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	495281	A. BUILDING _____ B. WING _____	C 06/28/2018

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BLUE RIDGE REHAB CENTER	**300 BLUE RIDGE STREET MARTINSVILLE, VA 24112**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/26/18 through 06/28/18. Significant Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 300 bed facility was 234 during the survey.	E 000		
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.	E 013		8/11/18

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

Electronically Signed | 07/27/2018

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E 013	Continued From page 1 *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the surveyor determined that the facility's emergency plan did not address procedures necessary for resident care staff to provide continuing care to residents in the case of evacuation of the facility. The procedures failed to address procedures for communication and provision of supplies when residents were evacuated. The surveyor reported the concerns to the administrator and director of nursing during a summary meeting on 6/28/18.	E 013	Submission of this response and Plan of Correction is not a legal admission that a deficiency was correctly cited. It is not to be construed as an admission of interest against the facility, the Administrator, Director of Nursing or any employee, agent, or other individuals who draft or may be discussed in this response or the Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged nor the correction of any conclusions set forth in this allegation by the survey agency. For the deficiencies cited during this survey, this facility has developed and implemented a facility-wide system to assure correction and continued compliance with the regulations. This	

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E 013	Continued From page 2	E 013		

facility will provide a complete copy of the deficiency list to the QAA Committee for review and appropriate actions.

We would like you to accept this PoC as our credible allegation of compliance.

Credible Allegation of Compliance

A. Policies and Procedures have been written for resident care staff to provide continuing care to residents if emergency preparedness occurs.

B. Policy now addresses who is responsible for communication and provision of supplies when residents are evacuated to maintain compliance in the event of emergency preparedness.

C. The facility will audit monthly to ensure fire equipment, power, water failure, care related emergencies, during natural disasters are in State and Federal compliance. Inservices and drills will be conducted by the maintenance department with follow-up by the Administrator.

D. Facility performance will be reviewed monthly in the Q.A.A. process for continued compliance by the Q.A. team updates and changes will be monitored also by the maintenance department, Administrator, Director of Nursing and Director of Professional Services.

The facility will be in substantial compliance by August 11, 2018.

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/26/18 through 06/28/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 300 certified bed facility was 234 at the time of the survey. The survey sample consisted of 36 current Resident reviews and 2 closed record reviews .	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		8/11/18

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F 550	Continued From page 4 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to respect Resident rights for 1 of 38 Residents, #229. The findings included: For Resident #229 the facility staff failed to knock on a closed room door prior to entering. Resident #229 was admitted to the facility on 10/15/14 and readmitted on 06/04/18. Diagnoses included but not limited to coronary artery disease, hypertension, gastroesophageal reflux disease, urinary tract infection, hyperlipidemia, hypothyroidism, arthritis, Alzheimer's disease, cerebrovascular accident, hemiplegia, seizure disorder, depression and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with	F 550	A. Dignity for Resident #229 is being met by establishing the importance in knocking on the door prior to entrance to maintain and protect a right to privacy. CNA #1 was re-inserviced about knocking on resident doors prior to entering their room. B. Social Services has conducted an interview with all interviewable residents to ensure compliance. C. To ensure the deficient practice will not recur, all staff has been re-inserviced to knock on all resident doors, to introduce themselves and to tell the resident what they are there to do. Monthly resident council meetings and resident interviews will continue.	

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F 550	Continued From page 5 and ARD (assessment reference date) of 06/11/18 coded the Resident as 12 of 15 in section C, cognitive patterns. This is a significant change MDS. The surveyor spoke with the Resident on 06/27/18 at approximately 1000. While the surveyor was in the room with the Resident, the Resident had requested the door to be closed. At approximately 1005, CNA (certified nurse's aide) #1 opened the door and entered the room without knocking or asking permission from the Resident. Surveyor asked the Resident if CNA's usually knocked on the door prior to entering, and he stated, "some do, some don't". The surveyor spoke with the DON (director of nursing) on 06/27/18 at approximately 1500 regarding the CNA knocking or asking permission to enter room and DON stated that CNA should have knocked before entering room. DON also stated that she would re-educate the CNA on Resident's rights. The surveyor requested and was provided with a facility policy entitled "Resident's Rights" which read in part "Provide Privacy: Knock on Resident's door before entering their room". The concern of the CNA not knocking on the Resident's door was discussed with the administrative team during a meeting on 06/28/18 at approximately 1255. No further information was provided prior to exit.	F 550	D. Nursing staff was re-inserviced during the survey to knock on residents□ doors. All other staff will be re-inserviced to knock on residents□ doors. The Administrator, Director of Professional Services, Director of Nursing, unit coordinators and Quality Assurance Team members will monitor for knocking on doors daily. The facility will be in substantial compliance by August 11, 2018.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		8/11/18

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the

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F 578	Continued From page 7 appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure code status was correct for 4 of 36 Residents, #90, #1, #232 and #226. The findings included: 1. For Resident #90 the facility staff failed to ensure code status was correct. Resident #1 was admitted to the facility on 11/08/17. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, hyperlipidemia, dementia, and anxiety. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/27/18 coded the Resident as 15 of 15 in section C, cognitive status. The Resident's clinical record was reviewed on 06/26/18. It contained a Virginia Department of Health DDNR (durable do not resuscitate) form, which was completed, signed and dated by the physician and the Resident's authorized representative. The clinical record also contained a signed physician's order summary for the month of June, which listed the Resident's code status as "full code". The surveyor spoke with the DON (director of nursing) on 06/27/18 at approximately 1435 regarding Resident #'90's code status. Surveyor asked the DON if the POS (Physician's Order Sheet) should indicate the Resident's code status and DON stated, "They should match".	F 578	A. Corrective action has been accomplished for Resident #90, Resident #1, Resident #232, and Resident #226. These residents have been placed on Do Not Resuscitate status. B. Audits on all units of all residents with Do Not Resuscitate status have been accomplished and are in compliance with physician□s orders to prevent re-occurrence. Persons assisting in the audits were the MDS team, unit coordinators, Director of Nursing and Director of Professional Services. C. To ensure the deficient practice does not occur again, the facility will be performing a monthly monitoring of audits on all new admissions and those residents with change in condition. We have a new system called the Red Dot System in which a red dot will be placed at each resident□s name which identifies Do Not Resuscitate accuracy. This will be updated with change in status by the charge nurses and unit coordinators. D. The facility will monitor its performance to ensure continued compliance through audits weekly and monthly and with change in condition. These audits will be turned in to the QAA team monthly to maintain compliance. Director of Nursing, Director of Professional Services and Administrator will follow up on audits monthly.	

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F 578	Continued From page 8 The DON and DPS (director of professional services) provided the surveyor with a copy of corrected physician's order summary for Resident #90 on 06/28/18 at approximately 0830. The DPS stated that they had completed a full audit of all clinical records to ensue code status was correct for each Resident and provided survey with a copy of the audit. The concern of the incorrect code status was discussed with the administrative team during a meeting on 06/28/18 at approximately 1255. No further information was provide prior to exit. 2. For Resident #1 the facility staff failed to ensure code status was correct. Resident #1 was admitted to the facility on 02/01/17 and readmitted on 02/15/18. Diagnoses included but not limited to hypothyroidism, hyperlipidemia, dementia, depression, anxiety, hypertension, pneumonia, hyperlipidemia, dementia, malnutrition, anxiety, depression, and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 03/13/18 coded the Resident as 9 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #1's clinical record was reviewed on 06/27/18. It contained a face sheet which was checked as DNR (do not resuscitate). The clinical record also contained a signed POS (physician's order summary) dated 05/29/18, which read in part "05/09/18 Code Status: Full Code". The	F 578	The facility will be in substantial compliance by August 11, 2018.	

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F 578	Continued From page 9	F 578		

surveyor could not locate a Virginia Department of Health DDNR (durable do not resuscitate) form in the clinical record.

The surveyor spoke with the DON on 06/27/18 at approximately 1435 regarding Resident #1's code status. DON stated that Resident #1 should be DNR. Surveyor showed the DON the face sheet and the POS, and the DON stated, "They should match".

On 06/27/18 at approximately 1520, MDS coordinator informed the surveyor that the Resident been out to hospital recently. Prior to that, the code status correct on POS. The Resident's DDNR form had been placed in discharge record while she was in hospital and when Resident was re-admitted, "full code" was written on POS in error and sent to pharmacy. MDS coordinator provided the surveyor with a copy of signed and dated VDH DDNR form for Resident #1.

The DON and DPS (director of professional services) provided the surveyor with a copy of corrected physician's order summary for Resident #1 on 06/28/18 at approximately 0830. The DPS stated that they had completed a full audit of all clinical records to ensue code status was correct for each Resident and provided survey with a copy of the audit. .

The concern of the incorrect code status was discussed with the administrative team during a meeting on 06/28/18 at approximately 1255.

No further information was provide prior to exit.
3. The facility staff failed to have the correct code status documented for Resident #232.

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Resident #232 was admitted to the facility on 2/12/15 with the following diagnoses of, but not limited to atrial fibrillation, high blood pressure, arthritis, diabetes, Alzheimer's disease, anxiety disorder and psychotic disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/1/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #232 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for bathing.

On 06/27/18 at 4:09 pm, the surveyor reviewed the clinical record of Resident #232. In this review, it was noted that on the Physician Order Sheet dated for 5/1/18, the resident was documented as being a "Full Code". The resident's face sheet in the electronic clinical record has Full Code marked with a check beside of it. The surveyor also noted during the paper chart clinical record review, the resident had a "Durable Do Not Resuscitate Order" dated for 2/18/18 and signed by the doctor and the resident's representative. The surveyor notified LPN (licensed practical nurse) #1 of the above documented findings at 4:30 pm.

On 6/28/18 at 12:42 pm, the surveyor notified the administrative team of the above documented findings.

At 1:30 pm, the director of nursing provided a copy of a physician order dated for 6/28/18 which stated, "D/C (discontinue) Full Code Status triangle sign (for change) to DNR".

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F 578	Continued From page 11	F 578		

No further information was provided to the surveyor prior to the exit conference on 6/28/18.

4. The facility staff failed to have the correct code status documented for Resident #226. Resident #226 was readmitted to the facility on 3/21/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, high blood pressure, diabetes, dementia and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/27/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #226 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor conducted a clinical record review of Resident #226's paper and electronic chart on 6/27/18. During this review, it was noted that in the paper chart there was a "Durable Do Not Resuscitate Order" that was signed and dated for 3/14/17. The surveyor also reviewed the electronic chart and it was noted that Code Status was marked as "Full Code".

At 2:05 pm, the surveyor notified LPN (Licensed Practical Nurse) #1 of the above documented findings. LPN #1 reviewed the electronic chart along with the paper chart. LPN #1 stated, "These don't match. I see what you were saying."

At 3:30 pm, the surveyor notified the director of clinical services of the above documented findings.

No further information was provided to the

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F 578	Continued From page 12 surveyor prior to the exit conference on 6/28/18.	F 578		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure complete and accurate Minimum Data Set (MDS) assessments for 6 of 38 in the sample survey, Resident #62, Resident #71, Resident #228, Resident #226, Resident #10 and Resident #88. The Findings Included: 1. For Resident #62 the facility staff failed to code/capture a diagnosis of Bipolar in Section I. Active Diagnoses 5900. on a Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) OF 4/16/18. Resident #62 was a 76 year old female who was admitted on 11/23/09. Admitting diagnoses included, but were not limited to the following: hyperthyroidism, bipolar disease, neuropathy, hypertension, contracture and cerebral infarct due to unspecified occlusion or stenosis of unspecified cerebral artery. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with the Assessment Reference Date (ARD) of 4/16/18. The facility staff coded that Resident #62 had a Cognitive	F 641	A. The MDS Assessment will accurately reflect the status for Residents #63, #71, #228, #226, #10 and #88. Corrective action has been accomplished for Resident #62. Diagnosis of Bipolar was corrected and a copy provided to the survey team. Resident #71 □MDS has been corrected and coded a fall; this was provided to the survey team. Resident #228□ MDS was corrected and aspirin has been removed from the MDS as an anticoagulant. Resident #10 □MDS was corrected and aspirin has been removed from the MDS as an anticoagulant. Resident #8 □MDS was corrected and aspirin has been removed from the MDS as an anticoagulant. Corrections were provided to the survey team before exit. Resident #226 □MDS Section K0310 now reflects proper coding of weight loss; dashes are not used. B. An audit review of all residents□ medical records of the MDS has been completed for dietary, anticoagulants, falls on all residents having the potential to be affected by the same deficient practice. Re-inservicing has been completed.	8/11/18

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F 641	Continued From page 13 Summary Score of 5. The facility staff also coded that Resident #62 required total nursing care (4/3) for Activities of Daily Living (ADL's). In Section I. Active Diagnoses, the facility staff did not code/capture the diagnosis of Bipolar in I. 5900 Manic Depression (Bipolar Disease). On June 27, 2018 at 8:28 a.m., the surveyor reviewed the clinical record. Review of the clinical record produced the face sheet that documented that Resident #62 had a diagnosis of being Bipolar. Review of the clinical record also produced physician visits dated 3/6/18 and 5/9/18 that documented that Resident #62 had a diagnosis of Bipolar. On June 27, 2018 9:00 a.m., the surveyor notified the Unit Manager (UM), who was a Licensed Practical Nurse (LPN), that Resident #62's Quarterly MDS with the ARD of 4/16/18 was incorrect. The surveyor reviewed the clinical record with the UM. The surveyor specifically pointed out that Resident #62 had diagnoses of being Bipolar. The surveyor then reviewed the Quarterly MDS with the ARD of 4/16/18. The surveyor specifically pointed out that Section I. Active Diagnoses I.5900 was not coded/captured for the diagnoses of Bipolar. The LPN stated she would do a correction to the Quarterly MDS. On June 28, 2018 at 12:40 p.m., the survey team met with the Chief Executive Officer (CEO), Administrator, Director of Nursing (DON) and Director of Profession Services (DOPS). The surveyor notified the Administrative Team (AT) that Resident #62's Quarterly MDS with the ARD of 4/16/18 was inaccurate. The surveyor notified the Administrative Team that Resident #62's Quarterly MDS with the ARD of 4/16/18 was not	F 641	C. To ensure the deficient practice will not recur, the following measures will be put into place. A review of all charts will be conducted by the MDS Coordinator and MDS nursing staff to identify other residents having the potential to be affected by the same deficient practice. This review will include emphasis on correct documentation that accurately reflects the resident□s status. Reviewed results will be collected by the Director of Nursing and Director of Professional Services monthly and reported to the quarterly Q.A. Committee. MDS Director and Director of Nursing have re-inserviced all MDS Coordinators and Dietary Service Manager. D. Senior nursing staff, including all unit coordinators, MDS nurses and dietary were re-inserviced on the necessity of the MDS assessment and how it must accurately reflect the resident□s status. This will be monitored weekly/monthly by the Q.A.A. team. The facility will be in substantial compliance by August 11, 2018.	

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coded to capture the diagnosis of Bipolar in Section I 5900.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #62.

2. For Resident #71 the facility staff failed to capture/code a fall on the Admission Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) OF 4/10/18.

Resident #71 was a 59 year old female who was admitted on 4/3/18. Admitting diagnoses included, but were not limited to: Meralgia parasthetica of the right lower limb, chronic pain, hypertension and unspecified abnormalities of gait and mobility.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Admission MDS assessment with an Assessment Reference Date (ARD) of 4/10/18. The facility staff coded that Resident #71 had a Cognitive Summary Score of 18. The facility staff also coded that Resident #71 required limited (2/2) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section J. Health Conditions 1800. the facility staff coded that Resident #71 had not had any recent falls.
On June 26, 2018 at 2:31 p.m., the surveyor reviewed Resident #71's 's clinical record. Review of the clinical record produced a facility fax to the physician that documented that Resident #71 had a fall on 4/7/18.

On June 26, 2019 at 3:09 p.m., the surveyor notified the Unit Manager (UM), who was a

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Licensed Practical Nurse (LPN), that Resident #71's Admission MDS with the ARD of 4/10/18 was incorrect. The surveyor reviewed Resident #71's clinical record with the UM. The surveyor pointed out the physician fax on 4/7/18 that documented Resident #71's fall. The surveyor then reviewed the Admission MDS with the UM. The surveyor specifically reviewed Section J of the MDS. The surveyor pointed out that the fall was not coded in Section J. 1800 Falls. The surveyor notified the UM that the facility staff had coded no falls.

On June 28, 2018 at 12:40 p.m., the survey team met with the Chief Executive Officer (CEO), Administrator, Director of Nursing (DON) and Director of Profession Services (DOPS). The surveyor notified the Administrative Team (AT) that Resident #71's Admission MDS with the ARD of 4/10/18 was inaccurate. The surveyor notified the Administrative Team that Resident #71's Admission MDS was not coded to capture Resident #71's fall on 4/7/18.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #71.

3.For Resident #228 the facility staff incorrectly coded Aspirin as an anticoagulant in Section N. Medications on an Annual Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) of 6/14/18.

Resident #228 was a 67 year old female who was admitted on 7/7/05. Admitting diagnoses included, but were not limited to the following: Keratoconjunctivitis, hypertension, dysphasia,

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pain and unsteadiness on feet.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with the Assessment Reference Date (ARD) of 6/14/18. The facility staff coded that Resident #228 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #228 required limited (2/2) to extensive assistance (4/2) with CTIVITIES OF Daily Living (ADL's). In Section N. Medications, the facility staff coded that Resident #228 received 7 days of an anticoagulant.

On June 27, 2018 at 9:06 a.m., the surveyor reviewed Resident #228's clinical record. Review of the clinical record did not produce a physician order for an anticoagulant. Signed physician orders included an order for "ASPIRIN 81 MG CHEWABLE TABLET (FOR ASPIRIN 81 MG CHEWABLE TA (tablet) 1 TABLET BY MOUTH DAILY DX (diagnoses): PROPHYLAXIS." (sic)

On June 27, 2018 at 9:30 a.m., the surveyor notified the Unit Manager (UM), who was a Licensed Practical Nurse (LPN), that Resident #228's Annual MDS with the ARD of 6/14/18 was incorrect. The surveyor notified the UM that the Annual MDS was coded that Resident #228 received 7 days of an anticoagulant. The surveyor informed the UM that Resident #228 was not on an anticoagulant. The surveyor reviewed the clinical record with the UM. The surveyor then reviewed the Annual MDS with the ARD of 6/14/18 with the UM. The UM stated she had coded the Aspirin as an anticoagulant. The surveyor informed the UM that Aspirin was not an anticoagulant. The UM stated she would do a correction on the Annual MDS assessment with

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the ARD of 6/14/18.

On June 28, 2018 at 12:40 p.m., the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON) and Director of Profession Services (DOPS). The surveyor notified the Administrative Team (AT) that Resident #228's Annual MDS with the ARD of 6/14/18 was inaccurate. The surveyor notified the Administrative Team that Resident #228's Annual MDS was coded that she received 7 days of an anticoagulant. The surveyor notified the AT that Resident #228 was on Aspirin and that Aspirin was not an anticoagulant.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #228.

4. The facility staff failed to complete an accurate MDS (Minimum Data Set) for Resident #226.

Resident #226 was readmitted to the facility on 3/21/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, high blood pressure, diabetes, dementia and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/27/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #226 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor performed a clinical record review on Resident #226 on 6/26/18. At this time, the surveyor noted that on the MDS with an ARD of

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3/27/18 under Section K0300 concerning weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months, this was answered with a dash in the box. Under Section K0310, concerning weight gain of 5% or more in the last month or gain of 10% or more in the last 6 months, this was also answered with a dash in the box.

The surveyor notified the dietary manager of the above documented findings at 1:30 pm. The dietary manager stated, "This resident refuses to be weighed so I put dashes in these boxes because of that."

The surveyor also notified MDS nurse #1 of the above documented findings at 2:30 pm.

On 6/27/18 at 8:30 am, the MDS nurse #1 returned to the surveyor and stated, "You were right. Those boxes should had been answered using the key that was provided and not with the dashes."

At 11 am, the MDS nurse #1 returned to the surveyor and provided copies of Section K on the MDS that had been resubmitted with corrections made to the above documented areas in Section K0300 and K0310.

On 6/28/18 at 12:45 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 6/28/18.
5. The facility staff improperly coded on MDS that Resident # 10 was on an anticoagulant.

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Resident # 10 is an 87-year-old-female who was originally admitted to the facility on 4/28/14, with a readmission date of 1/3/15. Diagnoses included but not limited to: dementia with behavioral disturbance, hypertension, atrial fibrillation, and, glaucoma.

The clinical record for Resident # 10 was reviewed on 6/27/18 at 9:20 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/22/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 10's cognitive status is severely impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 10 had received an anticoagulant for 7 days during the lookback period of the 3/22/18 ARD.

The current plan of care for Resident # 10 was reviewed and revised on 3/22/18. The facility staff documented a problem area for Resident # 10 as "Resident # 10 has the DX (diagnosis) of: CHF (congestive heart failure), HTN (hypertension), Chronic ischemic heart disease, & CAD (coronary artery disease) which all makes her at risk for cardiac distress." Interventions included but are not limited to: "Administer medications as ordered, monitor for any adverse reactions and notify the MD (medical doctor) as needed."

The physician signed the current orders for Resident # 10 on 5/13/18. Resident # 10 has current orders for "Aspirin 81 mg (milligram) chewable tablet, 1 tablet by mouth daily with breakfast." Upon further review of the current physician's orders and the physician's orders for March of 2018, this surveyor did not locate any

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orders for anticoagulant medications.

On 6/27/18 at 9:28 am, the surveyor spoke with unit coordinator # 1 and director of professional services about the aspirin being coded as an anticoagulant for Resident # 10 when it should not have been. Unit coordinator # 1 stated, "We will get it corrected."

On 6/28/18 at 12:30 pm, the MDS director provided the surveyor with a validation report that Section N of the MDS with 3/22/18 ARD had been corrected to reflect that the resident did not receive any anticoagulants.

On 6/28/18 at 12:54 pm, the administrative team was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 6/28/18.

6. The facility staff improperly coded on the MDS that Resident # 88 was on an anticoagulant.

Resident # 88 is a 55-year-old-male who was originally admitted to the facility on 8/15/12, with a readmission date of 1/22/18. Diagnoses included but were not limited to: major depressive disorder, seizures, cerebrovascular disease, and hypertension.

The clinical record for Resident # 88 was reviewed on 6/26/18 at 11:11 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/27/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 88 had a BIMS (brief interview for

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mental status) score of 7 out of 15, which indicates that Resident # 88's cognitive status is severely impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 88 had received an anticoagulant for 7 days during the lookback period for the 4/27/18 ARD.

The current plan of care for Resident # 88 was reviewed and revised on 4/30/18. The facility staff has documented a problem area as "Resident # 88 has had a CVA (cerebrovascular accident)/ TIA (transient ischemic attack) in the past and is at risk for recurrence." Interventions include nut are not limited to: "Administer medications as ordered, monitor for any adverse reactions and notify the MD (medical doctor) as needed."

The physician signed the current orders for Resident # 88 on 6/9/18. Resident # 88 has a current order for "Aspirin EC (enteric coated) 81 mg (milligram) tablet, 1 tablet by mouth daily with breakfast." Upon further review of the orders and the orders from April 2018, the surveyor could not locate any orders for anticoagulants.

On 6/26/18 at 1:39 pm, the surveyor spoke with unit coordinator # 1. The surveyor and unit coordinator # 1reviewed Section N of the MDS where Resident # 88 has been coded as receiving an anticoagulant. The surveyor asked unit coordinator # 1 what anticoagulant Resident # 88 was receiving. Unit coordinator # 1reviewed the physician's orders for Resident # 88 and stated, "He is on aspirin." The surveyor informed unit coordinator # 1 that aspirin should not be coded on the MDS as an anticoagulant. Unit coordinator # 1 stated that she would check into it

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F 641	Continued From page 22 and get back with the surveyor. On 6/26/18 at 1:52 pm, unit coordinator # 1 stated to the surveyor "I'm sorry, I made a mistake." "(Employee name withheld) is going to correct it now." On 6/27/18 at 1:50 pm, the MDS director presented the surveyor with a validation report that the Section N on the MDS with the ARD of 4/27/18 had been corrected to reflect that Resident # 88 had not received any anticoagulants during the lookback period. On 6/28/18 at 12:50 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 6/28/18.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		8/11/18

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F 657	Continued From page 23 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical, record review, and facility document review, the facility staff failed to include the necessary interdisciplinary team members in the care planning process for 1 of 38 Residents in the final survey sample, Resident # 88. The findings included: The facility staff failed to ensure that a nurse aide with responsibility to the Resident was included in the care planning process for Resident # 88. Resident # 88 is a 55-year-old-male who was originally admitted to the facility on 8/15/12, with a readmission date of 1/22/18. Diagnoses included but were not limited to: major depressive disorder, seizures, cerebrovascular disease, and hypertension. The clinical record for Resident # 88 was reviewed on 6/26/18 at 11:11 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/27/18. Section C of the MDS assesses cognitive patterns. In	F 657	A. Corrective action has been accomplished for those residents found to have been affected by the deficient practice. Audits have been completed by the Unit Coordinators and MDS staff. Resident #88 Care Plan does show that all care plan disciplines are aware of the Plan of Care. B. Residents moving forward from the date of exit will show nurse aide with the responsibility for the resident and will be aware of the Plan of Care with signature. Certified Nursing Assistants (CNA) will review the Plan of Care with Unit Coordinators and MDS team that is current. C. The MDS will be prepared by an interdisciplinary team that invites the CNA caring for that resident to attend the Care Plan meeting. Re-inservicing has been completed with all nursing staff and Social Service Director. D. To ensure that the deficient practice	

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F 657	Continued From page 24 Section C0500, the facility staff documented that Resident # 88 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicates that Resident # 88's cognitive status is severely impaired. On 6/26/18 at 11:46 am, the surveyor spoke with the social services director and asked who participated on the care plan team when preparing and revising the care plans for Resident # 88. The social services director stated to the surveyor that letters are sent out to invite the responsible party to the meetings and that the unit coordinator, social services, and dietary staff are usually in the meetings. The surveyor requested to see verification of who participated in the last care plan conference for Resident # 88. The social services director retrieved a paper from the clinical record of Resident # 88. The "Care Plan Conference Summary" sheet for Resident # 88 that the social services director presented to the surveyor was undated and had 3 signatures documented on the sheet. The surveyor verified with the social services director that this was the log from Resident # 88's most recent care plan. Social services director confirmed that it was. The surveyor asked the social services director to verify the signatures written on the sheet. The social services director confirmed that one signature was his own and the others were the unit coordinator #1 and the dietary manager. The surveyor asked the social services director if CNA staff is involved in the care planning process. The social services director stated to the surveyor "Not usually." "If we have a particular problem we can pull them in." On 6/26/18 at 3:09 pm, the surveyor spoke with	F 657	does not recur, the MDS Director, unit coordinators, Director of Nursing and Director of Professional Services will monitor Care Plan meetings that are scheduled for continued compliance weekly/monthly. The facility will be in substantial compliance by August 11, 2018.	

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F 657	Continued From page 25 the social services director regarding the interdisciplinary team that develops the plan of care for Resident # 88. The surveyor informed the social services director that the interdisciplinary team that must include a nurse aid with responsibility to the resident. The social services director stated, "I wasn't aware of that." On 6/27/18 at 9:55 am, the social services presented the surveyor with the facility policy on "Care Planning - Interdisciplinary Team." Within the policy, there is documentation that includes but is not limited to: " ...2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team, which includes, but is not necessarily limited to the following personnel: h. Nursing assistants responsible for the resident's care (if applicable); ..." On 6/28/18 at 12:50 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 6/28/18.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to provide fingernail care to a dependent resident for 1 of 38 Residents in the	F 677	A. Corrective action has been accomplished for resident #151; nails have been trimmed and nail care provided weekly or when needed.	8/11/18

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F 677	Continued From page 26 sample survey, Resident #151. The Findings Included: Resident #151 was an 87 year old male who was originally admitted on 7/24/13 and readmitted on 3/16/16. Admitting diagnoses included, but were not limited to: anxiety, sleep apnea, chronic pain, heart failure, hypertension, chronic obstructive pulmonary disease and oxygen dependence. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 5/21/18. The facility staff coded that Resident #151 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #151 required extensive (3/2) to total nursing care (4/3) with Activities of Daily Living (ADL's). The facility staff coded that Resident #151 required total nursing care (4/2) with personal care. On June 26, 2018 at 8:26 a.m., the surveyor observed Resident #151 lying in bed and sleeping. The surveyor observed that Resident #151's fingernails were very long and brown debris under the free edge of the nail. On June 26, 2018 at 9:44 a.m., the surveyor reviewed Resident #151's clinical record. Review of the clinical record produced the Comprehensive Care Plan. (CCP). The CCP identified the following Problem, Goals and Interventions. "Problem onset (name withheld) is at risk for self care deficit, he needs assistance with activities of daily living. He was chronic obstructive pulmonary disease, respiratory distress and CHF (congestive heart failure). He has Gout. Goal (resident name withheld) will	F 677	B. All residents have had their nails checked and those found to be dirty or soiled have been cleaned. C. Re-inservicing on ADL care has been completed by the unit coordinators, Director of Nursing, and Director of Professional Services. Nail care is to be provided with each bath and will be checked by the licensed nurses, unit coordinators, nursing supervisors, and Director of Nursing. D. Unit Coordinators and/or charge nurses, supervisors, Director of Nursing, and QA team members will monitor daily on walking rounds for continued compliance and reviewed in the Q.A.A. weekly/monthly. The facility will be in substantial compliance by August 11, 2018.	

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F 677	Continued From page 27	F 677		

continue to participate and accomplish ADLs with staff assistance and will be clean and well groomed daily X (times) 90 days. Interventions Nail care weekly and as needed." (sic)

On June 27, 2018 at 8:08 a.m., the surveyor observed Resident #151 up in the reclining Geri-chair. The surveyor noted that Resident #151 was feeding himself his breakfast and that his nails were very long and had a brown debris under the free edge of the fingernails.

On June 27, 2018 at 9:43 a.m., the surveyor observed that Resident #151 was up in the reclining geri chair. Resident #151's fingernails on both hands are very long, brownish debris under free edge of the nails.

On June 27, 2018 at 9:46 a.m., the surveyor asked for the Unit Manager (UM), who was a Licensed Practical Nurse (LPN), to accompany the surveyor to Resident #151's room. The surveyor and UM went with surveyor to room. The surveyor informed the UM that Resident #151 had very long dirty fingernails. The surveyor and UM stepped over to Resident #151's chair side. The surveyor pointed out that Resident #151's fingernails were very long and dirty. The UM lifted Resident #151's right hand and asked Resident #151 if the facility staff could cut his nails and Resident #151 stated, "I'd love for them do to it." The UM stated she would get a staff member to soak and cut the nails.

On June 27, 2018 at 12:12 p.m., the UM approached the surveyor and stated that Resident #151 declined to have his nails cut, but he allowed them to soak and get them clean.

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F 677	Continued From page 28 On June 28, 2018 at 12:40 p.m. the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON) and Director of Profession Services (DOPS). The surveyor notified the Administrative Team (AT) that Resident #151's fingernails were very long and had a brown debris under the free edge of the fingernails. No additional information was provided prior to exiting the facility as to why the facility staff failed to provide fingernail care to Resident #151. Resident #151 was dependent on staff for personal care.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		8/11/18

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F 690	Continued From page 29 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide appropriate treatment and services for care of a resident with a clinically-justified indwelling catheter for 1 of 38 residents (Resident #184). Resident #184's catheter tubing was observed touching the floor during the initial pool observations. The findings included: The facility staff failed to ensure Resident #184's indwelling Foley catheter tubing was not touching the floor. The clinical record of Resident #184 was reviewed 6/26/18 through 6/28/18. Resident #184 was admitted to the facility 9/1/2012 and readmitted 11/10/15 with diagnoses that included but not limited to retention of urine, adult failure to thrive, anorexia, central pain syndrome, Gastro-esophageal reflux disease, pruritus, pressure ulcer (unspecified site), acute kidney	F 690	A. The facility will ensure that indwelling Foley catheters are anchored to decrease pulling or dislodgement and to prevent tubing from touching the floor for Resident #184. B. An all nursing staff re-inservice has been completed by unit coordinators and the Director of Nursing. This inservice will prevent tubing from touching the floor and will be monitored by charge nurses. C. To ensure that the deficient practice does not recur, a list of residents with Foley catheters has been added to the weekly/monthly Q.A. meeting for Q.A. team members to monitor on Q.A. rounds. D. Residents with indwelling catheters will be monitored for continued compliance by Q.A. team. Each member of the Q.A team has been assigned to units to be monitored and will be reviewed weekly/monthly in the Q.A. meeting.	

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F 690	Continued From page 30 failure, urinary tract infection, rash, and bacteremia. Resident #184's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/31/18 assessed the resident with a BIMS score of 14 out of 15. Section H Bladder and Bowel was coded for an indwelling catheter. The current comprehensive care plan identified Genitourinary as a concern with onset date of 1/3/18. Resident #184 has an indwelling Foley catheter in place r/t (related to) neurogenic bladder and is at risk for infection. The resident has a hx (history) of UTIs (urinary tract infections) is at high risk for recurrence. The resident pulls at catheter tubing and anchor. Approaches: Ensure leg bag is in place when OOB (out of bed), ensure regular drainage bag is in place when in bed, Foley catheter care, Foley catheter to straight drainage, ensure privacy bag is in place over regular drainage bag when in bed, and ensure drainage tubing is secured to the leg. Resident #184's June 2018 physician orders included foley catheter care daily with soap and water, irrigate twice a day with normal saline, and change monthly and as needed. During the initial tour on 6/26/18 at 8:14 a.m., Resident #184 was observed in bed, Foley catheter in privacy bag but Foley tubing touching floor. The surveyor showed the unit manager licensed practical nurse #1 the Foley catheter tubing touching the floor. L.P.N. #1 stated she would take care of the concern. L.P.N. #1 was asked if the Foley catheter tubing should be touching the floor and she responded "No."	F 690	Areas out of compliance be re-inserviced on an ongoing basis. The facility will be in substantial compliance by August 11, 2018.	

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F 690	Continued From page 31	F 690		

L.P.N. #1stated the resident may have moved around in the bed. The resident was observed to be able to use the remote controls to raise and lower the head of the bed; however, the bed is a crank type of bed and staff are responsible for raising and lowering the bed.

The surveyor informed the director of nursing of the above concern on 6/26/18 at 8:45 a.m. and requested the facility policy on Foley catheter care.

The surveyor reviewed the facility policy titled "Catheter Care, Foley." The policy focused only on cleaning of the Foley.

The surveyor informed the administrator, the director of nursing, and the director of professional services of the above issue during a meeting on 6/28/18 at 10:15 a.m. Both the DON and DPS stated keeping the indwelling Foley tubing off the floor was a standard of practice-basic nursing practice. The surveyor asked for their standards of practice during the meeting. The DON provided the surveyor with a second policy currently being reviewed for implementation. The policy titled "Catheter Care, Urinary" read in part "11. Be sure the catheter tubing and drainage bag are kept off the floor." The DON and DPS provided the surveyor with the urinary drainage bag package insert from Medline. The insert read in part "3. Secure tubing to sheet with bedsheet clamp."

No further information was provided prior to the exit conference on 6/28/18.

This is a complaint deficiency.

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F 695	Continued From page 32	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to maintain oxygen equipment in a clean and sanitary manner for 2 of 38 residents in the survey sample, Resident #62 and Resident #11. Additionally, the facility staff failed to ensure that oxygen was administered as ordered by the physician for 1 of 38 Residents in the sample survey, Resident #234. The Findings Included: 1. For Resident #62 the facility staff failed to store and maintained oxygen equipment in a clean and sanitary manner. Resident #62 was a 76 year old female who was admitted on 11/23/09. Admitting diagnoses included, but were not limited to the following: hyperthyroidism, bipolar disease, neuropathy, hypertension, contracture and cerebral infarct due to unspecified occlusion or stenosis of	F 695	A. The facility staff will follow physician orders for oxygen management for resident #234 and all other residents receiving oxygen. For resident #234, re-inservicing has been completed for all nursing staff. For Residents #11 and #62, a nursing re-inservice has been completed on proper storage of oxygen and nebulizers to prevent deficient practice. B. All residents having orders for oxygen and nebulizer treatments will be placed on the weekly/monthly Q.A.A. for monitoring with re-inservicing to all nursing staff on proper oxygen storage and nebulizer masks. C. All licensed nurses have been re-inserviced by the unit coordinators and Director of Nursing for continued compliance to prevent deficient practice from reoccurring. D. To prevent reoccurrence, the residents	8/11/18

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F 695	Continued From page 33 unspecified cerebral artery. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with the Assessment Reference Date (ARD) of 4/16/18. The facility staff coded that Resident #62 had a Cognitive Summary Score of 5. The facility staff also coded that Resident #62 required total nursing care (4/3) for Activities of Daily Living (ADL's). On June 27, 2018 at 8:44 a.m., the surveyor made an initial tour of the facility. The surveyor noted in Resident #62's room, oxygen equipment was not stored in a clean and sanitary manner. The surveyor observed a nebulizer mask lying in a chair in-between Resident #62's bed and her roommate's bed. The nebulizer was not covered or dated. The nebulizer was available for use. On June 27, 2018 at 8:28 a.m., the surveyor reviewed the clinical record. Review of the clinical record produced signed physician orders for Resident #62. Signed physician orders did not include orders for oxygen or nebulizer treatments. On June 27, 2018 9:00 a.m., the surveyor notified the Unit Manager (UM), who was a Licensed Practical Nurse (LPN) that during initial tour of the facility the surveyor observed a nebulizer lying in a chair between Resident #62's bed and her roommate's bed. The surveyor notified the UM that the nebulizer was not covered or dated. The surveyor notified the UM that the facility staff failed to ensure that the nebulizer was not stored in a clean and sanitary manner. On June 28, 2018 at 12:40 p.m., the survey team met with the Chief Executive Officer (CEO),	F 695	on oxygen therapy and nebulizer treatments will be monitored by unit coordinators and charge nurses on walking rounds. This information will be followed up by the Q.A team on daily rounds with follow up in the weekly/monthly Q.A. meeting. The Director of Professional Services, Director of Nursing and Administrator will monitor for continued compliance. The facility will be in substantial compliance by August 11, 2018.	

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F 695	Continued From page 34	F 695		

Administrator (Adm), Director of Nursing (DON) and Director of Profession Services (DOPS). The surveyor notified the Administrative Team (AT) that on initial tour of the facility the surveyor observed a nebulizer mask lying in a chair between Resident #62 and her roommate's bed. The surveyor notified the AT that the nebulizer was not covered or dated. The surveyor notified the AT that the nebulizer was not stored in a clean and sanitary manner.

No additional information was provided prior to exiting the facility as to why the facility staff failed to store and maintain oxygen equipment in a clean and sanitary manner in Resident #62's room.

This is a complaint deficiency.
2. The facility staff failed to administer oxygen was administrated by the physician order rate for Resident #234.

Resident #234 was admitted to the facility on 12/20/16 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, stroke, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/14/18, the resident was coded as having short term and long-term memory problems and being severely impaired in daily decision-making. Resident #234 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

On 6/27/18 at 10:50 am, the surveyor observed the resident's oxygen setting was at 2 ½ liters/min by nasal cannula. The surveyor reviewed the clinical record and noted a physician order dated

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for 3/10/18, which stated, " ...O2 (oxygen) at 2 liters/minute via (by) nasal cannula continuous ..."

At 10:54 am, the surveyor met a CNA (certified nursing assistant) pushing a shower bed with Resident #234 on it. The surveyor asked the CNA where the resident was going and she stated, "To the shower room." The surveyor asked the CNA where the resident's oxygen was and the CNA stated, "I don't know." The surveyor immediately went to the LPN (licensed practical nurse) #1 and notified her of the above documented findings. LPN #1 went to the CNA and explained to her that the resident was on continuous oxygen. LPN #1 went and obtained a portable oxygen tank and connected it so the resident would have oxygen being administered as ordered while in the shower room.

On 6/28/18 at 12:45 pm, the surveyor notified the administrative staff of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 6/28/18.
3. The facility staff failed to ensure that the nebulizer mask for Resident # 11 was maintained in a clean sanitary manner.

Resident # 11 is a 73-year-old-female who was originally admitted to the facility on 12/6/13, with a readmission date of 4/17/16. Diagnoses included but are not limited to: dementia, type 2 diabetes mellitus, hypertension, and mood disorder.

The clinical record for Resident # 11 was reviewed on 6/26/18 at 9:52 am. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment

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F 695	Continued From page 36 reference date) of 3/22/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 11's cognitive status is severely impaired. Resident # 11 has a current order that was initiated on 6/22/18 for "Duoneb q (every) 6h (hours) prn (as needed) for congestion." On 6/26/18 at 8:29 am, during the initial tour of the facility, the surveyor observed a nebulizer mask on Resident # 11's nightstand that was uncovered. On 6/26/18 at 11:02 am, the surveyor observed a nebulizer mask on Resident # 11's nightstand that was uncovered. On 6/26/18 at 1:43 am, the surveyor observed a nebulizer mask on Resident # 11's nightstand that was uncovered. On 6/28/18 at 12:50 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/28/18.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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	F 698		8/11/18

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F 698	Continued From page 37 by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to assess and monitor a dialysis shunt for 3 of 38 Residents, Resident #63, Resident #164 and Resident #149. The findings included: 1. For Resident #63 the facility staff failed to assess, monitor and document auscultation /palpation of the AV fistula for pulse, bruit and thrill to ensure adequate blood flow. Resident #63 was an 84 year old male, who was originally admitted on 9/21/17 and readmitted on 3/21/17. Admitting diagnoses included, but were not limited to: anemia, hypertension, atrial fibrillation, osteoarthritis, chronic kidney disease, dependence on renal dialysis and congestive heart failure. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly review with an Assessment Reference Date (ARD) of 4/20/18. The facility staff coded that Resident #63 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #63 was independent with Activities of Daily Living (ADL's). In Section O. Special Treatments and Programs, the facility staff coded that Resident #63 received dialysis. On June 26, 2018 at 10:30 a.m., the surveyor reviewed Resident #63's clinical record. Review of the clinical record produced signed and dated, 6/26/18, physician orders. Physician orders included, but were not limited to: "Dialysis Mon/Wed/Fri (Monday, Wednesday and Friday)	F 698	A. Corrective action has been accomplished for Resident #63, #164, #149. Licensed nurses have been re-inserviced on the monitoring process and documentation of auscultation/palpation of the AV fistula for pulse, bruit and thrill to ensure adequate blood flow and has been added to the above residents'□ Medication Administration Record (MAR) for adequate documentation. Re-inservicing has been completed by the Director of Nursing. B. An audit of all residents receiving dialysis has been completed by unit coordinators and senior management. Residents identified have had the bruit and thrill added to their MAR. C. All licensed nurses have been re-inserviced by the Director of Nursing one-on-one for education purposes. D. To prevent reoccurrences, MARs will be audited by the 3rd shift supervisors, unit coordinators, Director of Nursing and Director of Professional Services for continued compliance with at least quarterly inservicing. This information will be provided to the Q.A.A. Committee for review. The facility will be in substantial compliance by August 11, 2018.	

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every week (7-3)." (sic)

Continued review of the clinical record failed to produce documentation for assessment and monitoring of Resident #63's fistula.

On June 26, 2018 at 2:02 p.m., the surveyor notified the Unit Manager (UM), who was a Licensed Practical Nurse (LPN) that the surveyor was unable to locate documentation of assessment and monitoring of Resident #63's fistula. The UM and surveyor reviewed Resident #63's clinical record. The UM was not able to find any documentation of assessment and monitoring of Resident #63's fistula in the clinical record. The surveyor requested the facility policy and procedure for care of dialysis fistulas.

Further review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following Problem and intervention. "Care of resident receiving dialysis: (Name of resident withheld) has ESRD (end stage renal disease) and goes to dialysis on Mondays, Wednesdays, and Fridays. He is on a Renal diet. ... Intervention-Protect/ monitor access site. (sic)

On June 27, 2018 at 7:50 a.m., the Director of Professional Services (DOPS) hand delivered the facility policy and procedure titles, 'Care of Shunt (Arteriovenous)." The policy and procedure read in part ...

"Purpose-Arteriovenous (AV) graft for hemodialysis "An arteriovenous (AV) graft is created by connecting a vein to an artery using a soft plastic tube. After the graft has healed, hemodialysis is performed by placing two needles; one in the arterial side and one in the

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venous side of the graft. The graft allows for increased blood flow. Grafts tend to need attention and upkeep. Taking good care of your access may limit problems." ... "Procedure 4. Assess condition of the site and any bleeding, pain/discomfort."

On June 28, 2018 at 12:40 p.m., the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON) and Director of Profession Services (DOPS). The surveyor notified the Administrative Team (AT) that Resident #63 received Dialysis three times a week. The surveyor notified the AT that the clinical record did not produce any documentation of assessment and monitoring of the hemodialysis fistula.

No additional information was provided prior to exiting the facility as to why the facility staff failed to assess and monitor Resident #63's hemodialysis fistula.

2. For Resident #164 the facility staff failed to assess, monitor and document auscultation /palpation of the AV fistula for pulse, bruit and thrill to ensure adequate blood flow.

Resident #164 was a 65 year old female, who was admitted on 2/12/18. Admitting diagnoses included, but were not limited to: anemia, hypothyroidism, schizophrenia, anxiety, hypertension, end stage renal disease and dependence on renal dialysis.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS with an Assessment Reference Date (ARD) of 5/28/18. The facility

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staff coded that Resident #164 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #164 was independent (0/0) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section O. Special Treatments and Programs, the facility staff coded that Resident #164 received dialysis.

On June 26, 2018 at 11:02 a.m., the surveyor reviewed Resident #164's clinical record. Review of the clinical record produced signed and dated, 5/15/18, physician orders. Physician orders included, but were not limited to: "Dialysis on Tues, Thurs, Sat (Tuesday, Thursday and Saturday) (name of vendor withheld) 7-3." (sic)

Continued review of the clinical record failed to produce documentation for assessment and monitoring of Resident #164's fistula.

Further review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following Problem and intervention. "Care of resident receiving dialysis: (Name of resident withheld) has ESRD (end stage renal disease) and goes to dialysis on Tues, Thurs, Sat. Resident has history of refusing to go and has called them to cancel her appointments and transportation. ... Intervention-Protect/monitor access site. (sic)

On June 26, 2018 at 2:02 p.m., the surveyor notified the Unit Manager (UM), who was a Licensed Practical Nurse (LPN) that the surveyor was unable to locate documentation of assessment and monitoring of Resident #164's fistula. The UM and surveyor reviewed Resident #164's clinical record. The UM was not able to find any documentation of assessment and

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monitoring of Resident #164's fistula in the clinical record. The surveyor requested the facility policy and procedure for care of dialysis fistulas.

On June 27, 2018 at 7:50 a.m., the Director of Professional Services (DOPS) hand delivered the facility policy and procedure titles, 'Care of Shunt (Arteriovenous)." The policy and procedure read in part ...

"Purpose-Arteriovenous (AV) graft for hemodialysis "An arteriovenous (AV) graft is created by connecting a vein to an artery using a soft plastic tube. After the graft has healed, hemodialysis is performed by placing two needles; one in the arterial side and one in the venous side of the graft. The graft allows for increased blood flow. Grafts tend to need attention and upkeep. Taking good care of your access may limit problems." ... "Procedure 4. Assess condition of the site and any bleeding, pain/discomfort."

On June 28, 2018 at 12:40 p.m., the survey team met with the Chief Executive Officer (CEO), Administrator (Adm), Director of Nursing (DON) and Director of Profession Services (DOPS). The surveyor notified the Administrative Team (AT) that Resident #164 received Dialysis three times a week. The surveyor notified the AT that the clinical record did not produce any documentation of assessment and monitoring of the hemodialysis fistula.

No additional information was provided prior to exiting the facility as to why the facility staff failed to assess and monitor Resident #164's hemodialysis fistula.

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3. The facility staff failed to assess and monitor a dialysis shut for Resident #149.

Resident #149 was readmitted to the facility on 10/20/17 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure diabetes and renal failure. On the quarterly MDS (Minimum Data Set) with an ARD of 5/22/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #149 was also coded as requiring extensive assistance from 1 staff member for dressing, personal hygiene and bathing.

The surveyor conducted a review of Resident #149's clinical record on 6/27/18 through 6/28/18. During this review, the surveyor could not find documentation of the resident's shunt being assessed and monitored for thrill or bruit.

At 10 am, the surveyor notified LPN (licensed practical nurse) #1 of the clinical record does not have any documentation of the assessments or monitoring of the resident's dialysis shunt by the facility staff. LPN #1 stated, "We don't do anything to that area. The dialysis center's staff takes care of all of that."

During the record review of Resident #149's clinical record, the surveyor noted that on the "Dialysis Communication Record" for the resident there was missing documentation from either the facility, dialysis center or both for the months of April, May and June 2018. LPN #1 was also notified of this finding.

On 6/28/18 at 12:45 pm, the surveyor notified the administrative staff of the above documented

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F 698	Continued From page 43 findings. No further information was provided to the surveyor prior to the exit conference on 6/28/18.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		8/11/18

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F 758	Continued From page 44 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that 2 of 38 Residents in the survey sample was free from unnecessary psychotropic medications, Resident # 10 and Resident # 206. The findings included: 1. The facility staff failed to identify target behaviors related to the use of Seroquel for Resident # 10. Resident # 10 is an 87-year-old-female who was originally admitted to the facility on 4/28/14, with a readmission date of 1/3/15. Diagnoses included but not limited to: dementia with behavioral disturbance, hypertension, atrial fibrillation, and, glaucoma. The clinical record for Resident # 10 was reviewed on 6/27/18 at 9:20 am. The most recent	F 758	A. Corrective action for Resident #10 and Resident #206 has been accomplished. Resident #10 □physician has discontinued the Seroquel order on 07/24/18 due to non-behaviors. Resident #206 □vital sign telephone order and the MAR has been re-inserviced to all licensed nurses on follow through when taking orders from the physician. B. A review of all residents on psychotropic medication/telephone orders has been completed by the unit coordinators, pharmacy consultants to prevent further occurrence. C. All licensed nurses will be re-inserviced by the pharmacy consultants on behavior management if on psychotropic medication and the monitoring process. Telephone orders have been re-inserviced on proper follow	

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F 758	Continued From page 45 MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/22/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 10's cognitive status is severely impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 10 received an antipsychotic for 7 days during the lookback period for the 3/22/18 ARD. The current plan of care for Resident # 10 was reviewed and revised on 3/27/18. The facility staff documented a problem area as "Resident # 10 is at risk for adverse side effects from the use of psychotropic medications. She is currently taking Seroquel for dementia with behaviors & remeron for appetite stimulation daily." Interventions include but are not limited to: "Monitor and document regarding effectiveness of psychotropic meds as evidenced by mood/behavior improvement or decline-notify MD (medical doctor) if there are significant changes." The physician signed the current orders for Resident # 10 on 5/13/18. Orders include but is not limited to: "Seroquel 25 mg (milligram) tab ½ tablet (12.5 mg) by mouth every morning," and "Seroquel 25 mg 1 tablet by mouth at bedtime." While reviewing the clinical record for Resident # 10, the surveyor observed several notations documented that reflected that Resident # 10 had no behaviors. Upon further review of the nurse's notes and the current plan of care, the surveyor was unable to locate the target behaviors that the nurses were monitoring that were associated with the use of Seroquel.	F 758	through and repeating order back to physician before end of phone order for accuracy. D. To prevent further occurrence, residents having physician orders for psychotropic medications will be followed up by the pharmacy consultants, unit coordinators and Director of Nursing. Telephone orders are to be followed up by Director of Nursing and unit coordinators daily for continued compliance. This will be brought to the attention of the Q.A.A. Committee for continued compliance quarterly by the Director of Nursing and Pharmacy Director The facility will be in substantial compliance by August 11, 2018.	

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On 6/27/18 at 10:27 am, the surveyor spoke with the unit coordinator # 1to determine what target behaviors Resident # 10 displays that would warrant the use of Seroquel. Unit coordinator # 1 reviewed the clinical record for Resident # 10 along with the surveyor and agreed that there were no target behaviors documented for Resident # 10.

According to the facility policy on "Medication Monitoring Medication Management," the "Guidelines for psychotropic medication monitoring includes documentation but is not limited to, ..."e. Before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior must be clearly and specifically identified and monitored objectively and qualitatively" ...

On 6/28/18 at 12:50 pm, the administrative team was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 6/28/18.

2. Facility staff failed to ensure Resident #206 was free from unnecessary antipsychotic medications.

Resident #206 was admitted to the facility on 12/6/17 with diagnoses including hypertension, heart failure, dementia, depression, and bipolar disorder. On the minimum quarterly data set assessment with assessment reference date 6/1/18, the Resident was assessed with impaired short and long term memory deficits and with severely impaired ability to make decisions regarding tasks of daily life, of having continuous symptoms of disorganized thinking and

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F 758	Continued From page 47 inattention, and of having physical and behavioral symptoms 1-3 days the previous week. During clinical record review on 6/27/18, the surveyor noted a physician order dated 6/3/18 for vital signs every 4 hours for medication error. The surveyor was unable to locate the vital signs in the clinical record. Nurses located a dedicated vital signs monitoring sheet for the vital signs every 4 hours. The day shift nurses on the unit reported the medication error on 6/3/18 that required monitoring was an excess dose of Haldol IM. A telephone order dated 6/2/18 at 11:20 PM "Give 2 ml (milliliters) Haldol IM one time dose now. The Haldol on the unit was 5 milligram per milliliter vials. The resident was given 2 milliliters, a 10 milligram dose, in the right deltoid. During shift change, nursing staff determined that the physician had intended the resident receive 2 milligrams of Haldol. The physician and responsible party were notified of the error. The surveyor reviewed the Telephone order policy and the Non-controlled Medication Orders Policy. The non-controlled medication orders policy Documentation of the Medication Order 2. a. stated "...If verbally received, the nurse writes down the complete order and then reads it back to the prescriber for confirmation." It was unclear whether the nurse had followed this step. The administrator and director of nursing were notified of the concern on 6/28/18 during a summary conference.	F 758		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)	F 825		8/11/18

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F 825	Continued From page 48 §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide rehabilitative services for 1 of 38 Residents in the survey sample, Resident # 88. The findings included: The facility staff failed to follow up on 2 rehabilitation referrals for Resident # 88. Resident # 88 is a 55-year-old-male who was originally admitted to the facility on 8/15/12, with a readmission date of 1/22/18. Diagnoses included but were not limited to: major depressive disorder, seizures, cerebrovascular disease, and hypertension.	F 825	A. Corrective action for Resident #88 has been accomplished. On 06/28/8 the resident was screened by the therapy department for specialized rehab and referrals made to the appropriate discipline. B. An audit was completed by the unit coordinators and therapy manager to ensure all residents□ needs are being met by specialized rehab. C. The Rehab Director and unit coordinators will follow up daily to ensure that screens are being completed timely. Re-inservicing has been started by the Therapy Director, unit coordinators and	

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F 825	Continued From page 49 The clinical record for Resident # 88 was reviewed on 6/26/18 at 11:11 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/27/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 88 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicates that Resident # 88's cognitive status is severely impaired. Section G of the MDS assesses functional status. The facility staff documented that Resident # 88 was non-ambulatory and requires total assistance of 1 person for bed mobility. The current plan of care for Resident # 88 was reviewed and revised on 4/30/18. The facility staff documented a problem area as, "Resident # 88 is at risk for self-care deficit because he requires the extensive to total assistance for all of his activities of daily living. He can bear weight on his right leg and use his right arm to assist with repositioning and transfers. He can feed himself after setup. He has a history of stroke with left paralysis and dysarthria. W/C (wheelchair) is primary mode of locomotion." Interventions included but are not limited to, "Therapy to screen as requested/per MD orders." The physician signed the current orders for Resident # 88 on 5/18/18. Orders included but are not limited to, "PT/ST/OT (physical therapy, speech therapy, occupational therapy) to eval and treat as indicated." On 6/26/18 at 12:07 pm, the surveyor observed Resident # 88 sitting in his wheelchair in the dining room. Resident # 88's buttocks was	F 825	the Director of Nursing. D. To ensure this practice does not reoccur, this will be monitored by the Rehab Director, Director of Nursing, Director of Professional Services and Administrator in the weekly/monthly Q.A.A. meeting and finding will be reviewed in the quarterly Q.A. The facility will be in substantial compliance by August 11, 2018.	

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F 825	Continued From page 50	F 825		

positioned in the middle of the wheelchair, his legs were stretched outward and his head was leaning backward.

On 6/27/18 at 8:09 am, Resident # 88 was observed in his room eating breakfast. The head of the bed was elevated and resident # 88 was observed leaning toward the right side of the bed with his head near the half side rail on the right side of his bed.

On 6/28/18 at 9:48 am, the surveyor observed 2 "Rehabilitation Referral" forms in the clinical record for Resident # 88. A Rehabilitation Referral dated 3/31/18 had a check mark next to" improper positioning in bed or w/c" as the reason for the referral. A Rehabilitation Referral dated 4/17/18 has, "family is requesting therapy so resident can get up and walk with walker again." The surveyor reviewed the clinical record for Resident # 88 further and did not locate any documentation of therapy screenings or that Resident # 88 was receiving therapy services.

On 6/28/18 at 9:55 am, the surveyor spoke with unit coordinator #1 about Resident # 88 receiving therapy services. Unit coordinator # 1 reviewed the clinical record for Resident # 88 along with the surveyor and did not locate any documentation that Resident # 88 had a therapy screening or was receiving therapy services. Unit coordinator # 1 contacted the therapy department for more information.

On 6/28/18 at 10:05 am, the surveyor spoke with the therapy manager in reference to the 4/17/18 rehab referral. The therapy manager informed the surveyor that Resident# 88's insurance would not pay for him to have therapy. The therapy

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F 825	Continued From page 51 manager then stated to the surveyor "(Employee's name withheld) is going to go down and screen him now and refer him to restorative." The surveyor then asked the therapy manager about follow up from the referral from 3/31/18 referral. The therapy manager stated that she did not have anything on that referral she was only aware of the 4/17/18 referral. The surveyor questioned the therapy manager in reference to the amount of time that has passed between the therapy referrals from 3/31/18 and 4/17/18 and the present date. The therapy manager responded that they were going to screen Resident # 88 "right now." The surveyor asked the therapy manager if there is an insurance charge for screening residents and the therapy manager replied "No." On 6/28/18 at 12:50 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 6/28/18.	F 825		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		8/11/18

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F 842	Continued From page 52	F 842		

professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(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 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.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 53 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for 1 of 38 Residents in the survey sample, Resident # 10. The findings included: The facility staff had a documented fall in the clinical record for Resident #10 that occurred with a different resident. Resident # 10 is an 87-year-old-female who was originally admitted to the facility on 4/28/14, with a readmission date of 1/3/15. Diagnoses included but not limited to: dementia with behavioral disturbance, hypertension, atrial fibrillation, and, glaucoma. The clinical record for Resident # 10 was reviewed on 6/27/18 at 9:20 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/22/18. Section B of the MDS assesses hearing, speech, and vision. The facility	F 842	A. Corrective action has been accomplished for Resident #10. The fall that was charted on this patient has been removed and placed on the correct medical record. B. An audit has been completed on all residents to ensure correct EHR information is correct. This was completed by the unit coordinators, Director of Nursing and Director of Professional services to maintain compliance. C. To ensure that the residents EHR is correct, the unit coordinators, Director of Nursing and Director of Professional services have completed a re-inservice on the EHR to ensure that the default to room 238 does not reoccur. D. This will be monitored by the unit coordinators, supervisors, MDS team, Director of Nursing and Director of	

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F 842	Continued From page 54 staff documented that Resident has unclear speech. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 10's cognitive status is severely impaired. Section G of the MDS assesses functional status. In Section G, the facility staff documented that Resident # 10 is non-ambulatory with functional limitation in range of motion in bilateral upper and lower extremities. The current plan of care for Resident # 10 was reviewed and revised on 3/23/18. The facility staff documented a problem area as "Resident is at risk for falls due to psychotropic med use, cognitive deficit, need of others for all transfers, and history of fall." Nursing staff has documented as "Evaluation" for the 3/23/18 care plan revision, "Continued risk. G/C (gerichair) is primary mode of locomotion. No falls noted this review period. Goal is ongoing x 90 days." On 6/27/18 at 9:34 am, the surveyor reviewed the nurse's notes and the MDS with 3/22/18 ARD. The surveyor observed a nurse's note dated 3/11/18 at 11:48 pm. The nurse's note stated "pt (patient) was found on floor on back in doorway of bathroom when doing rounds at 11:05 pm. Res (resident) stated that she did not know what happened. Rp (responsible party) notified Md (medical doctor) notified. Pt alert but confused. Pt denies pain but states that rt (right) hand is sore. Pt transferred self w/o (without) assist. Had kicked off shoes was found under legs. No apparent injuries noted. Two man assist back to bed. Neuros started. Vital signs WNL (within normal limits)." The surveyor reviewed Section J of the MDS with the ARD of 3/22/18. In Section J, the facility staff documented that Resident # 10 has not had any falls since the previous	F 842	Professional Services for continuous compliance. This audit information will be reviewed weekly/monthly in the Q.A.A. Committee. The facility will be in substantial compliance by August 11, 2018.	

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F 842	Continued From page 55 assessment. On 6/27/18 at 9:40 am, the surveyor spoke with unit coordinator # 1 about the discrepancy between the nurse's note and Section J of the MDS. Unit coordinator # 1 reviewed the nurse's note along with the surveyor and stated that the note was put in on the wrong resident. Unit coordinator # 1 pointed out that Resident # 10 is unable to ambulate on her own and is unable to verbally communicate in a way that staff can understand her. On 6/28/18 at 12:50 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 6/28/18.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		8/11/18

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F 880	Continued From page 56 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 57 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility failed to ensure its staff implemented appropriate infection control measures for 3 of 38 residents (Resident #184, Resident #149, and Resident #234). The findings included: 1. The facility failed to ensure its staff implemented appropriate infection control measures for placement of an indwelling Foley catheter tubing for Resident #184. Resident #184's catheter tubing was observed touching the floor during the initial pool observations. The facility staff failed to ensure Resident #184's indwelling Foley catheter tubing was not touching the floor. The clinical record of Resident #184 was reviewed 6/26/18 through 6/28/18. Resident #184 was admitted to the facility 9/1/2012 and readmitted 11/10/15 with diagnoses that included but not limited to retention of urine, adult failure to thrive, anorexia, central pain syndrome, Gastro-esophageal reflux disease, pruritus, pressure ulcer (unspecified site), acute kidney	F 880	A. Corrective action has been accomplished for Resident #184; during tour with the state team adjustments were made and anchored to prevent catheter tubing from touching the floor. Corrective action has been accomplished for Residents #149 and #234 on dressing changes and handwashing during glove changes. Nurse was re-inserviced at the time the state team informed the Director of Nursing and Director of Professional services of infection control during treatment change. A copy was provided to state team before state exit. B. All licensed nurses have been re-inserviced on Foley tubing not touching the floor, handwashing with glove changes during treatment changes to prevent the spread of infection to other residents having the potential for deficient practice. C. Unit coordinators on each unit will provide monitoring and education monthly on Foley catheter tubing and handwashing in between treatment changes when using gloves to prevent the	

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F 880	Continued From page 58 failure, urinary tract infection, rash, and bacteremia. Resident #184's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/31/18 assessed the resident with a BIMS score of 14 out of 15. Section H Bladder and Bowel was coded for an indwelling catheter. The current comprehensive care plan identified Genitourinary as a concern with onset date of 1/3/18. Resident #184 has an indwelling Foley catheter in place r/t (related to) neurogenic bladder and is at risk for infection. The resident has a hx (history) of UTIs (urinary tract infections) is at high risk for recurrence. The resident pulls at catheter tubing and anchor. Approaches: Ensure leg bag is in place when OOB (out of bed), ensure regular drainage bag is in place when in bed, Foley catheter care, Foley catheter to straight drainage, ensure privacy bag is in place over regular drainage bag when in bed, and ensure drainage tubing is secured to the leg. Resident #184's June 2018 physician orders included Foley catheter care daily with soap and water, irrigate twice a day with normal saline, and change monthly and as needed. During the initial tour on 6/26/18 at 8:14 a.m., Resident #184 was observed in bed, Foley catheter in privacy bag but Foley tubing touching floor. The surveyor showed the unit manager licensed practical nurse #1 the Foley catheter tubing touching the floor. L.P.N. #1 stated she would take care of the concern. L.P.N. #1 was asked if the Foley catheter tubing should be touching the floor and she responded "No."	F 880	spread of infections. D. Education/observation by the unit coordinators, supervisors and Director of Nursing will be provided to Q.A.A. team weekly/monthly to maintain good infection control The facility will be in substantial compliance by August 11, 2018.	

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L.P.N. #1stated the resident may have moved around in the bed. The resident was observed to be able to use the remote controls to raise and lower the head of the bed; however, the bed is a crank type of bed and staff are responsible for raising and lowering the bed.

The surveyor informed the director of nursing of the above concern on 6/26/18 at 8:45 a.m. and requested the facility policy on Foley catheter care.

The surveyor reviewed the facility policy titled "Catheter Care, Foley." The policy focused only on cleaning of the Foley.
The surveyor informed the administrator, the director of nursing, and the director of professional services of the above issue during a meeting on 6/28/18 at 10:15 a.m. Both the DON and DPS stated keeping the indwelling Foley tubing off the floor was a standard of practice-basic nursing practice. The surveyor asked for their standards of practice during the meeting. The DON provided the surveyor with a second policy currently being reviewed for implementation. The policy titled "Catheter Care, Urinary" read in part "11. Be sure the catheter tubing and drainage bag are kept off the floor."
The DON and DPS provided the surveyor with the urinary drainage bag package insert from Medline. The insert read in part "3. Secure tubing to sheet with bedsheet clamp."

No further information was provided prior to the exit conference on 6/28/18.

This is a complaint deficiency.
2. The facility staff failed to follow infection control guidelines during the wound observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495281	A. BUILDING _____ B. WING _____	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE REHAB CENTER	300 BLUE RIDGE STREET MARTINSVILLE, VA 24112

(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 Resident #149.

Resident #149 was readmitted to the facility on 10/20/17 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure diabetes and renal failure. On the quarterly MDS (Minimum Data Set) with an ARD of 5/22/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #149 was also coded as requiring extensive assistance from 1 staff member for dressing, personal hygiene and bathing.

During the wound care observation on 6/27/18 at 2:20 pm, the surveyor noted LPN (licensed practical nurse) #2 removed the old dressing from Resident #149's foot. LPN #2 cleaned the wound, removed her gloves and put a new pair of gloves on without washing her hands in between changing gloves. LPN #2 then dressed the wound with clean dressings and secured the dressing.

The surveyor notified the director of clinical services and director of nursing of the above observation made during wound care to Resident #149 on 6/27/18 at 4 pm. The director of nursing stated, "The nurse should had removed her gloves, washed her hands then applied clean gloves."

The surveyor notified the administrative team of the above documented findings on 6/28/18 at 12:45 pm.

No further information was provided to the surveyor prior to the exit conference on 6/28/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495281	A. BUILDING _____ B. WING _____	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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3. The facility staff failed to follow infection control guidelines during the wound care observation for Resident #234.

Resident #234 was admitted to the facility on 12/20/16 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, stroke, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/14/18, the resident was coded as having short term and long-term memory problems and being severely impaired in daily decision-making. Resident #234 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

During the wound care observation made on 6/27/18 at 1:30 pm, the surveyor observed LPN (licensed practical nurse) #2 remove the old dressing from the resident's sacrum area. LPN #2 removed her gloves and washed her hands before applying a pair of new gloves on. LPN #2 then cleaned the wound and applied the new, clean dressing to the sacral area. The surveyor did not observe LPN #2 washing her hands after the wound was cleaned and applying a new pair of gloves prior to the applying the clean dressing.

The surveyor notified the director of clinical services and director of nursing of the above observation made during wound care to Resident #149 on 6/27/18 at 4 pm. The director of nursing stated, "The nurse should had removed her gloves, washed her hands then applied clean gloves."

The surveyor notified the administrative team of the above documented findings on 6/28/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495281	A. BUILDING _____ B. WING _____	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE REHAB CENTER	**300 BLUE RIDGE STREET MARTINSVILLE, VA 24112**

(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 880	Continued From page 62 12:45 pm. No further information was provided to the surveyor prior to the exit conference on 6/28/18.	F 880		