze and santyl with his bare hands and placed them onto the clean field in the resident's room. On 3/08/18 at 11:11 a.m., ASM #3 put on gloves (from his pocket) and cleaned his scissors with an alcohol swap. On 03/08/18 at 11:15 a.m., ASM #3 took all the gloves from his pocket and put them on the clean field. He then placed gloves on and began to remove the old dressing. ASM #3 then washed his hands and put on gloves that were part of his wad of gloves. At 11:16 a.m., ASM #3 used the gauze that he had touched with his bare hands to clean the wound along with normal saline. ASM #3 then washed his hands and placed on gloves. ASM #3 then took a Q-tip of santyl and rubbed it on an excoriated area around the wound first; and then moved into the center of the wound bed using the same Q-tip. ASM #3 then threw out the Q-tip and removed his gloves, washed his hands, and went out of the resident's room to grab additional gloves. On 3/8/18 at 11:20 a.m., ASM #3 put on clean gloves and then packed Resident #45's wound with the saline-soaked gauze. This gauze was part of the stack that ASM #3 had touched with his bare hands. ASM #3 then placed the ABD (abdominal pad) over the wound and secured the dressing.	F 880		

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F 880	Continued From page 195 On 3/8/18 at 1:33 p.m., an interview was conducted with ASM #3. When asked how to maintain infection control during wound care, ASM #3 stated that he would wash hands and remove gloves after he removed the old dressing and started to clean the wound. ASM #3 stated he would wash his hands again and put on new gloves before applying the clean (new) dressing. When asked if he currently has any items in his pocket, ASM #3 stated no. When asked if gloves he was going to use for a dressing change should ever be placed in his pocket; ASM #3 stated that his pocket was clean because he washed his coat the night before. ASM #3 then stated he was wearing a new jacket. ASM #3 did state he made a mistake grabbing the gauze from the package with his bare hands and putting it on the TAR. When asked if it was ok to apply santyl to the outside of the wound and then move into the wound bed using the same Q tip; ASM #3 stated it wouldn't matter because the santyl was not used to clean the wound. On 3/8/18 at 5:12 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled "Dressing-Clean" documented in part the following: "Equipment and Supplies: Clean dressing instruments, clean gloves." [1] A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually	F 880		

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F 880	Continued From page 196 from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. Stage IV Pressure Ulcer Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. [2] *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>) 6. The facility staff failed to follow infection control practices during the administration of a treatment for Resident #5.	F 880		

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F 880	Continued From page 197 Resident #5 was admitted to the facility on 5/21/15 with a recent readmission on 2/25/18, with diagnoses that included but were not limited to: cancer of the left lung, dementia, alcohol abuse, Alzheimer's disease, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (1), absence of toes on left foot due to amputation. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/19/18, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. In Section M - Skin Conditions, the resident was not coded as having a pressure ulcer. A significant change assessment was in progress at the time of survey. Observation was made of LPN #4 performing the wound care for Resident #5's left foot on 3/7/18 at 2:04 p.m. LPN #4 gathered her supplies. She pulled her scissors out of her pocket and put them on her clean field. She cut the bandage that was on Resident #5's left foot wound off with her scissors and removed the old dressing that was dated 3/5/18. LPN #4 proceeded to wipe the wound with the Hibiclens liquid. She wiped from the inside out and then went down the sides of the wound and back to the center of the wound. The second time she wiped the wound she went from the center out and discarded her gauze pad. LPN #4 proceeded to administer the treatment to the wound. She then went on to administer the treatment to the resident's left buttock. She had taken off the dressing left buttock wound and	F 880		

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F 880	Continued From page 198	F 880		

cleaned the wound per the physician order. LPN #4 proceeded to measure the wound, 1.0 x .7 cm (centimeters). She stated that the wound was a stage 3 pressure ulcer*. When asked why it was a stage three LPN #4 stated there was now slough in the wound. She then washed her hands, put on new gloves. She took the pen, which was clipped to the neck opening of her scrubs, and wrote down the measurements. LPN #4 then proceeded to apply the physician prescribed dressing. LPN #4 proceeded to wash her hands and her scissors with soap and water. When asked the preferred method of cleaning scissors used for a dressing change, LPN #4 stated, "I guess it really should be alcohol." When asked if she was trained to be the treatment nurse, LPN #4 stated, "A while back, I oriented with the previous treatment nurse but then they hired another nurse but she's now doing MDS assessments."

*Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury. (1)

An interview was conducted with LPN #4 on 3/7/18 at 2:28 p.m. When asked how a nurse should clean a wound, LPN #4 stated, "You start from the inside out, then you discard the dirty gauze." The above observation of her cleansing

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F 880	Continued From page 199 the wound was shared with LPN #4. When asked when scissors should be cleaned, LPN #4 stated, "After we use them." When asked what was in her pocket, LPN #4 stated, "Pens." She paused and then stated, "I should wash them before the treatment." When asked what is preferred, soap and water versus alcohol, LPN #4 stated, "It's probably be alcohol." The facility policy, "DRESSINGS - CLEAN" documented in part, "8. Cleanse wound. When cleaning an area, clean from the inside out." If cleaning is needed again, then use another clean 4 x 4 (gauze pad). NEVER reuse the same one." "When cleaning, be sure to move from the least-contaminated area to the most-contaminated area. For a linear shaped wound, such as an incision, gently wipe from top to bottom in one motion, starting directly over the wound and moving outward. For an open wound, such as a pressure ulcer, gently wipe in concentric circles, again starting directly over the wound and moving outward. Us a separate gauze pad each time the wound is cleaned. Discard the gauze pad for each wiping motion; repeat the procedure until you've cleaned the entire wound. Dry the wound with 4" X 4" gauze pads, using the same procedure as for cleaning. Discard the used gauze pads in the plastic bag." (2) In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick. In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as	F 880		

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F 880	Continued From page 200 well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol. (3) The administrator and director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Fundamentals of Nursing Made Incredibly Easy, Lippincott, Williams & Wilkins, 2007, page 428. (3) Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000. 7. The facility staff failed to follow infection control practices in the administration of a tube feeding for Resident #8.	F 880		

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F 880	Continued From page 201 Resident #8 was admitted to the facility on 12/11/12 with a recent readmission on 11/6/17, with diagnoses that included but were not limited to: Alzheimer's disease, mood disorder, anxiety disorder, diabetes, stroke, high blood pressure, and history of subdural hematoma (a collection of blood beneath dura mater in the brain) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/7/17, coded the resident as having both short and long term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #8 was coded as being dependent upon one or more staff members for all of her activities of daily living. In Section K - Swallowing/Nutritional Status, the resident was coded as receiving all of her nutrition through a feeding tube. Observation was made of Resident #8's room on 3/8/18 at 8:45 a.m. The resident was not in the room. The tube feeding was hanging on the pole next to the bed. The end of the tubing, the part that connects to the resident, was not visible to this surveyor. An interview was conducted with CNA (certified nursing assistant) #3 on 3/8/18 at 8:49 a.m. When asked where Resident #8 was, CNA #3 stated she had just put her up by the nurse's station. When asked who disconnected the tube feeding from the resident, CNA #3 stated, "I did." When asked why she did it, CNA #3 stated, "The nurses show us how to do it." When asked if she had been trained in school to take care of a feeding tube, CNA #3 stated, "No, Ma'am." CNA #3 was asked where the end of the tubing was,	F 880		

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F 880	Continued From page 202 CNA #3 pulled the tubing out from under the covers. When asked why it is not good to have the tubing uncovered in the bed, CNA #3 stated, "It's an infection control issue." There was an odor of a bowel movement in the room, when asked about the odor, CNA #3 stated, "I just cleaned up (Resident #8) from having a BM (bowel movement)." CNA #3 was asked why the tubing for the tube feeding being found in the covers was a concern; CNA #3 stated it was an infection control issue. An interview was conducted with LPN (licensed practical nurse) #2 on 3/8/18 at 8:52 a.m. When asked if a CNA is allowed to disconnect a tube feeding, LPN #2 stated, "Never. They are never to touch a tube feeding." The above observation was shared with LPN #2, who then proceeded to change the entire set up of tube feeding. The physician order dated, 11/7/18, documented, "Diabetisource (nutritional replacement for food specific for diabetic residents) (2) @ (at) 40 ml/hr (milliliters per hour) via Peg tube (a feeding tube inserted through the abdominal wall). The comprehensive care plan dated, 10/30/16 and revised on 12/19/17, documented in part, "Focus: At risk for state of nourishment: less than body requirement characterized by inadequate intake, decreased appetite related to: being on a therapeutic diets, cognitive impairment depression." The "Interventions" documented in part, "Diet as ordered (Diabetisource @ 40cc per hour via peg tube." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/18 at 12:35 p.m. When asked if a CNA can	F 880		

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F 880	Continued From page 203 disconnect a resident from a tube feeding, ASM #2 stated, "No." The facility policy, "Gastrostomy Tube Feeding - Enteral Nutrition Pump" did not address infection control practices and did not document what to do with the end of the tubing when it was not in use. The administrator and the director of nursing were made aware of the above findings on 3/8/18 at 5:10 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 265 and 549. (2) This information was obtained from the following website: https://www.allegromedical.com/dietary-supplements-c522/enteral-feeding-diabetisource-xff8081812f688a20012f6abe767b4d0c$4050.html https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4f339e84-33be-44d1-bbae-e0579da12c7f. 8. The facility staff failed to follow infection control practices during the wound care observation on Resident #13. LPN (licensed practical nurse) #4, failed to change gloves before providing wound care to Resident #13 after touch multiple items, the bed controls, side rail, sheets and the resident with her gloved hands. Resident #13 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to: left mastectomy, difficulty swallowing, depression, anemia and Alzheimer's disease. The most recent MDS (minimum data set), a	F 880		

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F 880	Continued From page 204 quarterly assessment, with an ARD (assessment reference date) of 12/20/17 coded the resident as having scored a three 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. Review of the care plan initiated on 1/24/18 documented, "Focus. At Risk for skin breakdown or development of further pressure ulcers related to: High risk for pressure ulcer immobility (Stage II to coccyx) [1]." Review of the March 2018 physician's orders documented, "TX (treatment): CLEANSE COCCYX W/NS (with normal saline). APPLY AQUACEL (2) AND ALLEVYN FOAM (3) DRSG (dressing) QD (everyday) and PRN (as needed)." Review of the March 2018 medication administration record documented, "TX (treatment): CLEANSE COCCYX W/NS (with normal saline). APPLY AQUACEL (2) AND ALLEVYN FOAM (3) DRSG (dressing) QD (everyday) and PRN (as needed)." A wound care observation was conducted on 3/7/18 at 10:20 a.m. with LPN (licensed practical nurse) #4, the treatment nurse. LPN #4 put a protective cover on the resident's bedside table and placed the wound care supplies on it, opened the dressing and labeled it and then washed her hands. LPN #4 then put on a pair of gloves. She raised the height of the bed and lowered the resident's head using the bed controller. LPN #4 lowered the bed railing pulled the resident's sheet down. She turned the resident onto her left side, removed the resident's brief and washed the	F 880		

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F 880	Continued From page 205 wound with normal saline soaked gauzes that she took from her wound supplies on the resident's over bed table. LPN #4 did not wash her hands or change gloves after touching the resident's bed controls, sheets and resident prior to providing care to the pressure ulcer. The pressure ulcer was 4.5 cm (centimeters) by 1.5 cm and was partially covered with slough (4). An interview was conducted on 3/7/18 at 2:32 p.m. with LPN #4. When asked when staff changed gloves during wound care, LPN #4 stated, "After you take the dirty dressing off." The above wound care observation was reviewed with LPN #4. LPN #4 stated, "I should have changed the gloves." When asked why the gloves should be changed, LPN #4 stated, "Because I touched all those things. Because they probably had all those little microorganisms all over them." On 3/8/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, WOUND CARE/ULCER TREATMENT" did not evidence documentation regarding handwashing during wound care. No further information was provided prior to exit. 1. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar	F 880		

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F 880	Continued From page 206 are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 2. Aquacel - A textile fiber dressing composed of sodium carboxymethylcellulose with potential wound-healing activity. Sodium carboxymethylcellulose dressing protects the wound site from external factors that may cause pain, promote infection, or slow the natural wound healing process. Sodium carboxymethylcellulose is a non-toxic, non-allergenic, anionic water-soluble polymer derived from cellulose. Check for active clinical trials using this agent. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-drug/def/sodium-carboxymethylcellulose-dressing 3. Allevyn - a hydrocellular foam dressing which is able to absorb 10 times its weight in exudate, providing a cost-effective treatment option for exuding, granulating wounds. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/7703644 4. Slough -1. Necrotic tissue in the process of separating from viable portions of the body. This information was obtained from: http://medical-dictionary.thefreedictionary.com/slo	F 880		

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