State of Virginia

PRINTED: 10/26/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495268	A. BUILDING ______ B. WING ______	10/19/2017

NAME OF PROVIDER OR SUPPLIER: WESTMORELAND REHABILITATION & HEALTHCAI

STREET ADDRESS, CITY, STATE, ZIP CODE: 2400 MCKINNEY BOULEVARD, COLONIAL BEACH, VA 22443

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 10/17/2017 through 10/19/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities.. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 66 certified bed facility was 50 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13, and #18) and 5 closed records (Residents #13 through #17).	F 000	Please See Federal Plan of Correction	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following cross referenced Virginia Rules and Regulations: 12VAC5-371-150 Resident Rights 12VAC5-371-150 (C,D,E)-Cross reference to F-156. 12VAC5-371-360 Clinical Records 12VAC5-371-360 (B)-Cross reference to F-164. 12VAC5-371-220 Nursing Services 12VAC5-371-220 (H)-Cross reference F-157. 12VAC5-371-110 (B.1-3, C)-Cross reference to F-203	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 10/27/17

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F 001	Continued From Page 1 12VAC5-371-110 Management and Administration 12VAC5-371-110 (B.1-3, C)-Cross reference to F-225. 12 VAC5-371-140 (A) Policies and Procedures 12VAC5-371-140-Cross reference to F-226. 12VAC5-371-200 Director of Nursing 12VAC5-371-200 (B)-Cross reference to F-281. 12VAC5-371-220 Nursing Services 12VAC5-371-220 (A, B)-Cross reference to F-309. 12VAC5-371-220 Nursing Services 12VAC5-371-220 (D)-Cross reference to F-323.	F 001		

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 10/17/2017 through 10/19/2017. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow. The census in this 66 certified bed facility was 50 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #12, and #18) and 5 closed records (Residents #13 through #17).	F 000	Westmoreland shares the state focus on the health, safety, and wellbeing of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, it has implemented its plan of correction to demonstrate its continuing efforts to provide quality care to its residents. Any area cited by the survey team is placed into our Quality Assurance and Process Improvement process and monitored through this system to assure compliance.	
F 156 SS=E	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156	F156 1. State Advocacy Agency Groups contract information and related signage was lowered to a level visible for all residents on 10/18/17 during the annual survey. The resident council was reconvened to discuss the signage and to ensure residents were made aware of the location as well as the correction made. 2. All residents have the potential to be affected by this alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE (X6) DATE 10/27/17

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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F 156	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 156	3. The facility will monitor signage level one time per week for two weeks on rounds to ensure signage remains in compliance. 4. Audits will be submitted to the Quality Assurance and Process Improvement Committee for review. 5. Date of Completion: 11/16/17	

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F 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

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F 156	Continued From page 3	F 156		

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and

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F 156	Continued From page 4	F 156		

regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to display State Agency Advocacy Group information at a level visible to residents.	F 156		

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F 156	Continued From page 6 The State Agency Advocacy Groups contact information was posted across from the nursing station, above standing eye level, which made it difficult for residents in wheelchairs to read. The findings included: On 10/18/17 at 2:00 p.m. a resident group meeting was conducted with 9 alert and verbal residents. When the group was asked by the inspector, "Do you know how to contact an advocacy agency such as the ombudsman office?" 2 of 9 residents stated they did not and 2 of 9 residents stated the sign was "too high, can't see." On 10/18/17 at 3:45 p.m. the Advocacy Groups contact information was observed hung on the wall across from the nursing station. The information sheet was above eye level and potentially difficult to see if a resident was in a wheelchair. On 10/18/17 at 4:30 p.m., the Administrator and Director of Nursing were informed of the observation and resident concerns of the Advocacy Group information being posted too high on the wall. On 10/19/17 at 8:30 a.m. the posting was observed lowered to a level readable at wheelchair level. No further information was provided by facility staff.	F 156		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes.	F 157	F157 1. The physician and responsible party for R#2 was notified of medication refusals on 10/31/2017.	

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F 157	Continued From page 7 (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 (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	F 157	2. Residents that refuse medication are at risk for this alleged deficient practice. 3. Licensed nurses will be re-educated on facility policies related to medication refusal and for physician notification and resident representative notification. The Director of Nursing or designee will weekly monitor/audit residents reported to have refused medication for appropriate notifications to MD and resident representative. 4. Audit results of medication refusals will be reported to the monthly QAPI meeting for three months 5. Date of Completion: 11/30/2017	

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F 157	Continued From page 8 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). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility failed to notify the Responsible party, and physician of Resident refusals to accept medications for one Resident (Resident #2), in the survey sample of 18 residents. For Resident #2, the facility staff failed to notify the physician, and responsible party of medication refusals. The findings included: Resident #2 was admitted to the facility on 6-9-14. Diagnoses for Resident #2 included; schizophrenia, atrial fibrillation, high cholesterol, hypertension, anemia, and hypothyroidism. Resident #2's most recent Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9-6-17, was a quarterly assessment, and coded Resident #2 with a brief interview for mental status (BIM's) score of unable, as the Resident was severely cognitively impaired. In addition, the Minimum Data Set coded Resident #2, as requiring total assistance of two staff members for all Activities of Daily Living care, such as bed mobility, toileting, and bathing. A review of Resident #2's clinical record was	F 157		

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F 157	Continued From page 9 conducted during the survey. The review revealed medication administration records (MAR's), physician progress notes, and nursing progress notes which revealed that during the months of September, and October 2017 the Resident had spit out medications regularly, and would at times refuse meals as well. During that period there was no indication that the Resident's responsible party, or physician, was ever made aware of the medication refusals, and no changes were made to the care plan for the medication refusals. Interviews with staff members who administered medications indicated that none of the day or evening staff on duty during survey, and working with the Resident during survey, had made calls to the family or doctor to notify them of these refusals. An interview was conducted with the Director of nursing and the Corporate Registered Nurse Consultant revealed that they could find no evidence that the family, or doctor was aware of the recent medication refusals. When asked where one could locate that information, They responded "that would be documented in the progress notes." Review of all clinical progress notes for all disciplines revealed that the physician had not been notified that the medications had not been administered. The facility administration was informed of the findings during an end of day briefing on 10-18-17, and 10-19-17. The facility did not present any further information about the findings.	F 157		

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F 164	Continued From page 10	F 164		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 164	F164 1. The picture displayed in public view for R#18 was removed from the location identified on 10/19/17 during the annual survey and placed in a confidential area. 2. Residents identified as an elopement risk are at risk for this alleged deficient practice. 3. Staff members from all departments will receive re-training on confidentiality and privacy. Photos of residents at risk for elopement have been placed in designated notebooks. The Social Worker will monitor adherence to resident privacy by weekly monitoring notification boards for the presence of confidential resident information.	

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	495268	A. BUILDING ______ B. WING ______	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

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F 164	Continued From page 11 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure private health information was kept confidential for 1 Resident (Resident #18) in a survey sample of 18 Residents. Resident #18's picture was placed on a bulletin board across from the nursing station, in the main hallway of the facility, and was notated as a "code green" Resident, next to the code green policy, alerting to elopement status. The findings included: Resident #18 was admitted to the facility on 6-7-17. Diagnoses included: dementia, acute kidney failure, repeated falls, hypothyroid, adult fail to thrive, cellulitis, fractured scapula, and ulna, and gout. Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8-16-17 was coded as a quarterly assessment. Resident #18 was coded as having no cognitive deficits, with a BIM's (brief interview for mental status) score of 14 of a possible 15 points scored, and required extensive to total assistance of 2 staff members for activities of daily living, with the exception of eating which only required set up help.	F 164	4. Residents identified as at risk for elopement will be reviewed weekly by the interdisciplinary risk committee for continued risk/need for alert bracelet. Results of the weekly audits completed by the Social Worker will be reported to the monthly QAPI meeting for 3 months. Date of Completion: 11/16/2017	

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F 164	Continued From page 12 On 10-18-17, at 9:00 a.m. during observations of the nursing unit, it was observed that this Resident's picture was placed on a bulletin board across from the nursing station, in the main hallway of the facility, and Resident #18 was notated as a "code green" Resident. Also on the bulletin board (next to Resident #18's picture) was a copy of the code green policy, alerting other residents, visitors, and vendors to Resident #18's elopement status. The Assistant Director of Nursing was sitting at the nursing station and was asked why the picture was there. She stated that was a code green resident. Review of Resident #18's clinical record revealed nursing progress notes that documented on 8-29-17, the Resident as having exit seeking behaviors, confusion and searching for family. A physician's order was obtained for a wandergard, and it was applied. On 8-30-17 results of a urine culture showed that the Resident had a urinary tract infection (UTI), and an antibiotic was ordered and administered. No further exit seeking behaviors had been noted, and on 10-10-17, with the cessation of the behaviors, the Resident was reassessed. The wandergard was felt to be no longer necessary, and was discontinued. Even though the wandergard had been removed, the Resident remained on the bulletin board as an elopement risk. This oversight is secondary to the fact that the Resident's clinical information was available for anyone visiting the facility to openly view. The Administrator stated during interview, that the	F 164		

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F 164	Continued From page 13 picture should have never been placed on the bulletin board denoting Resident #18 as an elopement risk, as it was a breach of the Health Insurance Portability and Accountability Act (HIPAA). The picture was removed immediately after the interview by staff. The administrator and Director of Nursing were made aware of the deficient practice at the end of day debrief on 10-17-17, and on 10-18-17. The facility presented no further information.	F 164		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (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. (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 (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or	F 203	F203 1. R#14 no longer resides in the facility. 2. Residents discharged from facility for non-emergent reasons have the potential to be affected by the alleged deficient practice. 3. The interdisciplinary team was educated on facility policy for discharge notification. The Social Worker will be responsible for ensuring residents and/or their representatives receive written notice of discharge or transfer by maintaining a log documenting completion of discharge activities.	

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F 203	Continued From page 14 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 (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (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 203	4. The Social Worker will present his discharge log to the monthly QAPI meeting for review. 5. Date of Completion: 11/14/17	

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F 203	Continued From page 15 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. (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. (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	F 203		

F 203 Continued From page 16 F 203

notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

This REQUIREMENT is not met as evidenced by:

Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed for one (Resident #14) of 18 residents in the survey sample, to provide written notice of discharge prior to transferring the resident to another facility.

There was documented evidence that Resident #14's Responsible Party (RP) was aware of impending discharge however, the facility failed to obtain a written signed discharge agreement prior to discharging Resident #14 to another facility.

The findings included:

Resident #14 was admitted to the facility on 7/22/17 with the diagnoses of, but not limited to dementia without behavioral disturbance, chronic viral hepatitis C, and diabetes mellitus type 2. Resident #14 was discharged to another facility on 8/4/17. Resident #14 was a new admission, therefore no Minimum Data Set (MDS) was due to be completed.

Resident #14 was no longer in the facility therefore a closed record review was conducted.

On 10/19/17 at 10:15 a.m Resident #14's clinical record was reviewed. The review revealed the

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following "Resident Progress Notes:"

7/22/17 2:08 p.m. "7-3. Resident new admission arrived to facility at 10:00 for LTC DX Alzheimer's (long term care-diagnosis-Alzheimer's). Resident arrived in facility with family, ambulating. Resident is pleasant with confusion...requires verbal cues and redirecting..."

7/22/17 6:41 p.m. "...Resident wondering (sic) throughout facility, ambulates self. wanderguard on and working."
A wanderguard can be described as a device worn like a bracelet that triggers an alarm when a resident goes near or opens an exit door. The wanderguard allows the resident to ambulate around the facility but alerts staff to a resident attempting to exit.

7/22/17 4:37 a.m. "Patient was directed to bed on this shift..."

7/23/17 12:49 p.m. "...Resident wandering all of shift, going through front door several times, with wander guard in place. Resident stating "I just want to go home." Resident redirected each time...Family at bedside this afternoon, aware of wandering..."

7/23/17 7:31 p.m. "...Resident ambulates self. has not set off door alarms at this time. wanderguard on and working. In activity room doing puzzles...activity room after supper playing games w/other resident, listening to music, nurse redirecting resident at all times...Visual monitoring amongst all staff on 3p 11p shift..."

7/24/17 12:37 p.m. "Resident up ambulating on own throughout facility with wander guard intact

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F 203	Continued From page 18 to RLE (right lower extremity)..."	F 203		

7/24/17 3:22 p.m. " (Resident Name) is up early and walking building. Resident enjoys talking about golf and bowling...has a wonder (sic) guard but still likes to go outside with other staff."

7/24/17 7:30 p.m. "Resident went out 300 hallway door alarm went off, nurse went running down 300 hallway. nurse able to redirect resident back inside. resident wanted to call his girlfriend, nurse let resident call girlfriend. Redirected resident in activity room w/puzzles..."

7/25/17 3:15 p.m. "...redirecting by several different people. Resident has packed up his room and put things back later after SS (social services) director spoke to him. Wander guard in place to lower extremity. Resident ambulating throughout facility on own..."

7/29/17 1:35 p.m. "Resident upset with roommate. Had packed his clothes and wanted to leave facility..."

8/1/17 9:10 a.m. "7-3. During morning med pass resident obtained scissors off of med cart while nurse stepped away briefly. During the nurse absence, resident cut wander guard from ankle. Upon nurses return, resident handed wander guard to nurse stating, "I removed this for you because I am checking out today." Nurse kept resident in residents room until a new wander guard could be applied to ankle. Resident closely monitored throughout shift. MD and RP (responsible party) notified."

8/1/17 9:32 a.m. "...Resident's care plan updated. Residents wanderguard checks increased to Q2

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(every 2) hours."

8/1/17 8:37 p.m. "Resident wanders around unit. Monitoring him every 2 hours to see where he is at and what he is doing. Cooperative. Returns to his room periodically at times. Wanderguard intact right ankle."

8/2/17 9:58 a.m. "SW (social worker) called RP to discuss the dangers of resident wondering (sic) around the unit. The RP requested valume (sic-valium), or another form of medication to restrain resident. SW explained that we do not do restraints at this facility. It was discussed that resident needs a lock down unit, and recommended places in Richmond or Northern Virginia. RP requested closer facility and stated to "get him out today."

8/3/17 1:58 p.m. "7-3. Resident continuing to be monitored for wandering. Wander guard bracelet present and intact to right ankle...asked frequently for scissors or a knife to cut his bracelet. Resident kept asking to go home..."

8/3/17 2:30 p.m. "Dr. (Name) to unit at this time. MD made aware that resident is exhibiting increased wandering behavior. MD made aware that residents family member requesting that resident have medication to help decrease wandering behavior and "relax" resident. No new orders received at this time.

8/3/17 3:50 p.m. "Alarm to 300 hallway alerted at this time. Resident outside of building at this time. Residents primary nurse with resident. Resident refusing to reenter building at this time. Resident states that he "wants to go home" Attempting to redirect resident back into facility at

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this time. Resident agitated. Resident swinging arms in aggression. Resident states that he "does not want to come back inside. We cant make him do anything he doesn't want to do..." (note that Director of Nursing, social worker, administrator and police department were notified)...Resident continues to refuse to reenter facility. Will continue to sit with resident.

8/3/17 4:25 p.m. "Residents nephew/RP calling facility at this time. Resident agrees to reenter facility to talk to nephew..."

8/3/17 4:28 p.m. "Resident speaking with nephew at this time. RP made aware of residents intent to leave facility. RP made aware that resident is increasingly more difficult to redirect. Social worker discussing with RP the need for someone to come and visit with resident. Per social worker RP unable to come to visit with resident at this time. Will continue to monitor resident at this time."

8/3/17 5:00 p.m. "Received phone call from resident sister regarding residents behavior...Explained to sister that resident has been exhibiting increased wandering behavior and that it is determined by the administrator that the resident is posing a threat to his safety. Residents sister verbalizes understanding."

8/4/17 5:37 a.m. "...Wander guard intact to R ankle, working properly..."

8/4/17 12:45 p.m. "(Name of Facility resident was being discharged to) called and said they spoke to RP and RP was in agreement to send resident there. RP told social worker yesterday that he understands and he was okay with sending

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F 203	Continued From page 21 resident out." 8/4/17 1:01 p.m. "...wander guard in place to right ankle. No attempts to remove from ankle this shift..." 8/4/17 2:29 p.m. "social worker spoke to RP who said once he speaks to the dr (Resident Name) can be discharged." 8/4/17 2:39 p.m. "RP gave permission to send the resident at 4 pm." 8/4/17 2:51 p.m. "resident found in hallway at this time. wander guard noted to not be on resident ankle. Resident states that he does not know what happened to his wander guard...Wander guard found in residents toiletry bag at this time...Wander guard replaced at this time to R ankle..." 8/4/17 2:51 p.m. "Spoke with RP (sister) this morning regarding residents wandering, she mentioned while he was living at home he would pack up his things and try to leave..." 8/4/17 3:21 p.m. "resident d/c (discharged) with (Name of Medicaid transportation company) to (Name of Facility) in Richmond. RP aware and gave permission. (Receiving Facility name) confirmed they received pt. (patient)." The facility form titled "INTERDISCIPLINARY DISCHARGE SUMMARY" was reviewed and listed the reason for discharge as "higher level of care needed." The "POST-DISCHARGE PLAN OF CARE" included the receiving facility's name, address, and phone number; the State Ombudsman name, address, and phone number;	F 203		

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the transportation company's name and phone number; and "Resident requires Memory Care Unit." On the back page of the post-discharge plan of care there was a section that read:

"These discharge instructions have been reviewed with me in a language I understand. All questions have been answered to my satisfaction..." and an area for the resident/caregiver's signature. The signature line read: "Resident unable to sign/RP aware of transfer" with a date of 8/4/17.

On 10/19/17 at 11:35 a.m. an interview was conducted with the Social Worker (Admin-G). Admin-G explained that Resident #14 was a community referral and came to the facility from home not from a hospital. He stated he went to the resident's house to evaluate for potential admission. Admin-G stated the residents "nephew came in to request placement." He stated the facility was not originally aware that Resident #14 "Drove to Florida with $20 in his pocket and found there." Admin-G stated "If I knew I would not have admitted him." When asked why Resident #14 couldn't stay at the facility, Admin-G stated "He would stretch out the wanderguard, attempt to remove the wanderguard." He stated he spoke with the resident's nephew to discuss the need to move to a locked unit and the nephew (RP) was in agreement. When asked how the resident was transported to the receiving facility, Admin-G stated "(Medicaid transportation company name)," but did not know if it was a transport van or car that transported him.

On 10/19/17 at 11:55 a.m. an interview was conducted with Registered Nurse-B (RN-B).

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F 203	Continued From page 23 When asked about Resident #14's behaviors, RN-B stated they were told "he had mild dementia, was very sweet and very pleasant but was confused about location and continued to state he wanted to go home." She stated "Instead of acclimating to facility his wandering behaviors increased." RN-B stated "He had cut his wanderguard off and walked out of the facility." "He tried to hit me, became aggressive, the police were called." When asked why Resident #14 was discharged to another facility, RN-B stated "As a team, we decided a dementia unit would be beneficial. We told the family of his behavior issues and concern for his safety." She stated part of the safety concern was there was a main road outside of the facility. When asked who walked Resident #14 out the day of discharge, RN-B stated she "couldn't recall who walked him out but there was someone with him." When asked if she knew what type of vehicle Resident #14 was transported in, RN-B stated she did not know if he went via car/taxi or van. On 10/19/17 2:00 p.m. Resident #14's clinical record was reviewed. The Director of Nursing was informed that there was no written notification with an RP's signature found in the record. Any other documentation regarding written signed notification of discharge was requested. On 10/19/17 at 3:15 p.m. the Administrator, Director of Nursing and Corporate Nurse were informed of the failure to obtain signed written notification of discharge from the RP. No further information was provided by the facility staff. Complaint Deficiency.	F 203		

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	495268	A. BUILDING ______ B. WING ______	C 10/19/2017

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F 225	Continued From page 24	F 225		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that	F 225	**F225 and F226** 1. The report of fall related injury was filed for R#13 prior to the survey but identified as late. 2. The facility will identify all residents involved in incidents and/or accidents potentially resulting in major bodily injury as at risk for this alleged deficient practice. 3. The Director of Nursing, Unit Manager and licensed nurses, will receive training on reporting guidelines. The facility management team will discuss incidents/accidents at daily morning meeting. Incidents and/or accidents resulting in major bodily injury that occur after hours will be reported to the Director of Nursing and Administrator at the time of occurrence. Compliance with reporting guidelines will be audited weekly for four weeks to ensure compliance.	

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F 225	Continued From page 25 cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to report injuries of unknown origin in a timely manner, for 1 resident (Resident #13) of the survey sample of 18 residents. 1. For Resident #13, the facility staff failed to submit a Facility Reported Incident to the Office of Licensure and Certification (OLC) within 24 hours of an injury of unknown origin.	F 225	4. Incident/accidents will be reviewed at weekly Risk Committee meetings. Reportable incidents will be reviewed at monthly QAPI committee. 5. Date of Completion: 11/20/2017	

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F 225	Continued From page 26	F 225		

The Findings included:

1. Resident #13 was admitted to the facility on 6-27-16. Resident #13's diagnoses included; metabolic encephalopathy with psychosis, dementia, diabetes, vitamin D, and B deficiency, hypertension, glaucoma, seizures, and high cholesterol. Resident #13 was no longer in the facility, and documents were reviewed as a closed record.

The most recent Minimum Data Set, which was a quarterly Assessment with an Assessment Reference Date of 1-4-17, coded Resident #13 as being severely cognitively impaired. The Resident was also coded as extensive assistance of one to two staff members for activities of daily living, with the exception of eating which only required set up help.

On 10-18-17 a review was conducted of facility documentation, revealing a nursing progress note dated 1-7-17, which described finding the Resident on the floor of her room lying face down bleeding from her lip, with her pupils fixed and unreactive. 911 was called and an ambulance arrived and transported the Resident to the local hospital emergency room.

Hospital records were obtained, and reviewed. The documents revealed that Resident #13 had a large "cerebral hematoma surrounded by edema in the frontal lobes bilaterally," and "per the ER (emergency room) physician, it seems this is an injury that may require comfort care,", and "Nontraumatic intracerebral hemorrhage". The nursing home was notified of the Resident's admission that same night for the brain hemmorhage.

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F 225	Continued From page 27 The facility investigation, facility reported incident and follow up report were reviewed, and revealed that no initial report of the incident was made to the state agency until 7-10-17 (3 days after the incident), and no follow up report of the investigation was made to the state agency until 7-15-17 (8 days after the incident). Federal and state law required at the time that this incident occurred, that the initial report take place within 24 hours or as soon as it was identified, and a follow up report must take place within 5 days of the incident's discovery. On 10-18-17 an interview was conducted with the Administrator, who stated "yes, the reports are late". Injuries of unknown origin are defined as; An injury that was not witnessed, and the cognitively intact Resident can not explain it, and the injury is suspicious due to severity, suspicious location or number of injuries overtime. The facility policy and procedure on "Abuse-Reporting Actual or Suspected Resident Abuse" was reviewed and revealed that the policy does not include reporting requirements for injuries of unknown source, and misappropriation. On 10-18-17, and 10-19-17, the Administrator and Director of nursing were made aware of the deficient practice. The facility presented no further information.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 28 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and operationalize policies in regard to employee abuse pre-screening, and Resident abuse reporting for 1 Resident	F 226		

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F 226	Continued From page 29 (Resident #13) in a sample of 18 Residents. 1. For Resident #13, the facility staff failed to submit a Facility Reported Incident to the Office of Licensure and Certification (OLC) within 24 hours of an injury of unknown origin. The Findings included: 1. Resident #13 was admitted to the facility on 6-27-16. Resident #13's diagnoses included: metabolic encephalopathy with psychosis, dementia, diabetes, vitamin D, and B deficiency, hypertension, glaucoma, seizures, and high cholesterol. Resident #13 was no longer in the facility, and documents were reviewed as a closed record. The most recent Minimum Data Set, which was a quarterly Assessment with an Assessment Reference Date of 1-4-17, coded Resident #13 as being severely cognitively impaired. The Resident was also coded as extensive assistance of one to two staff members for activities of daily living, with the exception of eating which only required set up help. On 10-18-17 a review was conducted of facility documentation, revealing a nursing progress note dated 1-7-17, which described finding the Resident on the floor of her room lying face down bleeding from her lip, with her pupils fixed and unreactive. 911 was called and an ambulance arrived and transported the Resident to the local hospital emergency room. Hospital records were obtained, and reviewed. The documents revealed that Resident #13 had a large "cerebral hematoma surrounded by edema	F 226		

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F 226	Continued From page 30 in the frontal lobes bilaterally," and "per the ER physician, it seems this is an injury that may require comfort care,", and "Nontraumatic intracerebral hemorrhage". The nursing home was notified of the Resident's admission that same night for the brain hemmorhage. The facility investigation, facility reported incident and follow up report were reviewed, and revealed that no initial report of the incident was made to the state agency until 7-10-17 (3 days after the incident), and no follow up report of the investigation was made to the state agency until 8-15-17 (8 days after the incident). Federal and state law required at the time that this incident occurred, that the initial report take place within 24 hours or as soon as it was identified, and a follow up report must take place within 5 days of the incident's discovery. On 10-18-17 an interview was conducted with the Administrator, who stated "yes, the reports are late". Injuries of unknown origin are defined as; An injury that was not witnessed, and the cognitively intact Resident can not explain it,, and the injury is suspicious due to severity, suspicious location or number of injuries overtime. The facility policy and procedure on "Abuse-Reporting Actual or Suspected Resident Abuse" was reviewed and revealed that the policy does not include reporting requirements for injuries of unknown source, and misappropriation. These incidents are mandated by state and federal law to be reported immediately to the administrator and to other officials including the	F 226		

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F 226 Continued From page 31 — F 226

state agency. As this was omitted in the policy, staff were unaware of the reporting requirements, and so reporting requirements were not followed by the facility.

On 10-18-17, and 10-19-17, the Administrator and Director of nursing were made aware of the deficient practice. The facility presented no further information.

F 246 SS=D — 483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES — F 246

483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:

(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, Resident interviews, Contractor interview, and facility documentation review, the facility staff failed to accommodate the bathing needs and preferences of 3 Residents (Resident's #8, #4, and #9) in a survey sample of 18 Residents.

1. For Resident #8, the facility staff failed to accommodate her bathing needs and preferences, as both shower rooms in the facility were inoperable daily, as the hot water boiler was broken.

2. For Resident #4, the facility staff failed to accommodate her bathing needs and

Provider's Plan of Correction:

F246

1. Bathing facilities were restored to compliance. R#8, R#4, and R#9 were all made aware of compliance.
2. The facility has identified all residents to be at risk for this alleged deficient practice.
3. The facility has engaged a second contractor to work on the boiler system as the primary contractor was unable to fulfill the obligation. A daily review of water temperatures is ongoing and will continue to be ongoing indefinitely.
4. Water temperature logs will be submitted to monthly QAPI committee meeting for review.
5. Date of Completion: 11/20/2017

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F 246	Continued From page 32	F 246		

preferences.

3. For Resident #9, the facility staff failed to accommodate his bathing needs and preferences.

The findings included:

1. Resident #8 was originally admitted to the facility on 3-24-07. Diagnoses included; Hypertension, atrial fibrillation, Hypothyroidism, and seizure disorder/not active.

Resident #8's most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 7-15-17. The MDS coded Resident #8 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident #8 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except for bathing; Resident #8 was coded as requiring total assistance of one staff person for bathing, and required set up only for eating. The Resident was continent of bowel and bladder.

On 10-17-17 at 3 p.m., at the end of initial tour of the facility Resident #8 approached surveyors, and was complaining that she was angry about not getting to take a shower, and wanted to know why it took a month to fix the hot water heater/boiler. The Resident was asked if she had reported this to the Administrator, and she stated "yes" she went on to say that the administration there told her every day it was fixed, but it had not been fixed, and she was angry. She stated both shower rooms were inoperable because the facility did not have any hot water. Resident #8 stated the facility had not had hot water for four

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F 246	Continued From page 33 weeks. She stated she was not able to get a bath or shower because of no hot water. Resident #8 stated she preferred to get a shower but could not tolerate the cold water. She stated the staff used wipes/towelettes to bathe them, and this was unacceptable, and she was tired of "stinking, and feeling dirty all over". Resident #8 stated she only got to wash her "face, underarms and private area." Resident #8 stated the water was too cold to even wash those areas but she could do no better. Resident #8 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff let the water run a long time but it still stayed cold. Resident #8 stated she really hoped the surveyors could help them get some hot water, as the administration told them every day the hot water was fixed, and it wasn't. Resident #8 stated she was sure the cold water at the facility was going to make her get sick. Resident #8 stated "as much as we pay to stay here, don't you think we could get hot water for bathing?, this is ridiculous in this day and age." "no one wants to be near people stinking and nasty, it makes you not want to let anyone see you." On 10-17-17 directly after Resident #8's interview, the Housekeeping Director, Maintenance assistant, and CNA (C) were interviewed in the shower room, while testing the water temperature with a thermometer. The water had been running for "about 10 minutes" according to the House Keeping Director and maintenance assistant. The temperature was measured with 2 devices by the staff members and never went above 98 degrees Fahrenheit. According to the House Keeping Director and maintenance assistant, the hot water boiler had been not working correctly for "about 2 weeks".	F 246		

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F 246	Continued From page 34	F 246		

CNA (C) stated she was providing care for Resident #8 that day, and stated the water was too cold for the Resident to get a shower.

On 10-17-17 directly after the staff interview, the Administrator was interviewed, and stated the Resident's were being bathed, that they were receiving a "bath in a bag", which were wipes that could be heated. He stated the problem with the boiler had persisted "about 2 weeks".

On 10-18-17 a group council interview was held with Residents. Seven of the 9 resident attendees were in unanimous agreement that they were unable to receive showers or baths because of the lack of hot water, and were very frustrated with the situation. The time frame for the lack of shower facilities, as stated by those in attendance, ranged from 3-4 weeks.

On 10-18-17 the contractor working on the hot water boiler entered the facility, and was interviewed. He stated that the problem was that the boiler had been installed improperly and they kept having trouble with it, but he was there to fix it. When asked how long he had known about the problem, he stated he had made 2 trips to the facility and had known about the problem "at least 2-3 weeks".

On 10-19-17 the hot water problem was still a problem, and had not been completely repaired.

During the end of day debriefing on 10-18-17, and 10-19-17, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information was provided.

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2. For Resident # 4, the facility staff failed to accommodate her bathing needs and preferences.

Resident #4 was originally admitted to the facility on 3/3/2017, readmitted on 7/26/17 and again readmitted 8/11/2017 with the diagnoses of, but not limited to, Diabetes, Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease, Central Cord Syndrome C1-C4, Neurogenic Bladder with Foley Catheter, Neurogenic Bowel, Urethritis, Psychotic Disorder with Hallucinations, Seizure Disease and Morbid Obesity.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 9/2/17. The MDS coded Resident #4 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 4 was coded as requiring extensive assistance of one to two staff person for Activities of Daily Living except for bathing; Resident # 4 was coded as requiring total assistance of one staff person for bathing, and required set up only for eating; and was coded as frequently incontinent of bowel and bladder.

On 10/17/17 at 4 p.m., Resident # 4's clinical record was reviewed. The review of the MDS and clinical record revealed Resident # 4 required total assistance of one staff person for bathing.

On 10/18/2017 at 8:40 a.m., an interview was conducted with Resident # 4 who stated she was upset because the facility did not have any hot water. Resident # 4 stated the facility had not had hot water for over two weeks. She stated she was

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WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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not able to get a bath or shower because of no hot water. Resident # 4 stated she preferred to get a shower but could not tolerate the cold water. Resident # 4 stated she only allowed the staff to help her with a bed bath and to only wash her "face, underarms and private area." Resident # 4 stated the water was too cold to even wash those essential areas but that was the only way to feel a little bit clean. Resident # 4 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff let the water run a long time but it still stayed cold. Resident # 4 stated she really hoped the surveyors could help them get some hot water.

On 10/18/2017 at 10:30 a.m., Resident # 4 was observed blowing her nose and coughing while sitting in her room watching TV. Resident # 4 stated she was beginning to catch a cold and stated she was sure the cold water at the facility was going to make her get sicker. Resident # 4 stated "this is terrible! We need hot water."

On 10/18/2017 at 2:00 p.m., Resident # 4 was observed sitting in a wheelchair in her room getting her hair curled by a visitor. Resident # 4 stated she liked to go to Activities programs and sometimes liked to go outside during the day. Resident # 4 stated she did not want to go around other people if she did not feel clean and if she did not look good.

On 10/18/2017 at 4 p.m., Resident # 4 was observed wheeling herself in the hallway. Resident # 4 stated she had gone to the Activity Room after her hair was curled.

During the end of day debriefing on 10/18/2017, the facility Administrator, Director of Nursing and

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F 246	Continued From page 37 Corporate Consultants were informed of the findings. On 10/19/2017 at 8:50 a.m., Resident # 4 was observed sitting in her wheelchair in her room. Resident # 4 stated the water still was not completely fixed. No further information was provided. 3. For Resident # 9, the facility staff failed to accommodate his bathing needs and preferences. Resident # 9 was admitted to the facility on 3/13/2017, with the diagnoses of, but not limited to Hypertension, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Solitary Pulmonary Nodule, Diverticulitis, Heart Failure, Single Thyroid Nodule and Pressure Ulcer. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 9/14/2017. The MDS coded Resident # 9 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 9 was coded as requiring extensive to total assistance of one to two staff person for Activities of Daily Living; required set up only for eating; and was coded as always incontinent of bowel and bladder. On 10/18/2017 at 8:40 a.m. during medication pass and pour observation involving other residents on the 200 Hall, Resident # 9 was observed sitting in his bed watching TV. Resident	F 246		

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Continued From page 38
9 asked the surveyor to come into his room. Resident # 9 stated "something needs to be done about the hot water in this building. We don't have any hot water. We haven't had any for over a month." Resident # 9 consented to an interview and stated the problem with the hot water had been going on too long. Resident # 9 stated he could not take a shower because the water was too cold. He stated he had only taken 3 showers in the previous month because the water was "entirely too cold." Resident # 9 stated he talked with the facility staff about the lack of hot water and was told the hot water was fixed but it was not fixed. Resident # 9 stated " they say this is our home but I did not live like this at my home. I had hot water and could take a bath or a shower with hot or warm water whenever I wanted." Resident # 9 stated he did not really feel clean but could not tolerate a cold shower. Resident # 9 stated he observed that some of the other residents were given showers in cold water anyway and he thought that was terrible.

On 10/18/2017 at 2:00 p.m., Resident # 9 attended the Group Interview with 9 other residents and another surveyor. Other residents complained during the Group interview about the lack of hot water in the facility for an extended period of time.

On 10/18/17 at 3:30 p.m., Resident # 9's clinical record was reviewed. The review of the MDS and clinical record revealed Resident # 9 required extensive total assistance of two staff persons for bathing.

On 10/19/2017 at 9:00 a.m., Resident # 9 was observed sitting in his bed eating breakfast. Resident # 9 stated the hot water still was not

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F 246	Continued From page 39 fixed. He stated the staff said it was fixed but it "was warm one minute and then not warm the next time" he used it to wash his hands. Resident # 9 stated the facility really needed to fix the hot water. During the end of day debriefing on 10/19/2017, the facility Administrator, Director of Nursing and the Corporate Consultants were informed of the findings. No further information was provided.	F 246		
F 282	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (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, and clinical record review, the facility staff failed to transfer one (Resident #5) of 18 residents in the survey sample per plan of care. Resident #5 was transferred from her wheelchair to bed without the use of a mechanical (hoyer) lift as directed in her care plan. The findings included: Resident #5 was originally admitted to the facility on 12/1/15 and readmitted on 7/30/16 with the	F 282	F282 1. The care plan for R#5 has been clarified and R#5 is now being transferred per the care plan guidance. 2. Residents requiring mechanical lift transfers have been identified as at risk for this alleged deficient practice. 3. Nursing personnel will be trained on appropriate utilization of Care Plans and Resident Profile for resident transfer requirements. Additionally, a review of all transfer care plans for residents requiring mechanical lift transfers will be completed to ensure these are resident specific.	

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F 282	Continued From page 40 diagnoses of, but not limited to, dementia, Creutzfeldt-Jakob disease (rare, degenerative, invariably fatal brain disorder (ninds.nih.gov)), anxiety, and adult failure to thrive. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 8/8/17. The MDS coded Resident #5 with severe cognitive impairment; required extensive assistance from staff for bed mobility, transfers, toileting, hygiene dressing, and eating; was dependent of staff for bathing. On 10/18/17 at approximately 11:00 a.m. Resident #5's care plan was reviewed and included: "Problem Start Date: 12/28/2015 (Resident Name) is at risk for decline in ADLs (activities of daily living) due to diagnosis of Creutzfeldt-Jacob dementia and FTT (failure to thrive)." "Approach" included: "...12/28/2015 Transfer with hoyer lift and 2 staff members." On 10/18/17 at 1:45 p.m. Resident #5 was observed being rolled in her wheelchair by Certified Nursing Assistant-A (CNA-A) followed by CNA-B. Resident #5 was rolled in her wheelchair next to her bed. CNA-A and CNA-B placed their arms under Resident #5's underarms and gently lifted and performed a turn pivot transfer from the wheelchair to bed. They sat Resident #5 on the edge of the bed then assisted her to a lying position. Resident #5 did not show any signs of discomfort or anxiety during the transfer. When asked if they use a lift to transfer the resident, CNA-A stated she usually stands her to transfer.	F 282	4. The Director of Nursing and/or Designee will conduct audits three times per week for four weeks through visual monitoring of compliance. All audits will be submitted to the QAPI committee for review. Date of Completion: 11/30/2017	

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F 282	Continued From page 41 On 10/19/17 at 3:20 p.m. an interview was conducted with the Director of Nursing (DON). When asked how the CNA's know what care is needed to be provided to the residents, the DON stated "Each resident has a profile that's on the POC (point of care) electronic health record." The DON was informed of the observation of Resident #5 being transferred by a stand pivot rather than a lift use. The DON stated they will assess the resident and the care plan will have to be reviewed and revised. She presented the CNA "Resident Profile" which included "12/28/15 Transfer with hoyer lift and 2 staff members." No further information was provided by the facility staff.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including	F 309	F309 1. The PRN psychoactive medication ordered for R#5 has been discontinued. 2. Residents prescribed PRN psychoactive medication have been identified as being at risk for this alleged deficient practice. 3. Nursing staff will be trained on identifying target behaviors and their triggers, use of non-pharmacological approaches prior to PRN psychoactive medication administration and subsequent documentation.	

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but not limited to the following:

(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.

(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 documentation review, and clinical record review, the facility staff failed for one (Resident #5) of 18 residents in the survey sample, to attempt non-pharmacological approaches prior to administering the as needed (PRN) antianxiety medication, Xanax.

Resident #5 was administered PRN Xanax 4 times in September 2017 without attempted non-pharmacological approaches prior to administering the medication.

The findings included:

Resident #5 was originally admitted to the facility on 12/1/15 and readmitted on 7/30/16 with the diagnoses of, but not limited to, dementia, Creutzfeldt-Jakob disease (rare, degenerative, invariably fatal brain disorder (ninds.nih.gov)), anxiety, and adult failure to thrive.

The most recent Minimum Data Set (MDS) was a

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Residents on prn psychoactive medications will have their care plans reviewed for the presence of resident target behaviors, triggers and resident specific non-pharmacologic approaches.

4. The Director of Nursing and/or Designee will conduct a monthly audit of prn psychoactive medication use for review at the monthly QAPI committee meeting.
5. Date of Completion: 11/30/2017

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quarterly assessment with an Assessment Reference Date (ARD) of 8/8/17. The MDS coded Resident #5 with severe cognitive impairment; required extensive assistance from staff for bed mobility, transfers, toileting, hygiene dressing, and eating; was dependent on staff for bathing.

On 10/18/17 at 3:00 p.m. Resident #5's clinical record was reviewed. The review revealed physician orders which included:
Xanax (alprazolam) 0.5 mg (milligrams) on tab; oral as needed for agitation every 12 hours. The order date was 7/28/17.

Review of Resident #5's Medication Administration Record (MAR) for September 2017 revealed the PRN Xanax was administered on 9/14/17 at 2:08 p.m. for a reason of "other," 9/22/17 at 2:26 p.m. for a reason of "other," 9/27/17 at 7:49 p.m. for a reason of "other," and 9/28/17 at 12:50 p.m. for a reason of "other."

Review of "Resident Progress Notes" revealed a note dated 9/14/17 at 2:34 p.m. that read "Resident agitated. Trying to get out of bed. Husband requested something to calm her, Xanax given. Resident kicking and hitting me. Medicine given followed by a drink." There were no non-pharmacological approaches documented as attempted prior to administering the Xanax. There was no documentation for 9/22, 9/27 or 9/28/17 to describe the behaviors or interventions attempted prior to administering the Xanax.

Resident #5's care plan included an "Approach" of "Has prn order for anxiety put in place during restlessness form urinary tract infection. Monitor behaviors, adverse reactions and discontinue

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once assessed no longer needed."

On 10/19/17 at 1:30 p.m. the Administrator, Corporate Nurse, and Director of Nursing (DON) were informed of Xanax being administered without documented non-pharmacological approaches attempted first. The DON stated she would expect the nurses to "Document the behavior, severity and episodes" and "Try non-pharmacological, redirect, remove the cause then administer the medications and monitor for side effects." The facility psychotropic medication use and medication administration policies were requested by inspector.

Facility policy titled "PSYCHOACTIVE MEDICATIONS PRN/STAT, ADMINISTRATION OF" dated 7/2/12 was received and reviewed. The policy included:

"PURPOSE: The intent of these guidelines is to ensure that all possible non-pharmacological measures are implemented/attempted prior to obtaining orders and administering stat or p.r.n. antipsychotic medications to residents."
"POLICY: Facility is committed to providing a safe environment for resident and attempting non-pharmacological approaches for behavioral management prior to seeking an order from physician for medication.
"PROCEDURE: 1. P.R.N. psychoactive medications should be administered only when all non-pharmacologic approaches have been unsuccessfully attempted. Such approaches my include, but not limited to:
a. Calm, gentle redirection.
b. Diversional activities.
c. Assessment of the resident's surroundings: e.g., temperature; noise.

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F 309	Continued From page 45 d. Assessment of resident's physical condition: e.g., pain; fatigue; hunger; thirst. e. Allow the resident sufficient time to calm, and re-approach. f. When possible, ask family to come assist in efforts to calm resident..." No further information was provided by the facility staff.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323	F323 1. R#14 no longer resides in the facility. 2. The facility has identified all residents to be at risk for this alleged deficient practice. 3. All staff will be trained on appropriate placement of potentially dangerous items, including scissors, and ensuring safety of residents in the surrounding areas. Scissors will be stored in the treatment cart when not in use by nursing personnel. 4. The Director of Nursing and/or Designee will make rounds with an eye for monitoring the nursing area for unsafe objects. If objects are found, they will immediately remove them. Audits will be	

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by:
Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain a safe environment for one (Resident #14) of 18 residents in the survey sample.

Resident #14 obtained scissors from the medication cart and removed his wanderguard.

The findings included:

Resident #14 was admitted to the facility on 7/22/17 with the diagnoses of, but not limited to dementia without behavioral disturbance, chronic viral hepatitis C, and diabetes mellitus type 2. Resident #14 was discharged to another facility on 8/4/17. Resident #14 was a new admission, therefore no Minimum Data Set (MDS) was due to be completed.

On 10/19/17 at 10:15 a.m. Resident #14's clinical record was reviewed. The review revealed the following "Resident Progress Notes:"

7/22/17 2:08 p.m. "7-3. Resident new admission arrived to facility at 10:00 for LTC DX Alzheimer's (long term care-diagnosis-Alzheimer's). Resident arrived in facility with family, ambulating. Resident is pleasant with confusion...requires verbal cues and redirecting..."

7/22/17 6:41 p.m. "...Resident wondering (sic) throughout facility, ambulates self. wanderguard on and working."
A wanderguard can be described as a device worn like a bracelet that triggers an alarm when a resident goes near or opens an exit door. The wanderguard allows the resident to ambulate

Provider's Plan of Correction (F 323, continued):

discussed weekly in the Risk Committee meeting and then reported at the quarterly Safety Committee meeting.

5. Date of Completion 11/20/2017

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around the facility but alerts staff to a resident attempting to exit.

7/22/17 4:37 a.m. "Patient was directed to bed on this shift..."

7/23/17 12:49 p.m. "...Resident wandering all of shift, going through front door several times, with wander guard in place. Resident stating "I just want to go home." Resident redirected each time...Family at bedside this afternoon, aware of wandering..."

7/23/17 7:31 p.m. "...Resident ambulates self. has not set off door alarms at this time. wanderguard on and working. In activity room doing puzzles...activity room after supper playing games w/other resident, listening to music, nurse redirecting resident at all times...Visual monitoring amongst all staff on 3p 11p shift..."

7/24/17 12:37 p.m. "Resident up ambulating on own throughout facility with wander guard intact to RLE (right lower extremity)..."

7/24/17 3:22 p.m. " (Resident Name) is up early and walking building. Resident enjoys talking about golf and bowling...has a wonder (sic) guard but still likes to go outside with other staff."

7/24/17 7:30 p.m. "Resident went out 300 hallway door alarm went off, nurse went running down 300 hallway. nurse able to redirect resident back inside, resident wanted to call his girlfriend, nurse let resident call girlfriend, Redirected resident in activity room w/puzzles..."

7/25/17 3:15 p.m. "...redirecting by several different people. Resident has packed up his

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F 323	Continued From page 48 room and put things back later after SS (social services) director spoke to him. Wander guard in place to lower extremity. Resident ambulating throughout facility on own..." 7/29/17 1:35 p.m. "Resident upset with roommate. Had packed his clothes and wanted to leave facility..." 8/1/17 9:10 a.m. "7-3. During morning med pass resident obtained scissors off of med cart while nurse stepped away briefly. During the nurse absence, resident cut wander guard from ankle. Upon nurses return, resident handed wander guard to nurse stating, "I removed this for you because I am checking out today." Nurse kept resident in residents room until a new wander guard could be applied to ankle. Resident closely monitored throughout shift. MD and RP (responsible party) notified." 8/1/17 9:32 a.m. "...Resident's care plan updated. Residents wanderguard checks increased to Q2 (every 2) hours." 8/1/17 8:37 p.m. "Resident wanders around unit. Monitoring him every 2 hours to see where he is at and what he is doing. Cooperative. Returns to his room periodically at times. Wanderguard intact right ankle." 8/2/17 9:58 a.m. "SW (social worker) called RP to discuss the dangers of resident wondering (sic) around the unit. The RP requested valume (sic-valium), or another form of medication to restrain resident. SW explained that we do not do restraints at this facility. It was discussed that resident needs a lock down unit, and recommended places in Richmond or Northern	F 323		

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Virginia. RP requested closer facility and stated to "get him out today."

8/3/17 1:58 p.m. "7-3. Resident continuing to be monitored for wandering. Wander guard bracelet present and intact to right ankle...asked frequently for scissors or a knife to cut his bracelet. Resident kept asking to go home..."

8/3/17 2:30 p.m. "Dr. (Name) to unit at this time. MD made aware that resident is exhibiting increased wandering behavior. MD made aware that residents family member requesting that resident have medication to help decrease wandering behavior and "relax" resident. No new orders received at this time.

8/3/17 3:50 p.m. "Alarm to 300 hallway alerted at this time. Resident outside of building at this time. Residents primary nurse with resident. Resident refusing to reenter building at this time. Resident states that he "wants to go home" Attempting to redirect resident back into facility at this time. Resident agitated. Resident swinging arms in aggression. Resident states that he "does not want to come back inside. We cant make him do anything he doesn't want to do..." (note that Director of Nursing, social worker, administrator and police department were notified)...Resident continues to refuse to reenter facility. Will continue to sit with resident.

8/3/17 4:25 p.m. "Residents nephew/RP calling facility at this time. Resident agrees to reenter facility to talk to nephew..."

8/3/17 4:28 p.m. "Resident speaking with nephew at this time. RP made aware of residents intent to leave facility. RP made aware that resident is

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F 323	Continued From page 50 increasingly more difficult to redirect. Social worker discussing with RP the need for someone to come and visit with resident. Per social worker RP unable to come to visit with resident at this time. Will continue to monitor resident at this time." 8/3/17 5:00 p.m. "Received phone call from resident sister regarding residents behavior...Explained to sister that resident has been exhibiting increased wandering behavior and that it is determined by the administrator that the resident is posing a threat to his safety. Residents sister verbalizes understanding. 8/4/17 5:37 a.m. "...Wander guard intact to R ankle, working properly..." 8/4/17 12:45 p.m. "(Name of Facility resident was being discharged to) called and said they spoke to RP and RP was in agreement to send resident there. RP told social worker yesterday that he understands and he was okay with sending resident out." 8/4/17 1:01 p.m. "...wander guard in place to right ankle. No attempts to remove from ankle this shift..." 8/4/17 2:29 p.m. "social worker spoke to RP who said once he speaks to the dr (Resident Name) can be discharged." 8/4/17 2:39 p.m. "RP gave permission to send the resident at 4 pm." 8/4/17 2:51 p.m. "resident found in hallway at this time, wander guard noted to not be on resident ankle. Resident states that he does not know	F 323		

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what happened to his wander guard...Wander guard found in residents toiletry bag at this time...Wander guard replaced at this time to R ankle..."

8/4/17 2:51 p.m. "Spoke with RP (sister) this morning regarding residents wandering, she mentioned while he was living at home he would pack up his things and try to leave..."

8/4/17 3:21 p.m. "resident d/c (discharged) with (Name of Medicaid transportation company) to (Name of Facility) in Richmond. RP aware and gave permission. (Receiving Facility name) confirmed they received pt. (patient)."

The facility form titled "INTERDISCIPLINARY DISCHARGE SUMMARY" was reviewed and listed the reason for discharge as "higher level of care needed." The "POST-DISCHARGE PLAN OF CARE" included the receiving facility's name, address, and phone number; the State Ombudsman name, address, and phone number; the transportation company's name and phone number; and "Resident requires Memory Care Unit."

On 10/19/17 at 11:35 a.m. an interview was conducted with the Social Worker (Admin-G). Admin-G explained that Resident #14 was a community referral and came to the facility from home not from a hospital. He stated he went to the resident's house to evaluate for potential admission. Admin-G stated the residents "nephew came in to request placement." He stated the facility was not originally aware that Resident #14 "drove to Florida with $20 in his pocket and found there." Admin-G stated "If I knew I would not have admitted him." When

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asked why Resident #14 couldn't stay at the facility, Admin-G stated "he would stretch out the wanderguard, attempt to remove the wanderguard." He stated he spoke with the resident's nephew to discuss the need to move to a locked unit and the nephew (RP) was in agreement.

On 10/19/17 at 11:55 a.m. an interview was conducted with Registered Nurse-B (RN-B). When asked about Resident #14's behaviors, RN-B stated they were told "he had mild dementia, was very sweet and very pleasant but was confused about location and continued to state he wanted to go home." She stated "Instead of acclimating to facility his wandering behaviors increased." RN-B stated "He had cut his wanderguard off and walked out of the facility." "He tried to hit me, became aggressive, the police were called." When asked why Resident #14 was discharged to another facility, RN-B stated "As a team, we decided a dementia unit would be beneficial. We told the family of his behavior issues and concern for his safety." She stated part of the safely concern was there was a main road outside of the facility. When asked how he got the scissors and remove the wanderguard, RN-B stated "He had gotten a pair of safely scissors off the nursing cart." She stated "He actually removed and cut off the wanderguard 2 other times." She stated "he was a very intelligent man." When asked if scissors should be left on the cart, RN-B stated "No, they should not."

Resident #14's care plan included: "Problem Start Date: 7/22/17...is at risk for elopement and wandering due to dx of dementia and recent facility admission from home"

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Approaches included but not limited to:
"Attempt non-phamacologic approaches when resident starts wandering..."
"Ensure placement of wandering bracelet. Check functionality Q2 hours..."
"Maintain photo identification in resident records as well as the reception desk..."

Facility policy titled "ELOPEMENT RISK ASSESSMENT" with a revised date of 4/25/16 included:

"PURPOSE: To ensure residents residing within the facility are safe and enable facility staff to provide additional interventions for those who may by considered at risk for exiting facility."
"JUSTIFICATION: Some residents are safe to go outside independently, knowing that they are not going to walk into the street or parking lot unsafely. However, some of the residents who suffer from dementia are able to safely ambulate and/or perform locomotion but if allowed to go outside independently, those residents are at risk of wandering into traffic or away from facility."
"PROCEDURE:..3. The bracelet will be applied to the resident's extremity according to facility protocol...6. The wander alert bracelet will be observed at least daily for proper placement..."

On 10/19/17 at 3:15 p.m. the Administrator, Director of Nursing and Corporate Nurse were notified of the safety concern of Resident #14's ability to obtain a scissor and remove his wanderguard. No further information was provided by the facility staff.

Complaint deficiency.

F 456 483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE F 456

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F 456 SS=E	Continued From page 54 OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interviews, Contractor interview, and facility documentation review, the facility staff failed to maintain in good repair, hot water in 2 of 2 shower rooms for resident use, for approximately 2 to 4 weeks. Residents #8,# 4, and #9 in a sample of 18 Residents were affected by this, and so were added to the evidence provided for the deficient practice. 1. For Resident #8, the situation was identical. The facility staff failed to maintain operable bathing areas, as both shower rooms in the facility were inoperable daily, as the hot water boiler was broken. 2. For Resident #4, the situation was identical. The facility staff failed to maintain operable bathing areas, as both shower rooms in the facility were inoperable daily, as the hot water boiler was broken. 3. For Resident #9, the situation was identical. The facility staff failed to maintain operable bathing areas, as both shower rooms in the facility were inoperable daily, as the hot water boiler was broken.	F 456	F456 1. Bathing facilities were restored to compliance. R#8, R#4, and R#9 were all made aware of compliance. 2. The facility has identified all residents to be at risk for this alleged deficient practice. 3. The facility has engaged a second contractor to work on the boiler system as the primary contractor was unable to fulfill the obligation. A daily review of water temperatures is ongoing and will continue to be ongoing indefinitely. 4. Water temperature logs will be submitted to QAPI Committee for review. 5. Date of Completion: 11/20/2017	

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The findings included:

Resident #8 was originally admitted to the facility on 3-24-07. Diagnoses included; Hypertension, atrial fibrillation, Hypothyroidism, and seizure disorder/not active.

Resident #8's most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 7-15-17. The MDS coded Resident #8 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident #8 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except for bathing; Resident #8 was coded as requiring total assistance of one staff person for bathing, and required set up only for eating. The Resident was continent of bowel and bladder.

On 10-17-17 at 3 p.m., at the end of initial tour of the facility Resident #8 approached surveyors, and was complaining that she was angry about not getting to take a shower, and wanted to know why it took a month to fix the hot water heater/boiler. The Resident was asked if she had reported this to the Administrator, and she stated "yes" she went on to say that the administration there told her every day it was fixed, but it had not been fixed, and she was angry. She stated both shower rooms were inoperable because the facility did not have any hot water. Resident #8 stated the facility had not had hot water for four weeks. She stated she was not able to get a bath or shower because of no hot water. Resident #8 stated she preferred to get a shower but could not tolerate the cold water. She stated the staff used wipes/towelettes to bathe them, and this was

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unacceptable, and she was tired of "stinking, and feeling dirty all over". Resident #8 stated she only got to wash her "face, underarms and private area." Resident #8 stated the water was too cold to even wash those areas but she could do no better. Resident #8 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff let the water run a long time but it still stayed cold. Resident #8 stated she really hoped the surveyors could help them get some hot water, as the administration told them every day the hot water was fixed, and it wasn't. Resident #8 stated she was sure the cold water at the facility was going to make her get sick. Resident #8 stated "as much as we pay to stay here, don't you think we could get hot water for bathing?, this is ridiculous in this day and age." "no one wants to be near people stinking and nasty, it makes you not want to let anyone see you."

On 10-17-17 directly after Resident #8's interview, the Housekeeping Director, Maintenance assistant, and CNA (C) were interviewed in the shower room, while testing the water temperature with a thermometer. The water had been running for "about 10 minutes" according to the House Keeping Director and maintenance assistant. The temperature was measured with 2 devices by the staff members and never went above 98 degrees Fahrenheit. According to the House Keeping Director and maintenance assistant, the hot water boiler had been not working correctly for "about 2 weeks". CNA (C) stated she was providing care for Resident #8 that day, and stated the water was too cold for the Resident to get a shower.

On 10-17-17 directly after the staff interview, the

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F 456	Continued From page 57 Administrator was interviewed, and stated the Resident's were being bathed, that they were receiving a "bath in a bag", which were wipes that could be heated. He stated the problem with the boiler had persisted "about 2 weeks". On 10-18-17 a group council interview was held with Residents. Seven of the 9 resident attendees were in unanimous agreement that they were unable to receive showers or baths because of the lack of hot water, and were very frustrated with the situation. The time frame for the lack of shower facilities, as stated by those in attendance, ranged from 3-4 weeks. On 10-18-17 the contractor working on the hot water boiler entered the facility, and was interviewed. He stated that the problem was that the boiler had been installed improperly and they kept having trouble with it, but he was there to fix it. When asked how long he had known about the problem, he stated he had made 2 trips to the facility and had known about the problem "at least 2-3 weeks". On 10-19-17 at 10:00 a.m., Observation of the shower rooms was conducted again during the "General Observations" of the physical plant portion of the survey process. It was noted at this time, that the hot water problem was still a problem, and had not been completely repaired. During the end of day debriefing on 10-18-17, and 10-19-17, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information was provided.	F 456		

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2. Resident #4 was originally admitted to the facility on 3/3/2017, readmitted on 7/26/17 and again readmitted 8/11/2017 with the diagnoses of, but not limited to, Diabetes, Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease, Central Cord Syndrome C1-C4, Neurogenic Bladder with Foley Catheter, Neurogenic Bowel, Urethritis, Psychotic Disorder with Hallucinations, Seizure Disease and Morbid Obesity.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 9/2/17. The MDS coded Resident # 4 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 4 was coded as requiring extensive assistance of one to staff person for Activities of Daily Living except for bathing; Resident # 4 was coded as requiring total assistance of one staff person for bathing, and required set up only for eating; and was coded as frequently incontinent of bowel and bladder.

On 10/17/17 at 4 p.m., Resident # 4's clinical record was reviewed. The review of the MDS and clinical record revealed Resident # 4 required total assistance of one staff persons for bathing.

On 10/18/2017 at 8:40 a.m., an interview was conducted with Resident # 4 who stated she was upset because the facility did not have any hot water. Resident # 4 stated the facility had not had hot water for over two weeks. She stated she was not able to get a bath or shower because of no hot water.

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3. Resident # 9 was admitted to the facility on 3/13/2017, with the diagnoses of, but not limited to Hypertension, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Solitary Pulmonary Nodule, Diverticulitis, Heart Failure, Single Thyroid Nodule and Pressure Ulcer.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 9/14/2017. The MDS coded Resident # 9 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 9 was coded as requiring extensive to total assistance of one to two staff person for Activities of Daily Living; required set up only for eating; and was coded as always incontinent of bowel and bladder.

On 10/18/2017 at 8:40 a.m. during medication pass and pour observation involving other residents on the 200 Hall, Resident # 9 was observed sitting in his bed watching TV. Resident # 9 asked the surveyor to come into his room. Resident # 9 stated "something needs to be done about the hot water in this building We don't have any hot water. We haven't had any for over a month."

During the end of day debriefing on 10-18-17, and 10-19-17, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information was provided.