STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	R-C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 04/11/17 through 4/13/17, was conducted 5/31/17 through 6/1/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 145 certified bed facility was 133 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents 101 through 109 and 112) and four closed record reviews (Residents 110, 111, 113 and 114).	{F 000}		
{F 157} SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	{F 157}		6/23/17

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

Electronically Signed | 06/16/2017

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{F 157}	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to notify the physician of a need to alter treatment for one of 14 residents in the survey sample, Resident #106. The facility staff failed to make Resident #106's physician aware medications were unavailable and not administered to the resident on 5/29/17 and 5/30/17.	{F 157}	The Laurels of University Park wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is June 23, 2017. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity	

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{F 157}	Continued From page 2 The findings include: Resident #106 was admitted to the facility on 3/27/17. Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's cognition as moderately impaired. Review of Resident #106's clinical record revealed a physician's order summary signed by the physician on 6/1/17. The summary contained the following physician's orders: 4/28/17- Avapro (1) 300 mg (milligrams) - one tablet once per day for high blood pressure. 4/28/17-Toprol XL (2) - 25 mg- one half tablet once per day for high blood pressure. 4/28/17- Montelukast (3) 10 mg- one tablet once per day for asthma. 4/28/17- Cymbalta (4) 60 mg- one capsule once per day for depression. Review of Resident #106's May 2017 MAR (medication administration record) revealed the Avapro was not administered to the resident on 5/29/17; Cymbalta was not administered to the resident on 5/29/17 and 5/30/17; Montelukast was not administered to Resident #106 on 5/30/17; Toprol XL was not administered to the resident on 5/30/17. The MAR notes documented, "PHARMACY TO DELIVER." The MAR notes failed to document Resident #106's physician was made aware the above medications were not administered to the resident. There were no nurses' notes dated	{F 157}	of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F Tag 157: Resident # 106- No negative outcome occurred as a result of this practice. All residents currently in the facility have the potential to be affected. The DON/Designee will educate licensed nursing staff on notification to the MD in the event that treatment needs to be altered. Nursing administration will audit missed medication reports with notes for all current residents for any medication that has been held due to medication availability. If treatment has been altered, the medical record will be audit for MD notification of treatment requiring alterations. Nursing administration will continue to monitor missed medications and notes 5 x a week for 4 weeks for any altered treatment and documentation of MD notification in the daily clinical meeting . Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON to the quality assurance committee.	

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{F 157}	Continued From page 3 5/29/17 or 5/30/17. Resident #106's comprehensive care plan with a reference date of 4/4/17 failed to document specific information regarding the above medications. The nurse who was responsible for administering the above medications was not available for interview. On 6/1/17 at 11:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what should be done if medications are not available for administration. LPN #1 stated the nurse should notify the physician and either the physician will tell the nurse to obtain the medications at that time or the physician will state it is okay to give the medications when they arrive. On 6/1/17 at 12:45 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. A policy regarding physician notification was requested. On 6/1/17 at 1:30 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the facility did not have the requested policy. No further information was presented prior to exit. (1) Avapro is used to treat high blood pressure. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=18004 (2) Toprol XL is used to treat high blood pressure. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf	{F 157}	Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017	

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{F 157}	Continued From page 4 m?setid=4a5762c6-d7a2-4e4c-10b7-8832b36fa5f4 (3) Montelukast is used to treat asthma. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ccbbf0d6-efd9-4fdd-9e7b-e3d293062609 (4) Cymbalta is used to treat depression. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2f7d4d67-10c1-4bf4-a7f2-c185fbad64ba	{F 157}		
{F 280} SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	{F 280}		6/23/17

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{F 280}	Continued From page 5	{F 280}		

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(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

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{F 280}	Continued From page 6 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 observation, staff interview and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 14 residents in the survey sample, Residents #106 and #109. 1. The facility staff failed to revise Resident #106's care plan to reflect a pressure injury had healed. 2. The facility staff failed to revise Resident #109's care plan regarding the resident's non-compliance with a bed alarm. The findings include: 1. The facility staff failed to revise Resident #106's care plan to reflect a pressure injury had healed. Resident #106 was admitted to the facility on 3/27/17. Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's	{F 280}	Ftag 280 Resident # 106- The care plan has been revised and updated. No negative outcome occurred as a result of this practice. Resident #109- The care plan has been revised and updated. No negative outcome occurred as a result of this practice. Residents with Pressure Ulcers or Non-compliance related to fall interventions have the potential to be affected. The DON/designee will educate nursing administration, MDS staff, and licensed nursing staff on revising the care plan when wounds have resolved, and documenting non- compliance with fall devices.	

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{F 280}	Continued From page 7 most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's cognition as moderately impaired. Section M documented Resident #106 had one unstageable pressure injury (1). Review of a wound care specialist evaluation dated 5/5/17 revealed an unstageable pressure injury on Resident #106's upper back was resolved (healed) on 5/5/17. A weekly skin assessment dated 5/31/17 documented Resident #106's skin was intact. Resident #106's comprehensive care plan with a reference date of 4/4/17 documented, "At Increased risk for skin break down R/T (related to) Occasional urinary incontinence, Actual impaired skin integrity: pressure injury, site: Back..." On 6/1/17 at 11:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 confirmed Resident #106's pressure injury resolved on 5/5/17. LPN #1 also confirmed the resident's care plan documented Resident #106 continued to have a pressure injury. LPN #1 stated care plans should be updated when a pressure injury is healed and the nurse who discontinues the treatment orders should update the care plan. On 6/1/17 at 12:45 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. A policy regarding care plans was requested. On 6/1/17 at 1:30 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the facility did not have the requested policy. No further information was presented prior to exit.	{F 280}	Nursing administration will audit care plans for current residents with pressure ulcers and residents with resolved pressure ulcers for revisions needed. An audit will also be conducted for all residents who have orders for safety alarms for revisions needed. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON to the quality assurance committee. Nursing administration will review new orders and nursing notes for safety alarms, and pressure ulcer treatments 5 x week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017	

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{F 280}	Continued From page 8	{F 280}		

(1) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/?gclid=COOLvI_pptQCFQ-BaQodwvAMJg

2. The facility staff failed to revise Resident #109's care plan regarding non-compliance with a bed alarm.

Resident #109 was readmitted to the facility on 5/19/17. Resident #109's diagnoses included but were not limited to: high blood pressure, skin infections and seizure disorder. Resident #109's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference

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{F 280}	Continued From page 9	{F 280}		

date) of 3/6/17 coded the resident as being cognitively intact.

Review of Resident #109's clinical record revealed a physician order summary signed by the physician on 5/26/17. The summary documented an order dated 5/19/17 for a bed alarm.

Observations of Resident #109 were conducted on 5/31/17 at 3:10 p.m. and on 6/1/17 at 7:55 a.m. During both observations, Resident #109 was observed lying in bed and the bed alarm was disconnected.

Resident #109's comprehensive care plan with a reference date of 5/31/17 documented, "FALLS: At risk for fall related injury...Bed alarm check placement and function every shift..." The care plan failed to document Resident #109 was non-compliant with the bed alarm.

On 6/1/17 at 11:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated she had never personally seen Resident #109 disconnect the bed alarm but she had seen him "mess with" the alarm. LPN #1 stated she had heard from other staff that Resident #109 had disconnected the alarm in the past. When asked if the resident's non-compliance should be documented, LPN #1 stated, "Yes."

On 6/1/17 at 12:30 p.m. another interview was conducted with LPN #1. LPN #1 was asked if Resident #109's non-compliance with the bed alarm should be documented on the resident's care plan and stated, "Yes."

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{F 280}	Continued From page 10 On 6/1/17 at 12:45 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. A policy regarding care plans was requested. On 6/1/17 at 1:30 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the facility did not have the requested policy. No further information was presented prior to exit.	{F 280}		
{F 309} SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	{F 309}		6/23/17

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{F 309}	Continued From page 11 and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide services to maintain the highest physical well-being for two of 14 residents in the survey sample, Residents #106 and #105. 1. The facility staff failed to administer physician prescribed medications to Resident #106 on 5/30/17. 2. Resident #105 was admitted to hospice at the time of his facility admission on 3/29/17. The facility failed to develop a care plan for hospice services for Resident #105 to coordinate the care provided by the facility and the hospice provider. The findings include: 1. The facility staff failed to administer physician prescribed medications to Resident #106 on 5/30/17. Resident #106 was admitted to the facility on 3/27/17. Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's	{F 309}	Ftag 309 Resident #106- No negative outcome occurred as a result of this practice. All medications are currently available at the facility Resident #105- The care plan has been revised to reflect hospice services. The hospice provider has provided their care plan to the medical record. No negative outcome occurred as a result of this practice. DON or designee will educate nursing administration and licensed nursing staff on the procedure of obtaining medications that are not currently in the medication cart. The stat box medication list will be reviewed and made available to the nursing staff at all times. In addition to this they will be educated on notification to nursing administration and/or NHA so assistance can be provided to ensure medications are available. DON or designee will educate nursing administration, MDS and licensed nursing staff on putting a care plan in place for	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 12 cognition as moderately impaired. Review of Resident #106's clinical record revealed a physician's order summary signed by the physician on 6/1/17. The summary contained the following physician's orders: 4/28/17-Toprol XL (1) - 25 mg- one half tablet once per day for high blood pressure. 4/28/17- Montelukast (2) 10 mg- one tablet once per day for asthma. 4/28/17- Cymbalta (3) 60 mg- one capsule once per day for depression. Review of Resident #106's May 2017 MAR (medication administration record) revealed Cymbalta, Montelukast and Toprol XL were not administered to the resident on 5/30/17. The MAR notes documented, "PHARMACY TO DELIVER." Review of the pharmacy manifest dated 5/29/17 revealed these three medications were delivered to the facility on 5/29/17. The nurse who was responsible for administering the above medications was not available for interview. On 6/1/17 at 11:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what was the facility process for ensuring medications are available for administration. LPN #1 stated nurses should reorder medications when they run low. LPN #1 stated if medications are not available for administration then nurses should check the facility STAT (Immediate) box (a box containing various medications) to see if it contains the medications and if not, then nurses should call	{F 309}	those residents receiving hospice services. Nursing administration or designee will audit medication carts to assure that all medications are available and in place. Nursing administration will review care plans for all current residents receiving hospice services. Corrections will be made as appropriate and will be reported to the DON. Nursing administration will continue to monitor through the review of missed medications and notes 5 x week for 4 weeks for any altered treatment and documentation of MD notification in the daily clinical meeting . Nursing administration will review new admissions to hospice weekly x 4 weeks for hospice care plans. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017	

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{F 309}	Continued From page 13	{F 309}		

the pharmacy and have the medications sent STAT (immediately).

On 6/1/17 at 12:45 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. A policy regarding medication administration was requested. On 6/1/17 at 1:30 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the facility did not have the requested policy. At this time, ASM #2 was asked why the above medications were not administered to Resident #106 on 5/30/17 if the medications arrived at the facility on 5/29/17. ASM #2 stated she was trying to find out why the medications were not administered. ASM #2 stated medications are not always put into the medication cart as soon as the medications arrive.

No further information was presented prior to exit.

(1) Toprol XL is used to treat high blood pressure. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4a5762c6-d7a2-4e4c-10b7-8832b36fa5f4
(2) Montelukast is used to treat asthma. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ccbbf0d6-efd9-4fdd-9e7b-e3d293062609
(3) Cymbalta is used to treat depression. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2f7d4d67-10c1-4bf4-a7f2-c185fbad64ba

2. Resident #105 was admitted to hospice at the time of his facility admission on 3/29/17. The

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{F 309}	Continued From page 14	{F 309}		

facility failed to develop a care plan for hospice services for Resident #105 to coordinate the care provided by the facility and the hospice provider.

Resident #105 was admitted to the facility on 3/29/17 with diagnoses including, but not limited to: metastatic prostate cancer, Alzheimer's disease, and glaucoma. On the most recent MDS (minimum data set), an admission assessment with the assessment reference date of 3/29/17, he was coded as being severely cognitively impaired for making daily decisions. He was coded as receiving hospice services during the look back period.

A review of Resident #105's clinical record revealed the following order dated 3/29/17 signed by the physician on 3/30/17: "Pt (patient) is a pt of [name of hospice company]."

A review of Resident #105's comprehensive care plan dated 4/10/17 failed to reveal a care plan related to hospice care.

On 6/1/17 at 10:00 a.m., LPN (licensed practical nurse) #1, the unit manager for Resident #105, was interviewed. When asked how the facility staff members know, follow, and coordinate care with the hospice staff for Resident #105, LPN #1 stated: "The hospice nurse and aide come in and communicate with us." When asked how the facility staff members coordinate care with hospice when a hospice staff member is not in the facility, LPN #1 stated: "I don't know. Hospice always comes in and asks us. We don't ask hospice." When asked to review Resident #105's comprehensive care plan for information related to hospice care, LPN #1 reviewed the care plan and stated: "I don't see anything."

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{F 309}	Continued From page 15 When asked if the facility should develop a hospice care plan to coordinate the care with hospice, LPN #1 stated: "Yes, there should be a hospice care plan." On 6/1/17 at 10:10 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. At this time, she stated that the facility does not have a policy related to the coordination of hospice services/hospice care plans. No further information was provided prior to exit.	{F 309}		
{F 371} SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other	{F 371}		6/23/17

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{F 371}	Continued From page 16 visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. Two facility staff members failed to wear beard guards in the kitchen during an observation on 5/21/17. The facility staff failed to wash, rinse, and sanitize trays and plate covers between uses on 5/21/17. The findings include: An initial observation was made of the kitchen staff on 5/31/17 at 11:10 a.m. At the time of this observation, OSM (other staff member) #2, a dietary aide, was observed moving around in the food preparation area in the kitchen. He had a full beard and was not wearing a beard guard. OSM #2, a dietary aide, was observed moving items from the kitchen into the dry storage room, and taking food items into the walk-in refrigerator. He had partial beard, and was not wearing a beard guard. During this observation, OSM #1, the cook, informed the surveyor that the facility's automatic dishwasher was broken, and that all dishes and utility pieces were being washed by hand. At the end of this initial observation, on 5/31/17 at 11:35 a.m., OSM #2 was interviewed. When asked why he wore a hat on his head in the kitchen, OSM #2 stated: "To keep my hair out of the way." When asked if there were any other items he needed to be wearing to protect hair	{F 371}	Ftag 371 No negative outcome occurred as a result of this practice. The employees who require beard guards have them in place when in the kitchen. The trays and lids were all washed, rinsed, and sanitized on the same day that the deficient practice was identified. All residents have the potential to be affected by this practice. The acting dietary manager or designee will educate dietary staff on wearing beard guards and who qualifies to be wearing them. The acting dietary manager or designee will also educate the dietary department on the appropriate procedure for washing, rinsing, and sanitizing dishes. The acting Dietary manager or designee will conduct observations of beard guards in place 2 x day x 1 week. The acting dietary manager or designee will conduct observations of dishes being washed in the 3 compartment sink daily x 1 week. NHA and dietary manager will continue to monitor sanitation through weekly kitchen rounds x 4 weeks Additional education	

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{F 371}	Continued From page 17 from falling in the food, he stated: "I don't think so." When asked if he should have been wearing a beard guard, OSM # 2 stated: "Oh yeah. I guess so." At this same time, OSM #3 was interviewed. When asked if he should have been wearing a beard guard, OSM #3 stated: "No. I'm not always around the food. Most of the time I am somewhere else." When asked if he had been located in the kitchen during the time of the observation, OSM #3 stated: "Yes. But the rule is that my beard hair is not long enough. I'm not sure how long it has to be for me to wear one, but I know my hair is not long enough." On 5/31/17 at 2:25 p.m., the surveyor returned to the kitchen. At this time, OSM #4, a dietary aide, was observed rolling a cart stacked high with trays from the area where dirty dishes from lunch had been unloaded to the area at the beginning of the tray line. OSM #4 picked up eight trays from the cart, swiped each tray lightly with a dish towel, and placed each tray on a tray holder at the beginning of the tray line. When asked if he was putting the eight trays in a place where they were ready for use, he stated: "Yes." At this time, OSM #1, the cook walked over to ASM #4. OSM #1 stated: "If I have to tell you again, I don't know what I'm going to do. Take those trays back over there (pointing to the area where the dirty lunch dishes had been unloaded). OSM #4 rolled the cart of trays back to its original position. OSM #4 was asked if the trays he had just placed at the beginning of the tray line were clean. OSM #4 stated: "Yes. I wiped them off." OSM #1 was then asked if the trays OSM #4 had placed on the beginning of the tray line were clean. OSM #1 stated: "We washed them last night. And we	{F 371}	and/or counseling will be provided as indicated. Concerns will be reported to the quality assurance committee monthly until resolved. Dietary manager will continue to monitor beard guards being in place on staff in the kitchen weekly x 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored thought the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017	

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washed them after breakfast. But we did not wash them after lunch." When asked if the trays in question were clean, OSM #1 stated: "No. I told him. But he does not listen." OSM #1 stated the day was "all backwards" due to the broken dishwasher and absence of the dietary manager. She stated the trays and the plate covers had been washed that morning "between breakfast and lunch in the two compartment sink." When asked if all of these items had been washed, rinsed and sanitized, OSM #1 stated: "No. I did what we could. I thought that is how we should do it." OSM #1 returned to her activities of preparing dinner and did not address the dirty trays placed at the beginning of the tray line.

On 5/31/17 at 2:50 p.m., the surveyor returned to the kitchen with ASM (administrative staff member) #1, the administrator. OSM #2 was asked if he had washed the trays between breakfast and lunch that morning. OSM #2 stated: "Yes." He stated the trays and plate covers were placed in the two compartment sink after breakfast. He stated trays were placed on one side of the sink, and plate covers were placed on the other. He stated one side of the sink contained dish soap and bleach in the water, and the other side of the sink contained bleach only in the water. When asked to demonstrate how the dishes were washed, rinsed and sanitized, OSM #2 stated: "We washed them in the sink; then rinsed them under the water. We had to dry them off some with a towel." When asked if any of the trays or plate tops had been washed after lunch use, and prior to being stored for use at dinner, he stated they had not.

At this time, ASM #1 was also informed of the concerns regarding OSM #2 and OSM #3 not

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{F 371}	Continued From page 19 wearing beard guards. A review of the facility policy "Hair Restraints" revealed, in part, the following: "Hair restraints shall be worn by all dietary employees while on duty to cover all hair. The following are acceptable as hair restraints...beard restraint...This applies to all staff entering the kitchen including maintenance and administration." A review of the facility policy "Manual Ware Washing" revealed, in part, the following: "Manually washed pots, pans and cooking utensils shall be adequately sanitized...Manually washed pots, pans and cooking utensils shall be washed to ensure that all items are adequately sanitized using a three compartment sink...Pan(s) shall be allowed to air-dry on sanitized drain board/rack/cart...Pan(s) shall not be wiped with a dish towel." A review of the manufacturer's instructions for the dishwashing liquid used by the faculty failed to reveal information related to sanitizing dish and serving ware. No further information was provided prior to exit.	{F 371}		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must	F 425		6/23/17

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F 425	Continued From page 20 employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure medications were available for administration as ordered by the physician for one of 14 residents in the survey sample, Resident #106. The facility staff failed to ensure medications ordered by the physician were available for administration to Resident #106 on 5/29/17. The findings include: Resident #106 was admitted to the facility on 3/27/17. Resident #106's diagnoses included but were not limited to: congestive heart failure, pneumonia and a rib fracture. Resident #106's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/23/17, coded the resident's cognition as moderately impaired. Review of Resident #106's clinical record revealed a physician's order summary signed by the physician on 6/1/17. The summary contained the following physician's orders: 4/28/17- Avapro (1) 300 mg (milligrams) - one tablet once per day for high blood pressure. 4/28/17- Cymbalta (2) 60 mg- one capsule once per day for depression.	F 425	Ftag 425 Resident #106- No negative outcome occurred as a result of this practice. Medications are available in the facility. All residents have the potential to be affected. DON or designee will educate nursing administration and licensed nursing staff on the procedure of obtaining medications that are not currently in the medication cart. The stat box medication list will be reviewed and made available to the nursing staff at all times. In addition to this they will be educated on notification to nursing administration and/or NHA so assistance can be provided to ensure medications are available. Nursing administration or designee will audit medication carts to assure that all medications are available and in place. Corrections will be made as appropriate and will be reported to the DON. Nursing administration will continue to monitor through the review missed medications and notes 5 x a week for 4 weeks for any altered treatment and documentation of MD notification in the	

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F 425	Continued From page 21 Review of Resident #106's May 2017 MAR (medication administration record) revealed Avapro and Cymbalta were not administered to the resident on 5/29/17. The MAR notes documented, "PHARMACY TO DELIVER." There were no nurses' notes dated 5/29/17. Review of the facility STAT (Immediate) box lists revealed Avapro and Cymbalta were not available in the facility STAT boxes (boxes containing various medications). The nurse who was responsible for administering the above medications was not available for interview. On 6/1/17 at 11:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what was the facility process for ensuring medications are available for administration. LPN #1 stated nurses should reorder medications when they run low. LPN #1 stated if medications are not available for administration then nurses should check the facility STAT box to see if it contains the medications and if not, then nurses should call the pharmacy and have the medications sent STAT (immediately). LPN #1 stated sometimes it takes the pharmacy "a little while" to deliver STAT medications. LPN #1 stated it should not take the pharmacy more than two or three hours to deliver STAT medications. On 6/1/17 at 12:45 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. A policy regarding medication administration was requested. On 6/1/17 at 1:30 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the	F 425	daily clinical meeting . Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017	

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F 425	Continued From page 22 facility did not have the requested policy. No further information was presented prior to exit. (1) Avapro is used to treat high blood pressure. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=18004 (2) Cymbalta is used to treat depression. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2f7d4d67-10c1-4bf4-a7f2-c185fbad64ba	F 425		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to store hazardous chemicals in a safe manner for one of five shower rooms, the Jefferson Unit. Facility staff failed to store a bottle of Super HDQ Neutral (one-step disinfectant) spray in a safe manner on the Jefferson Unit shower room.	F 465	Ftag 465 The shower room cabinet has been locked. No negative outcomes occurred from this practice. Ambulatory residents have the potential to be affected by this practice.	6/23/17

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F 465	Continued From page 23 The findings include: On 5/31/17 at 12:00 p.m., general observation of the facility was conducted. On 5/31/17 at 12:10 p.m. an observation was made of the Jefferson Unit shower room. The shower room door was unlocked. A 32-ounce bottle of Super HDQ Neutral one-step disinfectant spray was found in an unlocked cabinet in the shower room. More than 750 ml (milliliters) of liquid was in the bottle. On 5/31/17 at 12:11 p.m., an interview was conducted with RN (registered nurse) #1, a nurse on Jefferson Unit. When asked who was responsible for ensuring chemicals were locked up in the cabinet in the shower rooms, RN #1 stated, "We are all responsible. CNAs (certified nursing assistants) and nurses. We are all responsible for locking up the cabinet when we are done." On 5/31/17 at 12:12 p.m. RN #1 was asked to follow this writer into the Jefferson Unit shower room. RN #1 opened the cabinet and stated, "It isn't locked." When asked if she could identify anything that could be hazardous to residents, RN #1 stated that the disinfectant spray was hazardous if ingested. When asked if she thought residents could reach the disinfectant spray, RN #1 stated, "If a resident walks and is not in a wheelchair, they could reach it. If they are in a wheelchair, I don't think they could." On 5/31/17 at 12:25 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above findings. On 5/31/17 at approximately 1:40 p.m., ASM #1	F 465	DON or designee will educate department managers, the nursing department, and the housekeeping department on locking shower cabinets and other areas that hazardous chemicals are stored. The DON or designee will conduct rounds on all shower rooms, housekeeping carts, and other storage areas with hazardous chemicals for proper storage and that they are locked. Corrections will be made as appropriate and will be reported to the DON. Nursing administration will round on shower rooms weekly for 4 weeks to assure that the cabinet doors remain locked. .Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: June 23, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	R-C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 24	F 465		

stated that she could not find a policy on storing chemicals.

Review of the Super HDQ Neutral label documented the following information: "KEEP OUT OF REACH OF CHILDREN. Corrosive. Causes irreversible eye damage and skin burns. Harmful if swallowed, inhaled or absorbed through the skin. Avoid breathing spray mist. Do not get in eyes, on skin, or on clothing. Wear goggles or face shield, rubber gloves and protective clothing when handling. Wash thoroughly with soap and water after handling, and before eating, drinking, or using tobacco. Remove contaminated clothing and wash clothing before reuse."

Review of the MSDS (Material Safety Data Sheets) documented the following information: "Hazard Statements: Harmful if swallowed. Harmful if inhaled. Causes severe skin burns and serious eye damage. May cause an allergic skin reaction. Precautionary statements: Wash hands and any exposed skin thoroughly after handling. Do not eat, drink, or smoke when using this product. Use only outdoors or in well ventilated area. Do not breathe mist, vapors or spray. Wear protective gloves. Wear eye/face protection. Wear protective clothing. Response: Immediately call a poison control center or physician. -Eyes: IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. -Skin: IF ON SKIN (or hair): Take off immediately all contaminated clothing. Rinse skin with water or shower. Wash contaminated clothing before use. -Inhalation: IF INHALED: Remove victim to fresh air and keep at rest in a position comfortable for breathing. -Ingestion: IF SWALLOWED: Rinse mouth. DO

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F 465	Continued From page 25 NOT Induce vomiting...Storage: Store locked up." No further information was presented prior to exit.	F 465		
{F 514} SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted 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 (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	{F 514}		6/23/17

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{F 514}	Continued From page 26 services reports as required under §483.50. 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 maintain a complete and accurate clinical record for one of 14 residents in the survey sample, Resident #109. The facility staff failed to document Resident #109's non-compliance with a bed alarm. The findings include: Resident #109 was readmitted to the facility on 5/19/17. Resident #109's diagnoses included but were not limited to: high blood pressure, skin infections and seizure disorder. Resident #109's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/6/17 coded the resident as being cognitively intact. Review of Resident #109's clinical record revealed a physician order summary signed by the physician on 5/26/17. The summary documented an order dated 5/19/17 for a bed alarm. Observations of Resident #109 were conducted on 5/31/17 at 3:10 p.m. and on 6/1/17 at 7:55 a.m. During both observations, Resident #109 was observed lying in bed and the bed alarm was disconnected. Review of nurses' notes from 5/19/17 through 5/31/17 failed to reveal any documentation that Resident #109 was non-compliant with the bed alarm. Resident #109's comprehensive care plan	{F 514}	Ftag 514 Resident #109: No negative outcome occurred as a result of this practice. Documentation has been made in the medical record to reflect non compliance with fall devices. . All residents with non compliance with fall interventions or other behaviors have the potential to be affected by this practice. DON or designee will educate licensed nursing staff, and social services staff on documentation in progress notes for residents with non compliance with fall interventions. Nursing administration will audit documentation in the medical record for residents with orders for safety alarms and documentation of any non compliance with the alarms. Corrections will be made as appropriate and will be reported to the DON. Nursing administration will continue to monitor by review of new orders for safety alarms 5 days a week weekly for 4 weeks. Concerns will be reported by the DON to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any	

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{F 514}	Continued From page 27 with a reference date of 5/31/17 documented, "FALLS: At risk for fall related injury...Bed alarm check placement and function every shift..." The care plan failed to document Resident #109 was non-compliant with the bed alarm. On 6/1/17 at 11:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated she had never personally seen Resident #109 disconnect the bed alarm but she had seen him "mess with" the alarm. LPN #1 stated she had heard from other staff that Resident #109 had disconnected the alarm in the past. When asked if the resident's non-compliance should be documented, LPN #1 stated, "Yes." On 6/1/17 at 12:45 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. A policy regarding documentation was requested. On 6/1/17 at 1:30 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the facility did not have the requested policy. No further information was presented prior to exit.	{F 514}	identified concerns. Completion date: June 23, 2017	