STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. BUILDING _____ B. WING _____	C 11/30/2016

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THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/28/16 through 11/30/16. One complaint was investigated during the survey. Corrections are required for complaince with 42 CFR Part 183 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 bed faciity was 54 at the time of the survey. The survey sample consisted of 14 current Resident Reviews (Residents 1 through 14) and 4 closed record reviews (Residents 15 through 18).	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain dignity of a Foley catheter for 1 of 18 residents. (Resident #7) The findings included: Resident #7 was admitted to the facility on 8/25/16 with the following diagnoses of, but not limited to atrial fibrillation, anxiety, depression, chronic pain, malaise, adult failure to thrive and retention of urine.	F 241	1. This Foley catheter privacy bag cover which was hanging on the side of the bed was corrected on the date of inspection. 2. Any resident with a Foley catheter is at risk. 3. Nursing staff will check every shift for Foley bag cover placement while performing Foley catheter care. 4. QA will conduct random audits for catheter cover placement monthly and submit results to QA.	1/6/17

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

Electronically Signed | 01/06/2017

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The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/31/16 with a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. The resident was also coded as requiring extensive assistance from 2 staff members for dressing and personal hygiene. Resident #7 was totally dependent on 2 staff members for personal hygiene.

On 11/29/16 at 4 pm in Resident #7 ' s room, the surveyor observed the Foley catheter bag hanging on the side of the bed with the blue privacy bag hanging further up on the side of the bed away from the bag. The Foley catheter bag was observed to be left hanging on the side of the bed with no privacy bag covering it.

The administrative team was notified of the above documented findings on 11/29/16 at 4:45 pm in the end of the day conference. The director of nursing stated " That ' s a dignity issue. I will tell the staff about this and have it corrected. " The surveyor requested a copy of the facilities ' policy on Foley catheters. The director of nursing stated that she would get a copy of this for the surveyor.

On 11/30/16 at 9 am, the director of nursing provided a copy on Foley catheters to the surveyor. The surveyor read the policy titled " Catheter (Indwelling) ... " and noted that the policy did not state anything about providing a privacy bag to cover a Foley catheter at all times. The director of nursing stated, " This is the only policy that we have on Foley catheters. But this is a dignity issue and the staff will be educated on this as soon as possible. "

No further information was provided to the

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F 241	Continued From page 2 surveyor prior to the exit conference on 11/30/16.	F 241		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		1/6/17

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA) for 6 of 18 residents in the sample survey (Resident #2, Resident #8, Resident #5, Resident #1, Resident #3, and Resident #7).
The findings included:
1. The facility staff failed to ensure Section V Care Area Assessment (CAA) Summary of the significant change in assessment MDS (minimum data set) with an assessment reference date (ARD) of 9/22/16 was accurate. The facility staff failed to document in the "Location and Date of CAA Documentation" where the supporting documentation could be located in the clinical record.
Resident #2's clinical record was reviewed 11/29/16. Resident #2 was admitted to the facility 11/10/11 with diagnoses that included but not limited to urinary tract infection, dementia, chronic venous embolism and thrombosis, hypertension, and Parkinson's disease.
Continued review of the clinical record revealed a significant change in assessment MDS assessment with the ARD of 9/22/16. The facility staff coded Resident #2 with a Cognitive Summary Score of 15. In Section V. Care Area Assessment (CAA) Resident #2 "triggered" for and the decision made to care plan the following: ADL (activities of daily living) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Falls, Nutritional Status,

1. This could not be corrected as it happened in the past.
2. All residents have the potential to be affected.
3. The MDS nurses will print a CAA at each full assessment and verify location and date of CAA documentation in the clinical record.
4. The MDS nurses will audit all CAAs monthly for 6 months and submit audit results to QA.

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Dental Care, Pressure Ulcer, Psychotropic Drug Use, and Pain. The decision was made to care plan Resident #2 for communication; however, that area had not been "triggered." The facility staff failed to document in the "Location and Date of CAA documentation" where the supporting documentation could be located in the clinical record for these areas: communication, psychosocial well-being, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use, and pain.

The surveyor interviewed registered nurse #1 (MDS) on 11/29/16 at 11:10 a.m. The surveyor asked RN #1 for the CAA worksheets. RN #1 stated CAA worksheets were not done but a progress note was made in the clinical record. The progress note dated 9/23/16 for social work and activities did not reveal location and date where the supporting information was located in the clinical record. RN #1 stated she had failed to write a progress note for nursing. After reviewing the progress notes, RN #1 stated there was no documentation of dates/location for the triggered areas supporting information.

The surveyor informed the administrator, director of nursing (DON), and the assistant director of nursing (ADON) of the above issue on 11/29/16 at 4:55 p.m.

No additional information was provided prior to exiting the facility on 11/30/16 as to why the facility staff failed to ensure a complete and accurate CAA Summary for Resident #2.

2. The facility staff failed to ensure the CAA (Care Area Assessment) Summary in Section V included the dates and location of supporting information for the triggered areas for Resident #8.

The clinical record of Resident #8 was reviewed 11/29/16. Resident #8 was admitted to the facility

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F 272	Continued From page 5 8/26/16 with diagnoses that included but not limited to cognitive communication deficit, Parkinson's disease, dementia with behavioral disturbances, anxiety, agitation, urinary retention, orthostatic hypotension, depression, and constipation. The admission minimum data set (MDS) with an assessment reference date (ARD) of 9/5/16 assessed the resident with short term memory problem, long term memory problem, and severely impaired skills for daily decision making. Section V Care Area Assessment Summary identified the following triggered and care planned areas: Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug Use, and Pain. Under the "Location and Date of CAA Documentation", these triggered areas had no documentation of the location/dates of supporting information in the clinical record: cognitive loss/dementia, falls, psychotropic drug use, and pain. The surveyor interviewed registered nurse #1 (MDS) on 11/29/16 at 11:10 a.m. The surveyor asked RN #1 for the CAA worksheets. RN #1 stated CAA worksheets were not done but a progress note was made in the clinical record. The progress note dated 9/8/16 for social work, nursing, and activities did not reveal location and date where the supporting information was located in the clinical record. After reviewing the progress notes, RN #1 stated there were no dates/location for the supporting information for triggered areas. The surveyor informed the administrator, director of nursing (DON), and the assistant director of nursing (ADON) of the above issue on 11/29/16 at 4:55 p.m. No additional information was provided prior to	F 272		

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exiting the facility on 11/30/16 as to why the facility staff failed to ensure a complete and accurate CAA Summary for Resident #8.
3. For Resident #5, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/16/16.

Resident #5 was admitted to the facility on 2/14/16. Her diagnoses include but are not limited to high blood pressure, stroke, and gastroesophageal reflux disease and Alzheimer ' s disease.

Resident #5's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/14/16 assessed her to understand and could be understood. She was assessed to have as cognitive status of 8 out of 15. Her assessment revealed in section G, she needed assistance with daily activities of living. Section K coded the resident to weigh 87 lbs. and to have had a weight loss of 5% or more in the past 6 months. She was also coded to have a therapeutic diet ordered.

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" for the area of cognitive loss, mood, activities, nutrition, falls, dental, and pressure. "The actual date and location(s) regarding the documentation was not recorded in

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section V.

On 11/30/16 at approximately 3:55 p.m. the surveyor and MDS nurse #1 reviewed the CAA worksheets. During this review MDS nurse #1stated " I told the other surveyor I updated them as of today. "

The administrative team was made aware of the MDS concerns on 11/30/16, during the end of the day meeting.

No further information regarding this issue was provided to the survey team prior to the exit conference.

4. The facility staff failed to document the dates of when the documentation could be found in Resident #1 ' s clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #1 was admitted to the facility on 3/11/16 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, and depression, and weakness, history of falling, edema and chronic pain. The most recent MDS quarterly assessment with an ARD (Assessment Reference Date) of 9/7/16 scored the resident with a BIMS (Brief Interview for Mental Status, an assessment tool) score of 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members for personal hygiene and was totally dependent on 2 staff members for bathing.

The surveyor reviewed the clinical record of Resident #1 on 11/29/16 at 2:05 pm. The surveyor noted that on the admission MDS with an ARD of 3/22/16 in Section V of the CAA Summary the dates of the documentation to support the triggered area for the following were

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not documented: Falls, Nutritional Status, Psychotropic Drug Use and Pain.
The MDS nurse was interviewed earlier on 11/29/16 at 10 am by the surveyor due to an earlier issue identified. The MDS nurse stated " We don ' t do the CAA worksheets. But we do an overall summary and that should include the dates that were not in the CAA Summary of the Section V. "
The administrative team was notified of the above documented findings in the end of the day conference on 11/29/16 at 4:45 pm by the surveyor.
No further information was provided to the surveyor prior to the exit conference on 11/30/16.
5. The facility staff failed to document the dates of where the documentation could be found in Resident #3s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).
Resident #3 was readmitted to the facility on 1/31/16 with the following diagnoses of, but not limited to high blood pressure, anemia, depression, edema and heart failure. The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 9/12/16 scored the resident as having a BIMS (Brief Interview Mental Status, an assessment tool) score of 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene. The resident is totally dependent on one staff member for bathing.
The surveyor reviewed the clinical record of Resident #3 on 11/29/16 at 2:15 pm. The surveyor noted that on the significant change MDS with an ARD of 3/18/16 in Section V of the CAA Summary dates of the documentation to support the triggered area for the following were

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not documented: Falls, Nutritional Status, Dehydration/Fluid Maintenance and Psychotropic Drug Use.
The MDS nurse was interviewed earlier on 11/29/16 at 10 am by the surveyor due to an earlier issue identified. The MDS nurse stated " We don ' t do the CAA worksheets. But we do an overall summary and that should include the dates that were not in the CAA Summary of the Section V. "
The administrative team was notified of the above documented findings in the end of the day conference on 11/29/16 at 4:45 pm by the surveyor.
No further information was provided to the surveyor prior to the exit conference on 11/30/16.
6. Resident #7 was admitted to the facility on 8/25/16 with the following diagnoses of, but not limited to atrial fibrillation, anxiety, depression, chronic pain, malaise, adult failure to thrive and retention of urine.
The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/31/16 with a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. The resident was also coded as requiring extensive assistance from 2 staff members for dressing and personal hygiene. Resident #7 was totally dependent on 2 staff members for personal hygiene.
The surveyor reviewed the clinical record of Resident #7 on 11/29/16 at 8:45 am. The surveyor noted that on the admission MDS with an ARD (Assessment Reference Date) of 8/31/16 in Section V of the CAA Summary the dates of the documentation to support the triggered area for the following were not documented: Visual Function, Psychosocial Well-Being, fall, Psychotropic Drug, and Pain.

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F 272	Continued From page 10 The MDS nurse was interviewed 11/29/16 at 10 am by the surveyor. The MDS nurse stated " We don ' t do the CAA worksheets. But we do an overall summary and that should include the dates that were not in the CAA Summary of the Section V. " The administrative team was notified of the above documented findings in the end of the day conference on 11/29/16 at 4:45 pm by the surveyor. No further information was provided to the surveyor prior to the exit conference on 11/30/16.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		1/6/17

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by:
Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for 1 of 18 residents (Resident #8).

The findings included:

The facility staff failed to develop a comprehensive care plan for pain for Resident #8 from the triggered areas/care plan decision in Section V Care Area Assessment.

The clinical record of Resident #8 was reviewed 11/29/16. Resident #8 was admitted to the facility 8/26/16 with diagnoses that included but not limited to cognitive communication deficit, Parkinson's disease, dementia with behavioral disturbances, anxiety, agitation, urinary retention, orthostatic hypotension, depression, and constipation.
The admission minimum data set (MDS) with an assessment reference date (ARD) of 9/5/16 assessed the resident with short term memory problem, long term memory problem, and severely impaired skills for daily decision making.
Section V Care Area Assessment Summary identified the following triggered areas with the decision made to care plan these areas: Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug Use, and Pain.
The surveyor reviewed the current comprehensive care plan dated 9/8/16. The surveyor was unable to locate a comprehensive care plan for pain.
The surveyor interviewed registered nurse #1 (MDS) on 11/29/16 at 11:10 a.m. R.N. #1

1. A pain assessment was completed at the time of inspection for this resident.
2. All residents have the potential to be affected.
3. The MDS nurses will print a CAT audit report at each full assessment and Care Plan each triggered area.
4. The MDS nurses will audit 10% of each other's care plans monthly for 6 months.

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F 279	Continued From page 12 reviewed the current comprehensive care plan and the progress note dated 9/8/16. The progress note documented that the pain assessment had been completed (no date of assessment) and that Resident #8 had not received any pain medication in the last 5 days. R.N. #1 stated that the surveyor was correct. The triggered area of pain with the decision made to care plan that area had not been completed. The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 11/29/16 at 4:55 p.m. No further information was provided prior to the exit conference on 11/30/16.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		1/6/17

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 18 residents (Resident #4).
The findings include:
The facility staff failed to review and revise the comprehensive care plan for Resident #4 to reflect the resident had refused his baths/showers.
Resident #4 was admitted to the facility on 10/11/15 and readmitted on 11/24/16; with diagnoses of anemia, high blood pressure, depression, asthma, acute kidney failure, and pulmonary fibrosis.
Resident #4 most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 10/26/16. Section C (cognitive patterns) of this assessment scored the resident a 14, indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood. He was also coded requiring assistance of 1-2 persons for bed mobility, dressing, toileting, bathing, and hygiene.
The comprehensive care plan was reviewed. The care plan indicated the resident was incontinent and requires assistance with all activities of daily living except for eating. The care plan was not individualized to note the resident had been refusing his baths.
At 10:45 on 10/29/16, CNA #2 was asked what she did when a resident refused showers. She stated. " We tell the nurse and there is a place in

1. This occurred in the past and cannot be corrected.
2. All residents who are assisted with bathing by staff are at risk for this documentation concern.
3. The MDS nurses will keep a copy of bathing logs provided to them by the bath team to keep track of residents who routinely decline bathing. The MDS nurses will care plan for refusals after two consecutive declinations. Bathing preferences will also be care planned.
4. QA will audit 10% of care plans of residents who are assisted with bathing for compliance with care plan documentation.

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F 280	Continued From page 14 care tracker we document refusals. " On 11/30/16 the director of nurses was asked if she would look and see if Resident #4 had been care planned for refusing bathing. At 12:00 PM, the director of nurses informed the surveyor. " I looked at Resident #4 ' s care plan and it did not contain documentation of his refusing care (bathing). " The administrator and director of nursing were informed of the findings during a meeting with the survey team on 11/30/16 at 2:15 p.m. Prior to exit no further information was provided to the surveyor related to the care plan.	F 280		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		1/30/17

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 18 residents was free of an unnecessary drug (Resident #8).

The findings included:

The facility staff failed to document the reason medication (Ativan) was administered to Resident #8 and failed to monitor and document the effectiveness of Ativan 1 milligram when the medication was administered for agitation on 9/27/16 at 3:10 a.m. to Resident #8.

The clinical record of Resident #8 was reviewed 11/29/16. Resident #8 was admitted to the facility 8/26/16 with diagnoses that included but not limited to cognitive communication deficit, Parkinson's disease, dementia with behavioral disturbances, anxiety, agitation, urinary retention, orthostatic hypotension, depression, and constipation.
The admission minimum data set (MDS) with an assessment reference date (ARD) of 9/5/16 assessed the resident with short term memory problem, long term memory problem, and severely impaired skills for daily decision making. Resident #8 was without any signs or symptoms of delirium, psychosis, or behaviors affecting others.
The current comprehensive care plan dated 9/8/16 for behaviors identified the following interventions/approaches to help the resident

1. This event occurred in the past and cannot be corrected.
2. All residents have the potential to be affected.
3. The DON will request a monthly PRN anxiety report from the pharmacy monthly to review. Staff will also be inserviced on the necessity of follow-up documentation of PRN medications.
4. QA will audit 10% of residents receiving PRN anxiety medications monthly for 4 months for documentation of need for medication and results of medication. Results will be submitted to QA.

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achieve his goals: speak respectfully to me, leave and return later, watch me for safety, tell me who you are and tell me what you are going to do before you start, and ask for my input.
Physician's order dated 9/19/16 read "Ativan 1 milligram (mg) [0.5 ml (milliliter)] every 12 hours prn (as needed) for anxiety." The September 2016 medication administration record documented the medication had been administered nine times since the medication was ordered. Resident #8 received Ativan 1 mg on 9/27/16 at 0310 for agitation as documented on the reverse side of the MAR. The entry on the reverse side of the MAR did not have documentation as to the effectiveness of the medication. The surveyor reviewed the interdisciplinary progress notes for 9/27/16. There were two entries for 9/27/16. First entry timed 0125 read "New orders noted lab slips done. Pharmacy faxed. MD (medical doctor) aware." Second entry for 9/27/16 0200 read "24 ° (hour) chart v (check) done." There was no documentation in the clinical record of Resident #8's behaviors that warranted the use of Ativan. The surveyor reviewed the September 2016 "Behavior/Intervention Monitoring" sheet. There were no entries of Resident #8's behavior symptoms, number of episodes, intervention code, outcome code, or staff initials. The clinical record did not have evidence as to why Resident #8 received Ativan 1 mg on 9/27/16 at 3:10 a.m. The surveyor interviewed the assistant director of nursing on 11/30/16 at 8:00 a.m. The ADON reviewed the information in the clinical record and stated the nurse didn't document anywhere as to why Resident #8 received Ativan or if the medication had been effective.
The surveyor informed the administrator, the director of nursing, the assistant director of

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F 329	Continued From page 17 nursing, and the quality assurance registered nurse of the failure of the facility staff to document behaviors and monitor the effectiveness when an antianxiety medication was administered to Resident #8 in a meeting on 11/30/16 at 2:20 p.m. No further information was provided prior to the exit conference on 11/30/16.	F 329		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and clinical record review, the facility staff failed to prepare 1 of 18 resident's meal according to the prepared menu (Resident #2). The findings included: 1. The facility staff failed to plate Resident #2's breakfast meal per the prepared menu. Resident #2's clinical record was reviewed 11/29/16. Resident #2 was admitted to the facility 11/10/11 with diagnoses that included but not limited to urinary tract infection, dementia, chronic venous embolism and thrombosis, hypertension, and Parkinson's disease.	F 363	1. This cannot be corrected as it happened in the past. 2. All residents have the potential to be affected. 3. Dining staff has implemented a Daily Meal Check to ensure compliance with items listed on the meal tickets. 4. The RD or Production Manager will conduct random try audits 3x/wk for 3 months with results submitted to QA.	1/5/17

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Continued review of the clinical record revealed a significant change in assessment MDS assessment with the ARD of 9/22/16. The facility staff coded that Resident #2 had a Cognitive Summary Score of 15. Section G Functional Status H. Eating assessed the resident to need supervision and setup help only.

The current comprehensive care plan dated 9/22/16 identified that the resident was at risk at meals due to a chewing and swallowing impairment and required a mechanically altered diet. Interventions listed to reach Resident #2's goals included honoring preferences, providing assistance at meals as needed, monitoring weight, encouraging the resident to drink extra fluids, respecting the resident's wishes to decline certain foods, offering alternatives, and providing additional protein at meals and snacks throughout the day.

The surveyor observed Resident #2 on 11/29/16 at 8:30 a.m. in the dining room. All of Resident #2's food items were in bowls-scrambled eggs, pureed fruit, and yogurt. Resident #2 also had milk and water in a glass and a cup of hot chocolate. C.N.A. #1 sat with the resident. The surveyor reviewed the meal ticket. Items on the meal ticket that were not present on the table included a peanut butter pack, hash browns, and buttermilk. The surveyor interviewed C.N.A. #1 about the peanut butter, hash browns, and buttermilk. C.N.A. #1 confirmed those items were not on the tray.

The surveyor interviewed the registered dietician on 11/30/16 at 8:00 a.m. regarding meal ticket and plating. The RD stated some residents were able to select the food items they want. When a

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F 363	Continued From page 19 resident was unable to select, a standard menu would be provided. The dietician was informed of the breakfast meal items missing from the breakfast tray on 11/29/16. The RD stated she would check why Resident #2 did not receive the peanut butter pack, hash browns, or buttermilk. The RD also stated Resident #2 could not select the food items from a menu. The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the quality assurance registered nurse of the above finding on 11/30/16 at 2:20 p.m. No further information was provided prior to the exit conference on 11/30/16.	F 363		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review it was determined the facility staff failed to provide physician ordered diets for 1 of 18 residents (Resident #5). The findings include: Resident #5 was admitted to the facility on 2/14/16. Her diagnoses include but are not limited to high blood pressure, stroke, and gastroesophageal reflux disease and Alzheimer '	F 367	1. The preferences requested cannot be corrected as it happened in the past. 2. All residents with stated preferences have the potential to be affected. 3. The "Every Bite Counts" (EBC) diet ordered by the physician was followed by the facility. However, stated resident preferences were not followed by the dining staff with the cutting style and meat and bread choice for the sandwich. All substitutions were within the scope of choice; the menu lists preferred flavors of	1/6/17

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F 367	Continued From page 20 s disease. Resident #5's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/14/16 assessed her to understand and could be understood. She was assessed to have as cognitive status of 8 out of 15. Her assessment revealed in section G, she needed assistance with daily activities of living. Section K coded the resident to weigh 87 lbs. and to have had a weight loss of 5% or more in the past 6 months. She was also coded to have a therapeutic diet ordered. Resident #5 diet order was a regular every bite counts and was on a personalized meal rotation per preference as documented by the registered dietitian. On 11/29/16 at 1:10 pm, the surveyor observed Resident #5 in her bed with her lunch tray on the over bed table in front of her. The CNA ' s said she had received her lunch late and they were attempting to get her to eat. The surveyor asked the resident if she could see the diet card on the resident ' s tray. Resident #5 said yes. The card read at the top wheat Bread; cut sandwich into quarters. Diet card also indicated she should have a 4oz mighty shake-strawberry. Review of what was on the residents tray was a bologna and cheese sandwich on white bread and cut in half not quarters. Her 4oz might shake was vanilla not strawberry. The surveyor asked the CNA ' s about the sandwich and mighty shakes CNA #1 said " she got her tray late and in not wanting to eat. " At 1:50 pm, the surveyor asked the nurse	F 367	items and choices of foods along with listing allergies and foods that are absolutely undesired/unwanted. The strawberry flavored shake was unavailable at the time of the inspection so a vanilla shake was substituted, and noted not to be a disliked item. The cut of the sandwich, meat choice and bread were also not listed as disliked items, but as a preference, not an order for a specific sandwich, cut or meat option. 4. The dining department will keep flavored syrups on hand to use when preferred flavors are unavailable. Nursing staff will consult meal ticket as a back-up for stated preferences.	

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F 367	Continued From page 21 supervisor to look at the tray card and told her what was observed with the deviation to the menu. Looking at the card she said " it is written write there. " On 11/29/16 during an end of the day meeting with the administrator and the director of nurses the surveyor discussed the diet card issue. On 11/30/16 at 1:25 the surveyor asked the dietary manager and her supervisor were asked about the diet card concern. The dietary manager said, " I corrected the cook; thank you for finding that. " The supervisor said yeah we corrected that. " Prior to exit no further information was provided to the surveyor related to Residents incorrect menu/ diet card.	F 367		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and a facility document review, the facility's staff failed to store, prepare, and serve food in a safe and	F 371	1. This is able to be corrected as it happened in the past. 2. All residents have the potential to be	12/1/16

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F 371	Continued From page 22 sanitary manner. The findings include: An initial tour of the kitchen was done on 11/28/16 at 7:45pm. The surveyor was accompanied by a dietary cook. The surveyor observed a rack containing multiple pans that were stacked. The cook stated that the pans were on a storage rack. The pans were stacked on top of one another. The surveyor asked the cook to pick up individual pans from the stack. As he did, water ran from inside and off the pans. Two more stacks of pans also had water run out from the inside. The cook removed the pans from the rack and requested they be washed over... On 11/29/16 at 2:15pm, the administrator, and director of nurses were informed of the nesting of the pans. Prior to exit, no further information was provided to the surveyor related to the kitchen issues.	F 371	affected. 3. The kitchen staff will follow proper washing and drying procedures as outlined by the policy. Dining staff will be reeducated on the proper method and policy. 4. Kitchen manager will perform random spot checks on pots and pans for wet-nesting 3x/wk for 3 months with the results submitted to QA.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		1/6/17

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the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for 2 of 18 residents in the survey sample. (Resident #1 and Resident #7)
The findings included:
1. The facility staff failed to ensure Vesicare was available for medication administration for Resident #1.
Resident #1 was admitted to the facility on 3/11/16 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, depression, weakness, history of falling, overactive bladder and chronic pain. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/30/16 the resident was coded as persistent vegetative state and required total dependence on 2 or more staff members for dressing, personal hygiene and bathing.
During the clinical record review performed by the surveyor on 11/29/16 it was noted on the November, 2016 MAR (Medication Administration Record that Vesicare was unavailable for medication administration on 11/16/16 for the time of 10:00 pm. On the back of the MAR, documentation was noted that stated, " Hold 2000 (10:00 pm) Vesicare unavailable from

1. This event occurred in the past and cannot be corrected.
2. All residents receiving medications from the pharmacy have the potential to be affected.
3. The nursing staff will be re-educated by staff development on the importance of projecting the date needed to re-order medications from the pharmacy. The pharmacy contract states that they are to provide the script to a back-up pharmacy if they are unable to supply the medication. The contract with the pharmacy will be reviewed by the facility administrator and the pharmacy GM to support understanding of this policy.
4. QA or designee will audit 10% of resident MARs for delay in receipt or availability of medications and report any out of compliance findings in QA.

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pharmacy. "
On 11/29/16 at 4:45 pm, the administrative team was notified of the above documented findings.
On 11/30/16 at 9 am, the director of nursing provided a copy of the medication order sheet for Vesicare that was faxed to the pharmacy on 11/15/16. Attached to the fax order sheet was a confirmation sheet of the fax that was sent with the date of " 11/15/16 " , time of " 16:33 (4:33 pm) " and result of the fax stated " OK " . The director of nursing stated, " I have called the pharmacy and spoke to the pharmacist about this and he told me that the pharmacy did not receive the fax for this medication and it was not until the facility called the next day that the pharmacy knew that this medication was needed. "
No further information was made available to the surveyor prior to the exit conference on 11/30/16.
2. The facility staff failed to ensure the medication Fentanyl was made available for the medication administration to Resident #7.
Resident #7 was admitted to the facility on 8/25/16 with the following diagnoses of, but not limited to atrial fibrillation, anxiety, depression, chronic pain, malaise, adult failure to thrive and retention of urine.
The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/31/16 with a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. The resident was also coded as requiring extensive assistance from 2 staff members for dressing and personal hygiene. Resident #7 was totally dependent on 2 staff members for personal hygiene.
On 11/29/16 at approximately 9:30 am, the resident ' s clinical record was reviewed. It was noted by the surveyor that a physician order was written that stated " 9/9/16 0840 (8:40 am) May

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F 425	Continued From page 25 hold Fentanyl patch until arrives from pharmacy. " The surveyor reviewed the monthly physician ' s order sheet for September, 2016 and the following order was noted " Fentanyl 25 mcg/hr. (microgram per hour) ...Remove and apply 1 patch every 72 hours (Pain) ... " On the back of the MAR (Medication Administration Record) dated for 9/1/16 thru 9/30/16, the surveyor also noted that on 9/9/16 it stated " Fentanyl patch hold d/t (due to) unavailable, MD ...notified ... " On 11/29/16 at 4:45 pm, the administrative team was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 11/30/16.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		1/6/17

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F 441	Continued From page 26 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow established infection control guidelines during a wound care observation for 1 of 18 residents (Resident #2). The findings included: The facility staff failed to follow infection control guidelines during a wound care observation on Resident #2. The registered nurse #3 failed to wear gloves when cleaning an open scabbed area on the resident's left foot and failed to wash hands for the required time as recommended by the CDC (Centers for Disease Control). Resident #2's clinical record was reviewed 11/29/16. Resident #2 was admitted to the facility 11/10/11 with diagnoses that included but not limited to urinary tract infection, dementia, chronic venous embolism and thrombosis, hypertension,	F 441	1. These items cannot be corrected as they happened in the past. 2. All residents receiving wound care have the potential to be affected. 3. All staff are expected to follow infection control and prevention procedures. Staff development will in-service all licensed nursing staff on infection control when providing wound care. 4. QA will conduct random observations of wound care procedures on 10% of residents, monthly, for 6 months and submit findings to QA.	

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and Parkinson ' s disease.
Continued review of the clinical record revealed a significant change in assessment MDS assessment with the ARD of 9/22/16. The facility staff coded that Resident #2 had a Cognitive Summary Score of 15. Section M Skin Conditions assessed the resident with a stage III (3) pressure ulcer that measured 0.5 cm (centimeters) x 0.5 cm x 0.0 cm.
The surveyor observed wound care on 11/29/16 at 9:40 a.m. with registered nurse #3. R.N. #3 obtained the supplies for the wound care from the treatment cart and placed them on top of the cart and opened the bottle of normal saline. R.N. #3 dropped the lid and stated she would throw that bottle away after the wound care. R.N. #3 entered the resident's room bringing the treatment cart with her and washed her hands for approximately 15 seconds. R.N. #3 removed the resident's socks. R.N. #3 applied normal saline to a gauze and cleaned the resident's hammer toe on the left foot. R.N #3 was observed cleaning the toe with the wound without gloves. R.N. #3 then washed hands for approximately 5 seconds. R.N. #3 than applied betadine to the top of the toe on the left foot. Again, no gloves were worn by R.N. #3. R.N. #3 then washed her hands for approximately 5 seconds.
R.N. #3 placed a long pad underneath Resident #2's feet. Gloves applied. R.N. #3 cleaned both heels with dermal wound cleanser. Gloves removed and hands washed for 5 seconds. Gloves applied. R.N. #3 then applied skin prep spray to both heels and rubbed the skin prep on the heels with the gloved hands. R.N. #3 then sprayed the toes on the right foot with skin prep spray and removed the gloves. Hands washed for approximately 5 seconds. With gloves on, kling was applied to both legs and ace wraps.

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R.N. #3 removed the gloves and washed her hands less than 15 seconds.
The surveyor requested the facility policy on infection control, dressing change protocol, and handwashing from the director of nursing on 11/29/16.
The survey team met with the administrator, the director of nursing, and the assistant director of nursing on 11/29/16 at 4:55 p.m. The surveyor asked if gloves should be used when providing wound care. The administrator stated yes.
The surveyor interviewed R.N. #3 on 11/30/16 at 8:00 a.m. concerning the wound care observed by the surveyor on 11/29/16. The surveyor asked about glove use and why gloves were not worn during the first part of the wound care. R.N. #3 stated she was nervous and that she thought she had put gloves on. The surveyor also asked how long were hands to be washed. R.N. #3 stated she washed her hands for a long time at the beginning and end of the wound care but didn ' t think she needed to wash her hands for the same amount time when she removed her gloves. She stated " I did wash my hands when I changed my gloves and changed my gloves about eight times but I didn ' t wash them as long.
The CDC (Center for Disease Control) accessed at cdc.gov was used as a reference for handwashing. Recommended hand hygiene technique read "Wet hands with water, apply soap, rub hands together for at least 15 seconds, rinse and dry with disposable paper towel, use towel to turn off faucet."
The surveyor reviewed the facility policies for infection control, dressing changes, and handwashing on 11/30/16
The policy titled "Standard Precautions" read in part "Gloves are to be worn whenever exposure to the following is planned or

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F 441	Continued From page 29 anticipated-blood/blood products, urine, feces, saliva, mucous membranes, wound drainage, drainage tubes, non-intact skin, amniotic, cerebral spinal, pericardial, pleural, peritoneal, synovial fluids, and performing venipunctures or invasive procedures." Resident #2 had a scabbed area on her left hammer toe. The skin was not intact. The policy titled "Dressing Change (Clean)" read in part "Observe standard universal precautions or other infection control standards as approved by the appropriate facility committee. Wash your hands before and after all procedures. Wear gloves when appropriate." The policy titled "Hand Washing" read in part under "General Instructions: 3. Hands should be vigorously washed for 20 seconds and must be performed under the following conditions: before donning gloves, if gloves are required, after removing gloves." No further information was provided prior to the exit conference on 11/30/16.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		1/20/17

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 4 of 18 residents (Resident #8, Resident #9, Resident #4, and Resident #1) and failed to record the dates water temperatures were obtained.

The findings included:

1. The facility staff failed to ensure accurate documentation on Resident #8's August 2016 and September 2016 medication administration records. All of the doses of Ampicillin administered were not documented on the MARs. The facility staff also failed to accurately complete a telephone order when the lab tests were unable to be completed and failed to document the reasons the physician order dated 9/26/16 was not completed.

The clinical record of Resident #8 was reviewed 11/29/16. Resident #8 was admitted to the facility 8/26/16 with diagnoses that included but not limited to cognitive communication deficit, Parkinson's disease, dementia with behavioral disturbances, anxiety, agitation, urinary retention, orthostatic hypotension, depression, and constipation.
The admission minimum data set (MDS) with an assessment reference date (ARD) of 9/5/16 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Resident #8 was without any

1. These events occurred in the past and cannot be corrected.
2. All residents have the potential to be affected.
3. Nurses taking off the medication orders will mark out dates/blocks for start and conclusion of time-frame specific medications (such as antibiotics) and ensure correct number of doses are projected. If missing doses are noted, especially at change-over of monthly MARS, the pharmacy will be notified immediately so the doses can be delivered. The DON will request a monthly PRN anxiety medication use report to review for complete documentation of use and effectiveness of medication. DNR forms will be completed prior to filing in the medical record. The MDS Nurses will keep a copy of bathing logs provided to them by the bath team to assist in keeping track of residents who routinely refuse baths. Refusals will be care planned after two consecutive declinations. Bathing preferences will be care planned. Staff Development will re-educate CNAs on bathing documentation in Care Tracker. The facility will maintain a copy of all flu consents that are given by outside contractors. Housekeeping staff will date the water temperature logs.

4. Staff will be in-serviced by Staff Development on documentation for

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signs or symptoms of delirium, psychosis, or behaviors affecting others.
(a). The clinical record had a physician order dated 8/30/16 that read "Ampicillin 500 mg (milligrams) p.o. (by mouth) tid (three times a day) x 7 days."
The surveyor reviewed the August 2016 medication administration records (MARs) and the September 2016 MARs. The August 2016 MARs documented 5 doses of Ampicillin were administered. The September 2016 MARs documented 15 doses had been administered. Resident #8 should have received 21 doses of Ampicillin.
The surveyor informed the director of nursing of the above concern on 11/29/16 at 1:00 p.m. and asked if Ampicillin was in the facility stat box and requested the pharmacy manifest for Ampicillin.
The DON provided the surveyor with the "Emergency Drug Kit Usage Report" dated 8/30/16. The report documented four pills of Ampicillin 250 mg had been used on 8/30/16.
The pharmacy manifest documented 21 Ampicillin 500 mg capsules had been delivered to the facility.
The medication administration records for August 2016 and September 2016 failed to document all doses of the Ampicillin administered.
(b) The clinical record had an order dated 9/26/16 0125 that read "1. UA (urinalysis) with C&S (culture and sensitivity) 2. BMP (basic metabolic panel)-abnormal urine" and an order dated 9/27/16 0125 "May obtain UA with C&S & BMP on 9/27/16 abnormal urine."
The surveyor was unable to locate the results of the 9/26/16 urinalysis and the BMP. There was no documentation in the clinical record why the urinalysis and BMP were not obtained and there was no current order to discontinue the physician

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physicians' orders and the procedure for follow-up of orders if they are unable to be collected. DON will audit 10% of records of residents who use PRN anxiety medications for documentation of use and effectiveness and will submit report to QA. QA will audit 10% of resident MARs, TARs and lab sheets. QA will audit all DNR forms for completion on the medical record, and then during the admission process through the new admission audit. QA will audit 10% of care plans of residents who are assisted with bathing for compliance with care plan documentation. QA to audit 10% of charts for flu-consent on the chart. Water temperature logs will be reviewed by the housekeeping supervisor for date and submitted to QA monthly.

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order dated 9/26/16.
The surveyor interviewed licensed practical nurse #2 on 11/30/16 at 7:45 a.m. L.P.N. #2 stated the resident had been combative. She stated the behaviors happened after midnight. L.P.N. #2 stated she was unable to get the urine and the lab work on 9/26/16. L.P.N. #2 stated that the order had been wrong. L.P.N. #2 stated the order written 9/26/16 should have been discontinued when not obtained and documented in the progress note.
The surveyor interviewed the director of nursing (DON) on 11/29/16 at 1:15 p.m. The DON explained the process for obtaining a laboratory test. The physician gives an order for the laboratory test either a stat order or for a specific day. Often times, especially with a urinalysis, the resident may not be able to provide a sample at the time of collection. If that is the case, the order would be discontinued and a new order would be obtained by the physician for the day of collection, and the physician would be notified the lab was unable to be obtained the day they requested. There are many scenarios this may occur, if the resident was combative, away from the facility at the time or maybe unable to provide a clean catch specimen and refused in and out catheter collection.

The surveyor requested the facility policy on documentation and medication administration from the director of nursing on 11/29/16. The surveyor reviewed the facility policy on medication administration/documentation on 11/29/16. The policy read in part "Medications and treatments must be charted immediately following the administration by the person administering the drugs or treatments. The date, time administered, dosage, etc., must be entered in

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the medical record and signed by the person entering the data." The policy titled "Nursing Documentation-24 hour report/Change of Condition" read in part "All nursing staff enter pertinent information on the assigned shift, including follow-up of existing conditions and the addition of new changes of condition. Each condition shall be documented on the 24-hour report and reviewed with the Care plan team as designated. Documentation of specific time and persons notified shall be completed in the interdisciplinary notes."

The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 11/29/16 at 4:55 p.m.

No further information was provided prior to the exit conference on 11/30/16.

2. The facility staff failed to ensure a complete and accurate DDNR (Durable Do Not Resuscitate) form for Resident #9.

The clinical record of Resident #9 was reviewed 11/30/16. Resident #9 was admitted to the facility 2/23/16 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, history of Hodgkin's Lymphoma, depression, hyperlipidemia, Vitamin B 12 deficiency, anxiety, gastroesophageal reflux disease, and psychosis.

Resident #9's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/3/16 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Resident #9 was without any signs or symptoms of delirium, behaviors, or psychosis.

The clinical record contained a "Durable Do Not Resuscitate (DDNR)" form dated 7/1/16. The

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DDNR form included in the clinical record read in part:
I further certify (must check 1 or 2):
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an informed decision...

If you checked 2 above, check A, B, or C below:
A. While capable of making an informed decision, the patient has executed a written advanced directive...
B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf "...
C. The patient has not executed a written advanced directive...

There were no checks in any of the boxes on the DDNR form. The section at the bottom of the DDNR form had been signed by the physician. The form was dated 7/1/16.

A review of the admission physician orders dated 11/1/16 identified Resident #9 as "DNR-Do Not Resuscitate".
The clinical record also contained a "Virginia Physician Orders for Scope of Treatment (POST)" form dated 9/14/15. The POST form was completed and included information on DNR status.
The surveyor informed the director of nursing of the above incomplete DDNR on 11/30/16 at 9:05 a.m. The DON stated the POST form was current, was the resident's direct wishes and was physician ordered and honored as an order. The DON stated the POST form was sent with the resident when sent out of the facility. The DON

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did confirm the incomplete DDNR in the clinical record and questioned how the form had been in the chart without being completed.
The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the quality assurance registered nurse of the above finding on 11/30/16 at 2:20 p.m.
No further information was provided prior to the exit conference on 11/30/16.
3. The facility staff failed to document Resident #4 ' s refusal of his baths/showers.
Resident #4 was admitted to the facility on 10/11/15 and readmitted on 11/24/16; with diagnoses of anemia, high blood pressure, depression, asthma, acute kidney failure, and pulmonary fibrosis.
Resident #4 most recent MDS (minimum data set) assessment completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 10/26/16. Section C (cognitive patterns) of this assessment scored the resident a 14, indicating the resident was cognitively intact. Section B coded the resident to understand and to be understood. He was also coded requiring assistance of 1-2 persons for bed mobility, dressing, toileting, bathing, and hygiene.
The comprehensive care plan was reviewed. The care plan indicated the resident was incontinent and requires assistance with all activities of daily living except for eating. The care plan was not individualized to note the resident had been refusing his baths.
Review of Resident #4 ' s Bathing detail report for the months of August, September, October and November of 2016, revealed he did not have regular documentation for showers or bed baths He had multiple partial baths documented but no showers where documented and only 8 full bed

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baths for four months were documented.
On 11/29/16 at 10:40am CNA #1 was asked if the resident had refused baths. She responded ' "
We took over doing showers in August. There is a something or some place in care tracker I need to document his refusals. "
At 10:45 CNA #2 was asked what she did when a resident refused showers. She stated. " We tell the nurse and there is a place in care tracker we document refusals. "
The care tracker report did have 8 declines for bathing documented for the 4 months reviewed.
On 11/30/16 the director of nurses was asked if she would look and see if Resident #4 had been care planned for refusing bathing. At 12:00 PM, the director of nurses informed the surveyor. " I looked at Resident #4 ' s care plan and it did not contain documentation of his refusing care (bathing). "
The administrator and director of nursing were informed of the findings during a meeting with the survey team on 11/30/16 at 2:15 p.m.
Prior to exit no further information was provided to the surveyor related to the lack of documentation.
4. The facility staff failed to maintain a complete and accurate clinical record for Resident #1.

Resident #1 was admitted to the facility on 3/11/16 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, and depression, and weakness, history of falling, edema and chronic pain. The most recent MDS quarterly assessment with an ARD (Assessment Reference Date) of 9/7/16 scored the resident with a BIMS (Brief Interview for Mental Status, an assessment tool) score of 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. BUILDING _____ B. WING _____	C 11/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

(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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for personal hygiene and was totally dependent on 2 staff members for bathing.

The surveyor reviewed the clinical record of Resident #1 on 11/29/16 at 2:05 pm. The surveyor noted that Influenza (Flu) Consent was not in the clinical record. It was documented in the in the nurses ' notes and on the MAR (Medication Administration Record) that Resident #1 received the Influenza Vaccine on 11/2/16.

Registered Nurse (RN) #1 was interviewed on 11/29/16 at approximately 2:15 pm at the nurses ' station. RN #1 stated " I cannot find the consent. I know the resident signed it but the company that gave it must have kept the consent. "

On 11/29/16 at 4:45 pm, the administrative team was notified of the above documented findings. The director of nursing (DON) gave the surveyor a copy of a signed consent that the resident signed on 10/14/16. The DON stated " the company that we had to give the flu vaccine kept the consent. We had to call them and they faxed this consent back to us for the chart. "

No further information was provided to the surveyor prior to the exit conference on 11/30/16.

5. The facility failed to record dates and /or initialed that the water temperatures were obtained.

The surveyor went into the housekeeping department with the maintenance director to review the water temperatures logs of the facility on 11/30/16 at 10 am. The surveyor noted a page in the facilities ' log book filed between the month of February, 2016 and April, 2016. The

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page was not dated but did have the following documentation: " Cove Hall #2 " with room numbers present, location, temperature and initials.

Another page in the log book was noted by the surveyor to be dated for " 5-10-16. " The page did not have the initials documented. The Housekeeping Director was interviewed by the surveyor at this time. The Housekeeping Director stated " Those are for the month of March. But I cannot prove this because the dates are missing. I just know they are in the log book between February and April. " The surveyor asked the Housekeeping Supervisor what was to be documented on these water temperature logs. The Housekeeping Supervisor stated. " the date, room number, location temperature and initials of the person that got the temperatures. "

The administrative team was notified of the above documented findings by the surveyor on 11/30/16 at 11 am.

No further information was provided to the surveyor prior to the exit conference on 11/30/16.