STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495085		C 04/27/2018

NAME OF PROVIDER OR SUPPLIER
RIVER VIEW ON THE APPOMATTOX HEALTH & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
201 EPPS STREET
HOPEWELL, VA 23860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		
	An unannounced Emergency Preparedness survey was conducted 04/24/2018 through 04/27/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 04/24/2018 through 04/27/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey. The census in this 124 certified bed facility was 112 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 5 closed record reviews.			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		5/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/11/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint, the facility staff failed to notify the doctor of a serious weight gain for one Resident (Resident	F 580	1.Resident #308 was discharged from the center. An associate education has been completed for LPN E for failing to follow care plan interventions for notifying the physician, physician assistant or nurse	

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F 580	Continued From page 2 #308) of 28 residents in the survey sample. For Resident #308 the facility staff did not notify the doctor of weight gain as was ordered for a dialysis patient on more than one occasion. The findings included: Resident #308 was admitted previously to the facility on 12-1-17, after amputation surgery of her left foot. The Resident was discharged home from the facility on 3-14-18. The Resident was readmitted after further amputation surgeries on 4-19-18 with the diagnoses of, but not limited to; hypertension, heart disease, chronic kidney disease with peritoneal dialysis, bilateral below the knee amputations, insulin dependant diabetes, glaucoma, and asthma. The most recent Minimum Data Set (MDS) for this admission was a quarterly assessment with an Assessment Reference Date (ARD) of 3-5-18, from the previous stay. The MDS coded Resident #308 with no cognitive impairment. The Resident needed extensive assistance from staff for toileting, hygiene, bed mobility and transferring. On 4-24-18 at 6:30 p.m. on initial tour of the facility the Resident was observed lying in bed, and when asked for an interview, she stated that tomorrow would be better, she was tired. On 4-25-18 at 10:30 a.m., the Resident was sitting on her bed and granted the request for an interview. The Resident stated she had been back at the facility for "About a week after having surgery on my legs." The Resident went on to say that her dialysis treatments were a problem,	F 580	practitioner of care planned interventions for weight changes on resident #308 a peritoneal dialysis resident. 2.Any resident has the potential to be affected if staff failed to notify the doctor of a serious weight gain. The Clinical Report for the past 72hrs will be reviewed to assess compliance with documentation of notification to the physician, physician assistant or nurse practitioner of any significant change in condition. The orders listing report and care plan interventions for residents receiving dialysis will be reviewed to assess staff compliance with following interventions. 3.The Administrator or designee will educate the Director of Nursing, Assistant Director of Nursing, Unit Managers and Supervisors on reviewing the 24hr Report and ensuring the physician, physician assistant or nurse practitioner have been made aware of any significant changes in condition. The Director of Nursing or designee will educate licensed nurses on ensuring care plan interventions are being followed and notifying the physician, physician assistant or nurse practitioner of significant changes in condition related to care plan interventions. 4.The Director of Nursing or designee will review the clinical report during the Clinical Meeting weekly x 4 weeks then monthly x 2 months to ensure the physician, physician assistant or nurse practitioner have been notified of significant changes in condition. The	

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F 580	Continued From page 3 and when asked why, she stated that the staff did not know how to do them correctly, and she had to monitor them closely so they "don't mess me up and give me an infection or worse." The Resident stated that the staff don't know what they are doing, they put the wrong bags on to dialyze with, they don't use good infection practices, and they put the bags and tubing on the floor, they didn't order the right equipment bag and tubing cassettes (5 prong instead of 3 prong tubing) and she stated she has to tell them step by step what to do, and sometimes at night she is asleep and has to wake up to watch what the staff is doing so the staff doesn't "mess me up". The Resident went on to say "I have gained 10 pounds since I have been here in one week." "Weight gain is a problem, and I guess I will have to call the doctor myself, since they won't." "I never use 1.5 bags cause I gain fluid with them, I told them that but they don't listen." "Yesterday they got the wrong stuff so I didn't even get my afternoon exchange at all, I had to wait for supplies to come, that's ridiculous". On 4-26-18 at 12:30 p.m. a peritoneal dialysis exchange was observed by surveyors. LPN E squirted a dime size amount of alcohol based hand sanitizer into her hands and briskly rubbed them together. She donned a pair of clean gloves from an open box in the Resident's room and applied them. After stating "We are going to weigh you now" to the Resident. The surveyors followed LPN E pushing Resident #308 in a wheel chair to the shower room at the nursing station where the Resident was weighed in her wheel chair. LPN E pushed electronic digital buttons on the wheel chair scale with her gloved hands to obtain	F 580	Director of Nursing or designee will review the orders listing report and care plan interventions for residents receiving dialysis weekly x 4 weeks then monthly x 2 to ensure care plan interventions are being followed and the physician, physician assistant or nurse practitioner have been notified of significant changes related to care plan interventions. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 580	Continued From page 4 the weight, while her uniform top touched the scale which was used to weigh all wheel chair bound residents. The Resident weighed 212.6 pounds in the wheel chair. LPN E then returned the Resident to the Resident's room. The nurse did not weigh the wheel chair prior to weighing the Resident. LPN E was asked what the Resident's weight was and she stated "I need to get my calculator out." LPN E removed the gloves and threw them in the regular garbage can next to the resident's bed. There were no biohazardous waste receptacles in the Resident's room. LPN E pulled the calculator out of her shirt pocket with bare hands which were now contaminated, and calculated the weight. LPN E stated "she weighs 174.6 pounds." When LPN E was asked how she came to that number, she stated "I subtracted 38 pounds from 212.6 pounds for the wheel chair weight." LPN E was asked how she knew the wheel chair weight, she stated it was written on the back of the wheel chair" that Resident #308 always used. The chair was inspected, and there was no weight written on the back of the chair. It is unknown if the chair was swapped out for a different chair, and what the weight of the current chair was, as the chair was not weighed even after this discussion. After the observations were completed, the Resident's clinical record was reviewed. The review revealed signed physician orders which included the below order: "4-21-18: Afternoon manual exchanges: Fill volume 2000 milliliter bags (use 1.5% solution, if blood pressure greater than 140/80 then use 2.5% solution one time a day related to end stage	F 580		

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F 580	Continued From page 5 renal disease). On 4-24-18 the entry was not signed as administered by staff, and referred the reader to a nursing note for explanation. The nursing note stated that the supplies for the exchange were unavailable and they were waiting for delivery. The exchange was never completed. The one care plan intervention "to monitor and report to doctor signs of acute renal failure with urine output of less than 400 milliliters in 24 hours" was not being measured for this Resident as she went to the toilet independently, and no device to catch urine was in the toilet. The intervention that was care planned for "Report to Doctor weight gain of over 2 pounds per day" was not followed. Resident #308 was admitted with a weight of 163 pounds per a physicians progress note dated 4-20-18, and by 4-26-18 the weight was 174.6 pounds, equaling greater than 10 pounds gained in the one week since admission. No call to the doctor had been made by 2:30 p.m. on 4-26-18 when the nursing notes were printed for surveyors. Further evidence from a physicians progress note dated 4-24-18, revealed the doctor documented a weight of 163 pounds, and was unaware of the weight gain. The Residents weight record from the Medication Administration Record (MAR) revealed the following; 4-21-18 (160 pounds), 4-22-18 (165 pounds), 4-23-18 (168.9 pounds), 4-24-18 (no weight taken nor PD administered), 4-25-18 (168 pounds), and during observation of weight on 4-26-18 (174.6 pounds).	F 580		

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F 580	Continued From page 6 LPN E was asked if she had been trained by a dialysis certified facility trainer, and she stated "yes, they came from [name of dialysis company] yesterday at 3:00 p.m. (4-25-18) to train us." She went on to say that was the first time they had trained her, and she had been providing care for a month, and for this Resident for a week. According to federal regulation, before providing peritoneal dialysis (PD), the facility staff must be trained by a qualified dialysis trainer from a certified dialysis facility. Training can not be provided by nursing home staff. That did not happen as LPN E had not been formally trained until 4-25-18, and had been providing PD for a week without training. On 4-26-18, and 4-27-18 at the end of day debrief, the Administrator and DON were made aware that the doctor had not been notified that the Resident had experienced a 10 pound weight gain since admission a week ago, and no intervention by staff had been taken for the Resident, hindering her quality of care and wellbeing. No further information was provided by the facility staff.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		5/31/18

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F 583	Continued From page 7 this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed, for 1 resident (Resident #31) of the survey sample of 23 residents, to ensure personal privacy. For Resident #31, the facility staff failed to knock on the door, announce themselves, and ask permission prior to entering the room. The Findings included: Resident #31 was a 63 year old who was	F 583	1.An observation of staff entering the room for resident #31 has been conducted and the privacy of the resident related to staff knocking on his door has been maintained. An associate education has been completed with CNA A for failing to maintain the privacy of resident #31 related to knocking on the door before entering. 2.Any resident has the potential to be affected if staff fail to knock on the door, announce themselves and ask permission	

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F 583	Continued From page 8 admitted to the facility on 11/9/17. Resident #31's diagnoses included Diabetes Mellitus Type 2, Urinary Tract Infection, Peripheral Vascular Disease, Chronic Atrial Fibrillation, Overactive Bladder, and Gastro-Esophageal Reflux Disease. The Minimum Data Set, which was a Quarterly Assessment with a an Assessment Reference Date of 2/13/18, coded Resident #31 with a Brief Interview of Mental Status Score of 15, indication that he was cognitively intact. On 4/26/18 at 9:10 A.M., an interview was conducted with Resident #31 in his bedroom. He was sitting up in a Geri chair. His right leg was elevated, and he was wearing a protective padded boot. He stated that he had enjoyed eating his breakfast. At 9:11 A.M. Certified Nursing Assistant (CNA A) suddenly entered the room and walked across the room to the window area, near Resident #31. She stated, "I came in for no special reason." When asked about her understanding of the proper way to enter a resident's room, she stated, "I'm supposed to knock on the door and introduce myself. I ask them how they are doing. I wash my hands. I was supposed to ask if I may enter. It's important because they may not want me to come in." CNA A further stated that she had worked at the facility for 12 years. On 4/26/18 at 9:45 A.M., an interview was conducted with the Director of Nursing (Administration B). The DON stated that the facility did not have a privacy policy. She further stated, "That's just part of nursing standard to knock before entering a persons room and ask permission before entering. Because it's their room and everyone needs to be respected."	F 583	prior to entering the room. A center observation of staff entering resident rooms has been completed to assess compliance with staff knocking on resident□s doors before entering. . 3.The QAPI Coordinator or designee will educate the center staff on ensuring resident privacy related to knocking on the door before entering is maintained. 4.The QAPI Coordinator or designee will conduct center observations of staff entering resident□s rooms weekly x 4 weeks then monthly x 2 months to ensure resident privacy is maintained related to staff knocking on the door before entering. The QAPI Coordinator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 583	Continued From page 9 On 4/26/18 at approximately 4:00 P.M., the facility Administrator was informed of the findings. No further information was received.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		5/31/18

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F 584	Continued From page 10 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interview, and facility and clinical documentation, the facility failed to maintain a clean and homelike environment. 1. For Resident #61, the room and bathroom needed cleaning and tiles replaced. 2. For Resident # 15, the facility staff failed to ensure that the room was free of a strong pervasive odor. The findings included: 1. On 4/24/18 at approximately 6:45 PM, during the initial tour, Resident #61's daughter was in the room. She expressed concerns over the cleanliness of the facility. She pointed out two smears of dark material on the bedside table, which she stated was food. She stated, "It has been there for months and I refuse to clean it." She also pointed out in the corner of the room, near the TV, a crack in the wall which was stuffed with what looked like paper. In addition, the toilet area (around the commode) were dark, stained areas, possibly rust and mildew. On 04/27/18 at 10:46 AM, A walk through with the Maintenance Director was conducted. He	F 584	1.The room and bathroom for resident #61 has been inspected by the Environmental Services Director and Maintenance Director. The room has been cleaned and replacement tiles for the affected area have been ordered. The room for resident #15 has been deep cleaned. 2.Any resident has the potential to be affected if staff fail to ensure the resident room is cleaned, bathroom tiles are in good repair and the room is free from odors. Environmental rounds have been conducted by the Environmental Services Director and Maintenance Director to assess compliance with cleaning, identifying tiles in need of repair and other maintenance needs.. 3.The Administrator or designee will educate the Environmental Services Director and Maintenance Director on ensuring routine environmental rounds are being completed to correct areas in need of cleaning and/or repair. The Maintenance Director or designee will educate the center staff on using the work order system to report areas in need of	

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F 584	Continued From page 11 was shown the areas around the toilet. The Maintenance Director stated, "It needs caulking." Also shown area of corner in room near the TV with paper wadded into corner. The Maintenance Director stated, "It is settling." Floor tiles throughout cracked, stained, discolored. Stated, "We are replacing some every quarter." On 4/27/18 at 11:30 AM, the Administrator was notified of above findings. 2. For Resident #15, the facility staff failed to ensure that the room was free of a strong pervasive urine-like odor. Resident #15 was an 86 year old who was admitted to the facility on 6/7/16. Resident #15's diagnoses included Dysphasia, Muscle Weakness-Generalized, Chronic Obstructive Pulmonary Disease, Hypertension, Major Depressive Disorder, Alzheimer's Disease with Early Onset, Unspecified Macular Degeneration, and Overactive Bladder. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 3/2/18, coded Resident #15 as having a Brief Interview of Mental Status Score of 13, indicating no significant cognitive impairment. In addition, she was coded as requiring the extensive physical assistance of at least 2 persons for transfers, and 1 person for toileting and hygiene assistance. Resident #15 was coded as being always incontinent of bowel and bladder. On 4/24/18 at 6:15 P.M., a tour was conducted of the facility. Resident #15's room was noted to	F 584	repairs. 4.The Interdisciplinary Team will conduct random environmental rounds weekly x 4 then monthly x 2 months to assess compliance with resident room cleanliness and to ensure rooms with maintenance needs have been identified and reported for repair. The Administrator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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	495085		C 04/27/2018

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F 584	Continued From page 12	F 584		
	have a strong, pervasive urine-like odor. The resident was not in her room at the time. Resident #15's room is located across from the soiled utility room. The surveyor noted that no odors were coming from the soiled utility room during the tour. On 4/25/18 at 9:53 A.M. a second observation was made of Resident #15's room. Resident #15 was sitting on her bed. She stated that she had finished her breakfast, and that she enjoyed it. Her room contained many stuffed animals and other personal decorative items. There was a very strong pervasive urine-like odor in her room. When asked about her opinion of the odor, she stated, "I think it's coming from me." She did not appear to be upset or embarrassed. She said that staff have to help her with her incontinence care. Resident #15 did not have a private room, she had a roommate who was unable to communicate. On 4/25/18 at 9:57 A.M., and interview was conducted with the outgoing Assistant Director of Nursing (ADON A) who was retiring, and the incoming Assistant Director of Nursing (ADON B). ADON A stated that his "nose was stuffy and that he couldn't smell any odor". ADON B stated that "It's hard to say what it smells like. It's strong, like a combination of things, I smell ammonia. I can't see where it's coming from. It's not pleasing to sit in this room. I couldn't do it." On 4/26/18 at approximately 4:00 P.M. an interview was conducted with the Administrator (Administration A), who stated the Resident #15's room had been "deep cleaned yesterday".			
F 607	Develop/Implement Abuse/Neglect Policies	F 607		5/31/18

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F 607 SS=D	Continued From page 13 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed for 2 residents (Resident #4 and #262) in a survey sample of 28 residents to implement the abuse policy. An allegation of abuse was made by Resident #262 regarding Resident #4. The allegation was not reported to the Administration or to the State Agency. The findings included: Resident #4, a 76 year old, was admitted to the facility on 6/30/11. Diagnoses included colon cancer, hypertension, cerebrovascular disease, depression, reflux, dementia, and schizophrenia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/11/18. Resident #4 was coded with a Brief Interview of Mental Status score of 4 indicating severe cognitive impairment	F 607	1.Resident #262 has been discharged from the center. A review of progress notes does not identify further documented or verbal reports of resident to resident sexually inappropriate behavior for resident #4. 2.Any resident has the potential to be affected if staff fail to implement the abuse policy. The clinical report for the past 72 hours will be reviewed for resident to resident incidents and to assess compliance with notification to Administration. The Office of Licensure & Certification will be notified for identified resident to resident incidents that meet reporting criteria. . 3.The Administrator or designee will educate the center staff on the abuse policy and procedure. 4.The Director of Nursing or designee will	

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F 607	Continued From page 14 and required extensive assistance with activities of daily living. Resident #4 was observed sitting in his wheel chair eating breakfast in his room on 4/25/18. He had no complaints at the time. Resident #262, an 88 year old, was admitted to the facility on 5/4/17. Diagnoses included diabetes, neuropathy, pulmonary hypertension, sleep apnea, reflux, anxiety and depression. A 14 day Minimum Data Set assessment with an assessment reference date of 5/18/17 coded Resident #262 with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. Resident #262 was no longer a resident at the facility. The following notes were documented in Resident #4's clinical record: 5/11/17, 07:30 "MD (doctor) and RP (responsible party) made aware of resident inappropriate sexual verbalizations. The resident was also observed to be rubbing his genital area via the outside of his pants. There was no exposure of genitals observed or reported. The resident's genital/ groin area will be assessed for skin alteration and the resident's urine will be obtained to rule out UTI (urinary tract infection)." 5/13/17, 14:10 "Another resident reported that resident was speaking inappropriately to her. Explained to resident he could not speak to resident or staff in that manner. Resident stated he did not say anything inappropriate, but understands. Supervisor made aware."	F 607	review the clinical report during the Daily Clinical Meeting weekly x 4 weeks then monthly x 2 months for resident to resident incidents to monitor compliance with notification to Administration and to ensure the Office of Licensure & Certification are notified of incidents that meet reporting criteria. The Administrator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 607	Continued From page 15 5/26/17, 06:20 "CNA (certified nursing assistant) reported that she asked a female resident why she was keeping her door closed at night when she had always left it open. Female resident replied that (Resident #4) made a sexual comment to her asking her if she wanted to play with it or suck his penis while he was pointing at his penis. She said this happened a couple of days ago." On 4/25/18 during the morning, the Administrator was asked to provide the name of the residents involved in the above nursing notes. The Administrator was also asked to provide any related investigations and reporting information. On 4/25/18 at 11:50 a.m., Licensed Practical Nurse B (LPN B) provided a "Concern Form" dated 5/11/17. She stated that Resident #262 was the female resident who made the allegation. Resident #262 was named on the form. LPN B stated that she talked with Resident #262 about the allegation. The interview was typed up and attached to the concern form. The interview was dated 5/11/17, 16:00 p.m. and read "Interview: (resident #262) (room #) CNA (certified nursing assistant) came to writer reported she had answered resident light in room (#) and was told that the man across the hall in red pants had come into her room and was rubbing his penis"." "Investigation: I spoke with resident- (#262) who stated 30 min ago the resident across the hall came into her room and started rubbing his penis with his hand, stated he didn't expose himself". She told him to stop don't do that, asked him what was the matter with him and told him to get along across the hall. She stated he never said anything and quietly went back across the hall.	F 607		

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F 607	Continued From page 16 Resident stated she was now worried about going to sleep tonight with him across the hall. I reassured her not to worry "we" will take care of this and asked her if she wanted her door shut she replied yes." "Follow-up: I asked her did he touch her she stated, "no". I asked her did he have his hands down his pants while he was touching himself she said, "no he was rubbing himself at front of his pants"." On 4/27/18 at 11:40 p.m., an interview was held with the Administrator and LPN B. At this time, they stated that the nursing notes dated 5/11/17, 5/13/17 and 5/26/17 in Resident #4's clinical record all concerned the same incident between Resident #4 and Resident #262 that occurred on 5/11/17. When asked if the incident was reported, the Administrator stated that she was aware of the 5/11/17 nursing note and an interview was conducted by LPN B on the date of the allegation, but the facility did not feel that the incident as documented on 5/11/17 needed to be reported. The Administrator and LPN B were asked to review the 5/26/17 nursing note that documented explicit sexual requests made by Resident #4 to Resident #262. The Administrator stated she was unaware of the allegations made in the 5/26/17 nursing note until it was brought to her attention by the survey team. She stated that based on the 5/26/17 note, the allegation should have been reported. The Administrator served as the abuse coordinator for the facility. When asked what types of allegations she reported to the state agency, the Administrator stated resident to resident abuse included allegations of physical,	F 607		

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F 607	Continued From page 17 sexual, mental, verbal and misappropriation. When asked when she would report, the Administrator stated that she would repot within 2 hours if there was an injury and within 24 hours for all other reportable incidents. According to Resident #4's clinical record, on three occasions Resident #262's verbalized the allegation of sexual abuse to staff. There was no documentation in Resident #262's nursing notes of the allegations. The facility's abuse policy dated 1/2017 was reviewed. The policy read "Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and on a facility basis. Outside agencies, including regulatory agencies, ombudsman, protective services, police, etc. will be notified and involved as appropriate to the situation." In addition, the "Reporting/ Response" section of the policy read "The Facility Administrator, DON (director of nursing) or designee must, report all alleged incidents of abuse, neglect, exploitation or mistreatment including injuries of unknown origin, misappropriation of property and unusual occurrences using the Virginia Office of Licensure & Certification "Facility Reported Incident" form to the (OLC) State Agency and to all other required agencies, immediately and take all necessary corrective actions depending on the results of the investigation." No further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		5/31/18

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F 609	Continued From page 18 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed for 2 residents (Resident #4 and #262) in a survey sample of 28 residents to report an allegation of abuse to facility administration or to the state agency. An allegation of abuse was made by Resident #262 regarding Resident #4. The allegation was	F 609	1.Resident #262 has been discharged from the center. A review of progress notes does not identify further documented or verbal reports of resident to resident sexually inappropriate behavior for resident #4. 2.Any resident has the potential to be affected if staff fail to report an allegation	

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F 609	Continued From page 19 not reported to the Administration or to the State Agency. The findings included: Resident #4, a 76 year old, was admitted to the facility on 6/30/11. Diagnoses included colon cancer, hypertension, cerebrovascular disease, depression, reflux, dementia, and schizophrenia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/11/18. Resident #4 was coded with a Brief Interview of Mental Status score of 4 indicating severe cognitive impairment and required extensive assistance with activities of daily living. Resident #4 was observed sitting in his wheel chair eating breakfast in his room on 4/25/18. He had no complaints at the time. Resident #262, an 88 year old, was admitted to the facility on 5/4/17. Diagnoses included diabetes, neuropathy, pulmonary hypertension, sleep apnea, reflux, anxiety and depression. A 14 day Minimum Data Set assessment with an assessment reference date of 5/18/17 coded Resident #262 with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. Resident #262 was no longer a resident at the facility. The following notes were documented in Resident #4's clinical record: 5/11/17, 07:30 "MD (doctor) and RP (responsible	F 609	of abuse to facility administration or the state agency.The clinical report for the past 72 hours will be reviewed for resident to resident incidents and to assess compliance with notification to Administration. The Office of Licensure & Certification will be notified for identified resident to resident incidents that meet reporting criteria. . 3.The Administrator or designee will educate the center staff on the abuse policy and procedure. 4.The Director of Nursing or designee will review the clinical report during the Daily Clinical Meeting weekly x 4 weeks then monthly x 2 months for resident to resident incidents to monitor compliance with notification to Administration and to ensure the Office of Licensure & Certification are notified of incidents that meet reporting criteria. The Administrator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 609	Continued From page 20 party) made aware of resident inappropriate sexual verbalizations. The resident was also observed to be rubbing his genital area via the outside of his pants. There was no exposure of genitals observed or reported. The resident's genital/ groin area will be assessed for skin alteration and the resident's urine will be obtained to rule out UTI (urinary tract infection)." 5/13/17, 14:10 "Another resident reported that resident was speaking inappropriately to her. Explained to resident he could not speak to resident or staff in that manner. Resident stated he did not say anything inappropriate, but understands. Supervisor made aware." 5/26/17, 06:20 "CNA (certified nursing assistant) reported that she asked a female resident why she was keeping her door closed at night when she had always left it open. Female resident replied that (Resident #4) made a sexual comment to her asking her if she wanted to play with it or suck his penis while he was pointing at his penis. She said this happened a couple of days ago." On 4/25/18 during the morning, the Administrator was asked to provide the name of the residents involved in the above nursing notes. The Administrator was also asked to provide any related investigations and reporting information. On 4/25/18 at 11:50 a.m., Licensed Practical Nurse B (LPN B) provided a "Concern Form" dated 5/11/17. She stated that Resident #262 was the female resident who made the allegation. Resident #262 was named on the form. LPN B stated that she talked with Resident #262 about the allegation. The interview was typed up and	F 609		

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F 609	Continued From page 21 attached to the concern form. The interview was dated 5/11/17, 16:00 p.m. and read "Interview: (resident #262) (room #) CNA (certified nursing assistant) came to writer reported she had answered resident light in room (#) and was told that the man across the hall in red pants had come into her room and was rubbing his penis"." "Investigation: I spoke with resident- (#262) who stated 30 min ago the resident across the hall came into her room and started rubbing his penis with his hand, stated he didn't expose himself". She told him to stop don't do that, asked him what was the matter with him and told him to get along across the hall. She stated he never said anything and quietly went back across the hall. Resident stated she was now worried about going to sleep tonight with him across the hall. I reassured her not to worry "we" will take care of this and asked her if she wanted her door shut she replied yes." "Follow-up: I asked her did he touch her she stated, "no". I asked her did he have his hands down his pants while he was touching himself she said, "no he was rubbing himself at front of his pants"." On 4/27/18 at 11:40 p.m., an interview was held with the Administrator and LPN B. At this time, they stated that the nursing notes dated 5/11/17, 5/13/17 and 5/26/17 in Resident #4's clinical record all concerned the same incident between Resident #4 and Resident #262 that occurred on 5/11/17. When asked if the incident was reported, the Administrator stated that she was aware of the 5/11/17 nursing note and an interview was conducted by LPN B on the date of the allegation, but the facility did not feel that the incident as documented on 5/11/17 needed to be reported.	F 609		

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F 609	Continued From page 22 The Administrator and LPN B were asked to review the 5/26/17 nursing note that documented explicit sexual requests made by Resident #4 to Resident #262. The Administrator stated she was unaware of the allegations made in the 5/26/17 nursing note until it was brought to her attention by the survey team. She stated that based on the 5/26/17 note, the allegation should have been reported. The Administrator served as the abuse coordinator for the facility. When asked what types of allegations she reported to the state agency, the Administrator stated resident to resident abuse included allegations of physical, sexual, mental, verbal and misappropriation. When asked when she would report, the Administrator stated that she would repot within 2 hours if there was an injury and within 24 hours for all other reportable incidents. According to Resident #4's clinical record, on three occasions Resident #262's verbalized the allegation of sexual abuse to staff. There was no documentation in Resident #262's nursing notes of the allegations. The facility's abuse policy dated 1/2017 was reviewed. The policy read "Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and on a facility basis. Outside agencies, including regulatory agencies, ombudsman, protective services, police, etc. will be notified and involved as appropriate to the situation." In addition, the "Reporting/ Response" section of the policy read "The Facility Administrator, DON (director of nursing) or designee must, report all alleged incidents of	F 609		

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F 609	Continued From page 23 abuse, neglect, exploitation or mistreatment including injuries of unknown origin, misappropriation of property and unusual occurrences using the Virginia Office of Licensure & Certification "Facility Reported Incident" form to the (OLC) State Agency and to all other required agencies, immediately and take all necessary corrective actions depending on the results of the investigation." No further information was provided.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		5/31/18

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F 656	Continued From page 24 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to develop and implement a comprehensive person centered care plan for three Residents (Residents #308, #61, and #104) of 28 residents in the survey sample. 1. Resident #308's care plan did not include person centered interventions for peritoneal dialysis. 2. Resident #61's care plan did not contain information regarding his left sided neglect from a previous stroke affecting his communication. 3. For Resident #104 the facility failed to provide a comprehensive care plan that was accurate and resident centered, tailored to resident needs. The findings included:	F 656	1.Resident #308 has been discharged home. The care plan for resident #61 has been reviewed and revised to reflect communicating speaking to the resident on his neglect side. The care plan for resident #104 has been reviewed and revised to reflect resident specific non-pharmacological interventions for management of her behaviors. 2.Any resident receiving peritoneal dialysis has the potential to be affected if the care plan does not include person centered interventions. Any resident has the potential to be affected if care plans are not tailored to the resident□s needs. A review of care plans for residents receiving peritoneal dialysis, communication deficits and behaviors will be completed to verify care plan reflects resident centered care. .	

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F 656	Continued From page 25 Resident #308 was admitted previously to the facility on 12-1-17, after amputation surgery of her left foot. The Resident was discharged home from the facility on 3-14-18. The Resident was readmitted after further amputation surgeries on 4-19-18 with the diagnoses of, but not limited to; hypertension, heart disease, chronic kidney disease with peritoneal dialysis, bilateral below the knee amputations, insulin dependant diabetes, glaucoma, and asthma. The most recent Minimum Data Set (MDS) for this admission was a quarterly assessment with an Assessment Reference Date (ARD) of 3-5-18, from the previous stay. The MDS coded Resident #308 with no cognitive impairment. The Resident needed extensive assistance from staff for toileting, hygiene, bed mobility and transferring. On 4-24-18 at 6:30 p.m. on initial tour of the facility the Resident was observed lying in bed, and when asked for an interview, she stated that tomorrow would be better, she was tired. On 4-25-18 at 10:30 a.m., the Resident was sitting on her bed and granted the request for an interview. The Resident stated she had been back at the facility for "About a week after having surgery on my legs." The Resident went on to say that her dialysis treatments were a problem, and when asked why, she stated that the staff did not know how to do them correctly, and she had to monitor them closely so they "don't mess me up and give me an infection or worse." The Resident stated that the staff don't know what they are doing, they put the wrong bags on to dialyze with, they don't use good infection	F 656	3.The Director of Nursing or designee will educate nurses and MDS staff on center□s protocol for developing resident centered care plans to reflect resident□s individual needs. 4.The Unit Manager or designee will review resident care plans weekly x 4 weeks then monthly x 2 months according to the MDS schedule to ensure reviewed and revised care plans are person centered. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 656	Continued From page 26 practices, and they put the bags and tubing on the floor, they didn't order the right equipment bag and tubing cassettes (5 prong instead of 3 prong tubing) and she stated she has to tell them step by step what to do, and sometimes at night she is asleep and has to wake up to watch what the staff is doing so the staff doesn't "mess me up". The Resident went on to say "I have gained 10 pounds since I have been here in one week." "Weight gain is a problem, and I guess I will have to call the doctor myself, since they won't." "I never use 1.5 bags cause I gain fluid with them, I told them that but they don't listen." "Yesterday they got the wrong stuff so I didn't even get my afternoon exchange at all, I had to wait for supplies to come, that's ridiculous". On 4-26-18 at 11:00 a.m. LPN E was observed obtaining a 1.5% dextrose dialysis bag full of fluid to instill in the Resident's abdomen after the old fluid was drained out of the Resident's abdomen. The bag was opened by LPN E with gloved hands from it's protective clear wrapper one hour prior to the planned 12:00 noon exchange, and was placed on a warming tray. There was condensation liquid on the outside of the inner bag when LPN E opened the outer protective clear wrapper and LPN E began wiping it off with a paper towel. On 4-26-18 at 12:30 p.m. Resident #308 was observed before and during a peritoneal dialysis exchange. The Resident was sitting in a wheel chair in her room. Two surveyors were present with the Resident, LPN E (licensed practical nurse #E), and the ADON RN A (assistant director of nursing registered nurse #A). LPN E squirted a dime size amount of alcohol	F 656		

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F 656	Continued From page 27 based hand sanitizer into her hands and briskly rubbed them together. She donned a pair of clean gloves from an open box in the Resident's room and applied them. After stating "We are going to weigh you now" to the Resident. The surveyors followed LPN E pushing Resident #308 in a wheel chair to the shower room at the nursing station where the Resident was weighed in her wheel chair. LPN E pushed electronic digital buttons on the wheel chair scale with her gloved hands to obtain the weight, while her uniform top touched the scale which was used to weigh all wheel chair bound residents. The Resident weighed 212.6 pounds in the wheel chair. LPN E then returned the Resident to the Resident's room. The nurse did not weigh the wheel chair prior to weighing the Resident. LPN E was asked what the Resident's weight was and she stated "I need to get my calculator out." LPN E removed the gloves and threw them in the regular garbage can next to the resident's bed. There were no biohazardous waste receptacles in the Resident's room. LPN E pulled the calculator out of her shirt pocket with bare hands which were now contaminated, and calculated the weight. LPN E stated "she weighs 174.6 pounds." When LPN E was asked how she came to that number, she stated "I subtracted 38 pounds from 212.6 pounds for the wheel chair weight." LPN E was asked how she knew the wheel chair weight, she stated it was written on the back of the wheel chair" that Resident #308 always used. The chair was inspected, and there was no weight written on the back of the chair. It is unknown if the chair was swapped out for a different chair, and what	F 656		

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F 656	Continued From page 28 the weight of the current chair was, as the chair was not weighed even after this discussion. The Resident's vital signs were obtained with a machine from the hallway and were "Temperature 98.0 Fahrenheit orally, blood pressure 134/75, and heart rate 80. LPN E put on a clean pair of gloves from the same container in the Resident's room without washing her hands. The room door remained open. LPN E and all observers donned masks, no gowns were used. The nurse did not check the temperature of the dialysis bag of fluid. The nurse opened a second bag containing an empty dialysis bag with 2 sets of tubing attached to it which she brushed against her uniform top and pants. The empty bag was placed on the bottom shelf of a 2 shelf push cart which was visibly dusty and soiled. LPN E did not clean the shelf nor put a barrier layer down under the empty bag which was now contaminated. The tubing was laying on top of the empty bag with a loop of the tubing hanging down in front of the cart and laying on the floor, which contaminated it. An IV (intravenous) medication pole was pulled over to hang the bag of fluids on (which was not cleaned) that would drain into the Resident, after the fluid in her abdomen was drained into the empty bag on the bottom of the cart. LPN E placed 2 clamps (which had been open and laying on the cart on top of the now contaminated tubing) and closed them so as to allow no fluid to pass through either tubing. The clamps were not cleaned, and were	F 656		

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F 656	Continued From page 29 contaminated. LPN E picked up a canister of cleaning wipes and cleaned the Resident's abdominal peritoneal dialysis tube with the wipes which were now contaminated by her contaminated gloves, allowed no time for the tubing to dry, and connected the tubing (which had been on the bottom of the cart and contaminated) and touched to the Resident after pulling a cap off of the tubing. LPN E then pulled the IV pole over closer to the Resident, hung the full bag of fluid on it, and connected the second line of tubing to it making a circuit of the 2 bags and the Resident, which were now all contaminated. The clamp for the drain bag was released and fluid began filling the bag from the Resident's abdomen. After the observation LPN E and the ADON were made aware of the breaches in infection control, and the need for aseptic technique when providing peritoneal dialysis. The ADON stated this is a clean procedure, and there are levels of aseptic techniques. The ADON was then asked what nursing standard of practice the facility followed for infection control and aseptic technique, and the reply was CDC (the centers for disease control). The ADON went on to say he taught peritoneal dialysis to staff and he was asked to provide the text information used for that training, and his certificate of completion for his training. No certificate of training was produced, however, the Director of nursing provided a 3 page document entitled "Baxter CAPD Exchange Procedure" , which was not followed by LPN E, and a 2 page document entitled CAPD "Continuous Ambulatory Peritoneal Dialysis". The Director of Nursing	F 656		

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F 656	Continued From page 30 (DON) stated the facility professional standard for nursing practice was obtained from "Potter and Perry".	F 656		

The documents were reviewed and the CAPD document stated "Use strict aseptic technique when performing bag exchanges.". and "As with all peritoneal dialysis procedures, aseptic technique is essential during catheter insertion, exchanges, and dressing changes to prevent peritonitis." Peritonitis is a life threatening inflammation of the sterile abdominal cavity which is often fatal.

The CDC requires aseptic technique for all dialysis. The CDC definition of aseptic technique is "free from all pathogenic microorganisms, to protect from infection, and to prevent the spread of pathogens".

The director of Nursing provided the policy for dialysis, and stated this is the only dialysis policy we have. The policy referred only to hemodialysis. No mention of peritoneal dialysis existed in this document. The facility did not provide hemodialysis in the facility.

After the observations, the Resident's clinical record was reviewed. The review revealed signed physician orders which included the below order:

"4-21-18: Afternoon manual exchanges: Fill volume 2000 milliliter bags (use 1.5% solution, if blood pressure greater than 140/80 then use 2.5% solution one time a day related to end stage renal disease). On 4-24-18 the entry was not signed as administered by staff, and referred the reader to a nursing note for explanation. The

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F 656	Continued From page 31 nursing note stated that the supplies for the exchange were unavailable and they were waiting for delivery. The exchange was never completed. Resident #308's old admission care plan, and new admission care plans were reviewed and revealed that no specific step by step individualized instructions were ever care planned to direct nursing home staff in provision of care before, during and after peritoneal dialysis, and did not specify that strict aseptic technique must be used. There was no doctor's order, nor care plan for access site care, or aseptic technique or infection control standards to be observed for PD. No directions were care planned for pre and post dialysis weights, the care plan simply stated follow doctor's orders for weight. There were no doctor's order for weights. No intake and output amounts of fluids consumed and excreted were obtained or ordered. There was no doctor's order, nor care plan for access site care. There was no order to follow, nor care plan derived for vital signs, and how and when to stop peritoneal dialysis and or seek help when handling complications and emergencies. No guidance was care planned for handling clinical symptoms of dialysate contamination. No dwell time was specified, no specific drain time was specified in orders or care planning, and no target weight during the provision of peritoneal dialysis was included in orders or care planning. The one care plan intervention "to monitor and report to doctor signs of acute renal failure with urine output of less than 400 milliliters in 24 hours" was not being measured for this Resident as she went to the toilet independently, and no	F 656		

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F 656	Continued From page 32 device to catch urine was in the toilet. The intervention that was care planned for "Report to Doctor weight gain of over 2 pounds per day" was not followed. Resident #308 was admitted with a weight of 163 pounds per a physicians progress note dated 4-20-18, and by 4-26-18 the weight was 174.6 pounds, equaling greater than 10 pounds gained in the one week since admission. No call to the doctor had been made by 2:30 p.m. on 4-26-18 when the nursing notes were printed for surveyors. Further evidence from a physicians progress note dated 4-24-18, revealed the doctor documented a weight of 163 pounds, and was unaware of the weight gain. The Residents weight record from the Medication Administration Record (MAR) revealed the following; 4-21-18 (160 pounds), 4-22-18 (165 pounds), 4-23-18 (168.9 pounds), 4-24-18 (no weight taken nor PD administered), 4-25-18 (168 pounds), and during observation of weight on 4-26-18 (174.6 pounds). LPN E was asked if she had been trained by a dialysis certified facility trainer, and she stated "yes, they came from [name of dialysis company] yesterday at 3:00 p.m. (4-25-18) to train us." She went on to say that was the first time they had trained her, and she had been providing care for a month, and for this Resident for a week. On 4-26-18, and 4-27-18 at the end of day debrief, the Administrator and DON were made aware that PD was not being provided in accordance with federal regulations. The care	F 656		

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F 656	Continued From page 33 plan for this Resident was not developed to adequately guide staff in the provision of care for PD, and that breaches in infection control during PD were observed by surveyors. They were made aware that their policy was for hemodialysis only, and gave no guidance to staff for PD. They were also made aware that the Resident had experienced a 10 pound weight gain since admission a week ago, and no intervention by staff had been taken for the Resident, hindering her quality of care and wellbeing. No further information was provided by the facility staff. 2. Resident #61's care plan did not contain information regarding his left sided neglect from a previous stroke affecting his communication. Resident #61 was admitted to the facility 3/16/16. Diagnoses included, but not limited to, dementia, stroke, diabetes and aphasia. Resident #61's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/13/18 was coded as an annual assessment. Resident #61 was coded as having a BIMS (brief interview of mental status) of "5" out of a possible 15 or severe cognitive impairment. Resident #61 was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. On 4/24/18 at approximately:10 PM during the facility tour, the resident was observed in his bed with his daughter nearby. While speaking to the resident, the daughter stated, "He has left side neglect from his stroke and will not recognize anyone from his left side, you have to come around to his right." This was done and the	F 656		

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F 656	Continued From page 34 resident maintained eye contact. The daughter went on to state that he will refuse medications if this happens. Review of the care plan revealed the resident does have behaviors of refusing medications. Review of the clinical record revealed a care plan dated 3/30/18 which documented a communication deficit due to aphasia (lack of speech). The care plan did not address the issue of communicating with the resident from the right side. On 4/27/18 at approximately 1:30 PM, an interview was conducted with the MDS coordinator. The MDS coordinator was asked to review the care plan for his communication deficit. She stated, "Oh, OK." On 4/27/18 at approximately 11:30 AM, the facility Administrator and DON (director of nursing) were notified of above findings. 3. For Resident #104 the facility failed to provide a comprehensive care plan that was accurate and resident centered, tailored to resident needs. Resident #104 had a care plan for a seizure disorder however, the resident did not have a seizure disorder AND interventions listed psychoactive medication were not specific. Resident # 104, a 73 year old female was admitted to the facility on 12/15/2014 with diagnoses of but not limited to Dysphagia, High Blood pressure, Intellectual disabilities, Paranoid Schizophrenia, Major Depressive Disorder, Contractures, Reflux Gout and Arthritis.	F 656		

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F 656	Continued From page 35 Resident # 104's most recent MDS (Minimum Data Set) dated 4/10/18 was coded as a significant change. She was coded as having a BIMS (Basic Interview of Mental Status) score of 99, indicating severe cognitive impairment. She was coded as needing extensive assistance of 2 staff members for activities of daily living. A review of resident's care plan initiated upon admission and latest revision date 4/25/18 stated that Resident #104 was at risk for injuries due to a Seizure Disorder. A review of the resident's record showed no diagnosis of Seizure Disorder. The care plan also stated Resident # 104 used psychoactive medication/ antidepressants related to depression and mood disorder. The interventions were listed as Utilize non-pharmacological interventions to address symptoms/behaviors. However, there were no resident- specific interventions listed on the care plan. During the survey an an interview with Employee A (LPN) was conducted. Emplyee A stated that Resident # 104 was on Valproic Sodium for paranoid schizophrenia and the Gabapentin is for her diabetic peripheral neuropathy. According to Employee A Resident #104 has no history of seizures. During exit conference on 4/27/18 @ 2:45 pm the facility was notified and no further information was provided.	F 656		
F 657	Care Plan Timing and Revision	F 657		5/31/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=B	Continued From page 36 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 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, facility documentation review and clinical record review, the facility staff failed to ensure a comprehensive care plan was reviewed and revised after each MDS quarterly or MDS comprehensive assessment for one resident (Resident # 8) in a survey sample of 28 residents. There were multiple areas in the comprehensive care plan that were not reviewed.	F 657	1.It is duly noted that Resident # 8□s Care Plan was not reviewed and revised quarterly. 2.Any resident has the potential to be affected if staff fail to review the care plan after each assessment. A review of care plans for current residents will be	

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F 657	Continued From page 37 For Resident # 8, the facility staff did not review the care plan after the MDS Quarterly assessment on 10/15/17. Findings included: Resident # 8 was a 66-year-old male who was admitted to the facility on 9/17/2014 with diagnoses of but not limited to: Hypertensive Heart Disease, Diabetes, End Stage Renal Disease, Hypotension, Anxiety , Bacteremia, Hyperkalemia, Pneumonia, Hyperlipidemia, and Dyspnea. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/17/2018. The MDS coded Resident # 8 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 8 required extensive assistance of 1-2 staff persons with Activities of Daily Living except required supervision and set up for eating; and was coded as frequently incontinent of bowel and bladder. Review of the clinical record was conducted on 4/25/2018 at 3:50 PM. The review showed the following MDS and Care plan review dates: MDS Comprehensive (annual) 9/17/17 Care Plan 9/17/17 MDS Quarterly 10/15/17 No Care Plan reviewed MDS Quarterly 1/15/18	F 657	completed to ensure that the care plan is reviewed and revised quarterly. . 3.The Administrator or designee will educate the Interdisciplinary Team in regards to reviewing and revising a resident□s Care Plan quarterly. 4.The MDS Coordinators will review clinical records for 10 residents weekly x 4 weeks, then monthly x 2 months to ensure care plans have been reviewed and revised timely. The MDS Coordinator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 657	Continued From page 38 Care Plan 1/15/18 MDS Quarterly 4/17/18 Care Plan 4/17/18 The review showed there are 120 days between the review of the care plan on 9/17/17 and 1/15/18. On 4/26/2018 at 10:05 AM, the Director of Nursing (DON) was interviewed about the care plans. The DON stated care plans should be reviewed. During the end of day debriefing on 4/26/2018, the administrator, DON and corporate nurse (Admin C) were informed of the findings. On 4/27/2018 at approximately 11:10 AM, the corporate nurse (Admin C) stated the facility staff did complete a care plan because the care plan opened was on 9/17/2017 but was not completed until 10/6/2017. Admin C stated the facility had 21 days to review information prior to completing the care plan. During the end of day debriefing on 4/27/2018, the administrator, DON, and corporate nurse were informed of the findings. No further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		5/31/18

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F 658	Continued From page 39 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow the professional standards of quality for medication and treatment administration for two Residents (Residents # 8 and # 407) in a survey sample of 28 Residents. 1. For Resident # 8, the facility staff failed to administer medications as ordered by the physician. 2. For Resident #407, Facility staff administered Oxygen without a Physician's order. Findings included: 1. For Resident # 8, the facility staff failed to administer medications as ordered by the physician. Resident # 8 was a 66-year-old male who was admitted to the facility on 9/17/2014 with diagnoses of but not limited to: Hypertensive Heart Disease, Diabetes, End Stage Renal Disease, Hypotension, Anxiety, Bacteremia, Hyperkalemia, Pneumonia, Hyperlipidemia, and Dyspnea. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/17/2018. The MDS coded Resident # 8 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of 1-2 staff persons with Activities of Daily Living except required supervision and set	F 658	1.Resident #8 is receiving medication and treatments as ordered. There were no negative effects for the resident. An associate education was completed with the licensed nurses assigned to administer medications on the days that documentation was omitted. Resident #407 was assessed by the licensed nurse and a prn order was given for oxygen. A medication error report has been completed and an associate education was completed with the licensed nurse that failed to transcribe the physician□s order for oxygen. 2.Any resident has the potential to be affected if staff fail to administer medications as ordered or if oxygen is administered without an order. Medication administration records for current residents will be reviewed for the past 72hrs to assess compliance with documentation of medication administration. An associate education and a medication error report will be completed with physician and responsible party notification as applicable. The Clinical Report will be reviewed for the past 72hrs to identify residents using oxygen to ensure physician orders have been obtained for administration. 3.The Administrator or designee will educate the Director of Nursing and Assistant Director of Nursing on the process for monitoring medication	

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F 658	Continued From page 40 up for eating; and coded as frequently incontinent of bowel and bladder. Review of the clinical record was conducted on 4/25/2018 at 3:50 PM. Review of the April MAR (Medication Administration Record) revealed missing documentation of administration of medications: 4/3/2018- 6 AM-Fluticasone Suspension 50 micrograms per activation one spray in both nostrils one time a day. Tuesday, Thursday and Saturday 4/3/2018- 6 AM-Calcium Acetate 667 milligrams one capsule by mouth three times a day 4/3/2018- 6 AM- 4/3/2018- 6 AM- Novolog Insulin Inject as per Sliding Scale: if 150-200= 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units over 400 call md (medical doctor), subcutaneously before meals and at bedtime (Notify MD for BS (Blood Sugar) < 60 Not documented as having been administered on 4/3/2018 at 6 AM, Review of the March 2018 MAR revealed missing documentation of medications: Novolog Insulin Inject as per Sliding Scale: if 150-200= 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units over 400 call md (medical doctor), subcutaneously before meals and at	F 658	administration documentation. The Director of Nursing or designee will educate the licensed nurses on the policy and procedure for Medication Administration and Documentation. The Director of Nursing or designee will educate licensed nurses on the process for transcribing physician□s orders. 4.The Director of Nursing or designee will review medication administration records during the Daily Clinical Meeting weekly x 4 weeks and monthly x 2 months to ensure compliance with medication administration and documentation. The Director of Nursing or designee will review the Clinical Report during the Daily Clinical Meeting weekly x 4 weeks then monthly x 2 months to ensure residents using oxygen have physician orders for administration. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 658	Continued From page 41 bedtime (Notify MD for BS (Blood Sugar) < 60 Not documented as having been administered on 3/4/2018 at 6 AM, 3/21/2018 at 6 AM, 3/28/2018 at 11 AM 3/4/2018- 6 AM- 3/8/2018- 5 AM- Docusate Sodium 100 milligrams one capsule by mouth one time a day every Tuesday, Thursday and Saturday 3/8/2018- 6 AM- Flomax 0.4 milligrams give one capsule by mouth one time a day every Tuesday, Thursday and Saturday 3/8/2018- 5 AM-Fluticasone Suspension 50 micrograms per activation one spray in both nostrils one time a day. Tuesday, Thursday and Saturday 3/8/2018- 6 AM- Lexapro 20 milligrams one tablet by mouth one time a day every Tuesday, Thursday and Saturday 3/28/2018 - 8 AM Fluticasone Suspension 50 micrograms per activation one spray in both nostrils one time a day. Sunday, Monday, Wednesday and Friday 3/28/2018 at 9 AM-Levemir Insulin inject 6 units subcutaneously in the morning every Sunday, Monday, Wednesday and Friday 3/28/2018 at 9 AM-Lexapro 20 milligrams one tablet by mouth one time a day every Sunday, Monday, Wednesday and Friday 3/28/2018 at 9 AM-Midodrine 10 milligrams one tablet by mouth one time a day every Sunday, Monday, Wednesday and Friday 3/28/2018 at 9 AM Calcium Acetate 667	F 658		

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F 658	Continued From page 42 milligrams one capsule by mouth three times a day every Sunday, Monday, Wednesday and Friday 3/28/2018 at 9 AM Renvela 800 milligrams one tablet by mouth with meals every Sunday, Monday, Wednesday and Friday 3/28/2018 at 9 AM every Sunday, Monday, Wednesday and Friday 3/28/2018 at 9 AM every Sunday, Monday, Wednesday and Friday every Sunday, Monday, Wednesday and Friday 3/28/2018 at 12 noon-Renvela 800 milligrams one tablet by mouth with meals every Sunday, Monday, Wednesday and Friday 3/28/2018 at 1 PM Calcium Acetate 667 milligrams one capsule by mouth three times a day every Sunday, Monday, Wednesday and Friday Review of the February 2018 MAR revealed missing documentation of medications: 2/8/2018- 5 AM- Docusate Sodium 100 milligrams one capsule by mouth one time a day every Tuesday, Thursday and Saturday 2/8/2018- 5 AM- Flomax 0.4 milligrams give one capsule by mouth one time a day every Tuesday, Thursday and Saturday 2/8/2018- 6 AM-Fluticasone Suspension 50 micrograms per activation one spray in both nostrils one time a day. Tuesday, Thursday and	F 658		

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F 658	Continued From page 43 Saturday 2/8/2018- 5 AM- Lexapro 20 milligrams one tablet by mouth one time a day every Tuesday, Thursday and Saturday Novolog Insulin Inject as per Sliding Scale: if 150-200= 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units over 400 call md (medical doctor), subcutaneously before meals and at bedtime (Notify MD for BS (Blood Sugar) < 60 Insulin was not documented as having been administered on 2/8/2018 at 6 AM and 2/26/2018 at 6 AM. Review of the March 2018 TAR (Treatment Administration Record) revealed missing documentation of treatments on 2/8/2018 at 9 AM 3/8/2018- 5 AM- Lotrimin Antifungal Powder 2 % Apply to ABD (Abdomen) folds topically two times a day every Tuesday, Thursday and Saturday Review of the February 2018 TAR (Treatment Administration Record) revealed missing documentation of treatments on 2/8/2018 at 9 AM 2/8/2018- 6 AM- Lotrimin Antifungal Powder 2 % Apply to ABD (Abdomen) folds topically two times a day every Tuesday, Thursday and Saturday Review of the Progress Notes revealed no documentation of reasons for missing documentation of administration of medications and treatments on the above listed dates. Review of the Facility policy on Medication	F 658		

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F 658	Continued From page 44 Administration effective 6/21/2017 revealed statements: "11. Administer medication and remain with resident while medication is swallowed. ..." "14. Return to the medication cart and document on the MAR. Note refusal or ingestion of less than 100% of dose on the MAR in the designated area. " Guidance for nursing standards for the administration of medication was provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." On 4/26/2018 at 3 PM, an interview was conducted with the Director of Nursing who stated the nurses should administer medications as ordered by the physician. During the end of day debriefing on 4/26/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings.	F 658		

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F 658	Continued From page 45 The Director of Nursing stated the nurses should administer medications as ordered by the physician and document on the Medication Administration Record at the time of administration. On 4/27/2018 at 11:45 AM, the Director of Nursing stated she could find no documentation in the nurses notes or on the MAR about the medications that were not documented as having been administered. No further information was provided. 2. For Resident #407, Facility staff administered Oxygen without a Physician's order. Resident #407 was admitted on 4/7/2018. His most recent MDS (Minimum Data Set) Assessment was an Admission/Medicare 15 Day Assessment with an Assessment Reference Date of 4/14/2018. His BIMS (Brief Interview for Mental Status) score was a 3, indicating severe impairment. Resident #407 required extensive assistance of 2+ staff for dressing and toileting, and was totally dependant on 2+ staff for transfers, eating, and hygiene. On 4/24/18 at 6:45 p.m., an interview was conducted with Resident #407's family, specifically his sister and niece. The family stated that "last week" on Thursday, Resident #407 experienced an episode of respiratory distress. His niece informed facility staff that her uncle was having difficulty breathing, and they proceeded to apply oxygen, which the family indicated calmed	F 658		

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F 658	Continued From page 46 Resident #407 significantly. On 4/25/18 at 10:10 a.m., an interview was conducted with LPN (Licensed Practical Nurse) D. LPN D stated she had been caring for Resident #407 on the date of his episode of respiratory distress. She stated that she had asked the Physician for an order for Oxygen and received a verbal order. She stated that she applied the Oxygen at 2 liters per minute, and that is calmed Resident #407. LPN D stated that the resident remained on the Oxygen for "a couple of days", until he began attempting to remove the oxygen tubing. LPN D stated she believed that the Oxygen order was changed to PRN (as needed). Upon review of Resident #407's Physician Orders, no order for Oxygen was found. When viewing expired and discontinued ordered, no order for Oxygen was found. The Administrator and DON (Director of Nursing) were informed of the findings at the end of day meeting on 4/26/18. On the morning of 4/27/18, the DON provided survey staff with a document entitled "Medication or Treatment Error Report". It stated Date of Error as 4/19/2018 and Date Error Discovered as 4/25/2018. The document stated "Medication ordered: None" and "Medication Given: Oxygen @ 2L/min." This document was not part of the clinical record. No further documents were provided.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		5/31/18

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F 677	Continued From page 47 §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, resident interview, family interview, staff interview, and clinical record review the facility staff failed to provide Activity of Daily Living (ADL) assistance for 1 resident (Resident #258) of 28 residents in the survey sample. For Resident #258, facility staff failed to provide feeding assistance. The finding included: Resident #258, a 69 year old, was admitted to the facility on 4/18/18. Diagnoses included multiple myeloma, dysphagia, hypertension, anemia, and critical illness myopathy (muscle weakness). Resident #258 was new to the facility and did not have a Minimum Data Set completed. Her care plan documented that she was able to make basic care decisions and express care preferences. Resident #258's family was interviewed on 4/24/18 at 7:30 p.m. The family was concerned that the facility staff did not assist the resident during meal time. They stated they helped her when the visited. They stated that the resident had just come to the facility from the hospital where she had been fed via feeding tube. They stated they were taking her home the next morning.	F 677	1.Resident #258 was discharged home. An associate counseling has been completed with CNA B for failing to offer assistance to resident #258. 2.Any resident has the potential to be affected if staff fail to provide feeding assistance. Observations will be conducted during meal times to assess compliance with staff offering feeding assistance to residents in need. 3.Director of Nursing or designee will educate nursing staff on providing feeding assistance to residents as needed. 4.The Unit Manager or designee will conduct 3 random meal observation weekly x 4 weeks then monthly x 2 months to ensure compliance. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 677	Continued From page 48 On 4/25/18 at 8:15 a.m., Resident #258 was observed in bed. Her eyes were closed. The head of the bed was elevated and the over bed table was placed in front of Resident #258. The breakfast meal tray was on the over bed table. The cover had been removed from the plate. The food had been untouched. Resident #258 was asked if she was going to eat any of her breakfast. She stated that the tray was too far away to eat. Resident #258 remained in bed with her eyes closed and meal tray untouched at 8:40 a.m., 8:45 a.m., and 9:00 a.m. At 9:05 a.m., Certified Nursing Assistant C (CNA C) went into Resident #258's room and came back out with the breakfast tray. CNA C put the tray on the cart with the dirty dishes. CNA C was asked if Resident #258 ate any food. CNA C stated "not much". The lid was taken off of Resident #258's plate. It was stated to CNA C that it did not appear that Resident #258 ate any food on the tray. Resident #258's care plans were reviewed. The CNA care plan (kardex) read the following in the "Eating/ Nutrition" section, "Provide assistance for eating and drinking as needed." The full care plan dated 4/18/18 read "Demonstrates the need for ADL assistance" with the intervention "Provide assistance for eating and drinking as needed." On 4/27/18 at 10:10 a.m., CNA B was asked how she knew what "as needed" meant when a residents care plan listed feeding assistance "as needed". CNA B stated that she would ask the	F 677		

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STREET ADDRESS, CITY, STATE, ZIP CODE
201 EPPS STREET
HOPEWELL, VA 23860

(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 677	Continued From page 49 resident if they liked the food or if they needed help eating. She stated she would also be on the look out to see if the resident could not reach their food, if there was spilling down the front of the shirt or if there was an issue using the utensils. Resident #258's meal tracking information was requested. Out of the 20 meal served to Resident #258, she was documented to have eaten 0% of her food at 10 meals. On 4/26/18 at 4:30 p.m., the Administrator and Director of Nursing were notified that Resident #258's breakfast tray had sat untouched for almost an hour prior to the CNA taking the tray away without offering feeding assistance. No further information was provided.	F 677		
F 684 SS=D	COMPLAINT DEFICIENCY Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to	F 684	1.Resident #308 was discharged home. The Admissions Director and Administrator reviewed pre-admission	5/31/18

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	495085		C 04/27/2018

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F 684	Continued From page 50 provide peritoneal dialysis services to maintain the highest practicable well being for one Resident (Resident #308) of 28 residents in the survey sample. Resident #308 did not receive peritoneal dialysis services to maintain her highest practicable wellbeing. The findings included: Resident #308 was admitted previously to the facility on 12-1-17, after amputation surgery of her left foot. The Resident was discharged home from the facility on 3-14-18. The Resident was readmitted after further amputation surgeries on 4-19-18 with the diagnoses of, but not limited to; hypertension, heart disease, chronic kidney disease with peritoneal dialysis, bilateral below the knee amputations, insulin dependant diabetes, glaucoma, and asthma. The most recent Minimum Data Set (MDS) for this admission was a quarterly assessment with an Assessment Reference Date (ARD) of 3-5-18, from the previous stay. The MDS coded Resident #308 with no cognitive impairment. The Resident needed extensive assistance from staff for toileting, hygiene, bed mobility and transferring. On 4-24-18 at 6:30 p.m. on initial tour of the facility the Resident was observed lying in bed, and when asked for an interview, she stated that tomorrow would be better, she was tired. On 4-25-18 at 10:30 a.m., the Resident was sitting on her bed and granted the request for an interview. The Resident stated she had been	F 684	communication to identify barriers that affected the timely availability of resident #308 dialysis supplies. An associate education was completed with the licensed nurse that was responsible for failing to provide dialysis services in a manner that is consistent with professional standards of practice. The resident had no negative effects from the provision of dialysis services. 2.Any resident receiving peritoneal dialysis has the potential to be affected if services are not performed in a manner that maintains the highest practicable wellbeing. Currently there are no residents in the center receiving peritoneal dialysis. 3.The Administrator or designee will educate the Admissions Director on ensuring peritoneal dialysis supplies are available to staff the day before admission. The Director of Nursing or designee will educate the licensed nurses on the protocol for monitoring availability of peritoneal dialysis supplies. The Director of Nursing or designee will schedule peritoneal dialysis training to be completed with current licensed nurses that have not been trained by a qualified dialysis trainer from a certified dialysis center prior to the employee being assigned to care for a resident receiving peritoneal dialysis. The Director of Nursing or designee will schedule peritoneal dialysis training to be completed with new hires by a qualified dialysis trainer from a certified dialysis center prior to the employee being	

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F 684	Continued From page 51 back at the facility for "About a week after having surgery on my legs." The Resident went on to say that her dialysis treatments were a problem, and when asked why, she stated that the staff did not know how to do them correctly, and she had to monitor them closely so they "don't mess me up and give me an infection or worse." The Resident stated that the staff don't know what they are doing, they put the wrong bags on to dialyze with, they don't use good infection practices, and they put the bags and tubing on the floor, they didn't order the right equipment bag and tubing cassettes (5 prong instead of 3 prong tubing) and she stated she has to tell them step by step what to do, and sometimes at night she is asleep and has to wake up to watch what the staff is doing so the staff doesn't "mess me up". The Resident went on to say "I have gained 10 pounds since I have been here in one week." "Weight gain is a problem, and I guess I will have to call the doctor myself, since they won't." "I never use 1.5 bags cause I gain fluid with them, I told them that but they don't listen." "Yesterday they got the wrong stuff so I didn't even get my afternoon exchange at all, I had to wait for supplies to come, that's ridiculous". On 4-26-18 at 11:00 a.m. LPN E was observed obtaining a 1.5% dextrose dialysis bag full of fluid to instill in the Resident's abdomen after the old fluid was drained out of the Resident's abdomen. The bag was opened by LPN E with gloved hands from it's protective clear wrapper one hour prior to the planned 12:00 noon exchange, and was placed on a warming tray. There was condensation liquid on the outside of the inner bag when LPN E opened the outer protective clear wrapper and LPN E began wiping it off with a paper towel.	F 684	assigned to care for a resident receiving peritoneal dialysis. The Director of Nursing or designee will educate licensed nurses on aseptic technique. The Director of Nursing or designee will educate the licensed nurses on the policy and procedure for handwashing and General Infection Control Guidelines. The Director of Nursing or designee will educate the licensed nurses on the protocol for obtaining weights for residents receiving peritoneal dialysis services to include notification to the physician and responsible party when weights are not within parameters. The Director of Nursing or designee will educate the Unit Managers and Supervisors on ensuring care plans for residents receiving peritoneal dialysis accurately reflect the resident□s current conditions and appropriate interventions for treatment and monitoring. The Director of Nursing or designee will educate the licensed nurses on ensuring residents receiving peritoneal dialysis have complete and accurate orders. 4.The Unit Manager or designee will check the availability of dialysis supplies weekly x 4 weeks then monthly x 2 months. The QAPI Coordinator or designee will conduct random observations of the provision of peritoneal dialysis services as available for 2 licensed nurses trained to provide peritoneal dialysis services weekly x 4 weeks then monthly x 2 months to ensure services are being provided in a manner that is consistent with professional	

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F 684	Continued From page 52 On 4-26-18 at 12:30 p.m. Resident #308 was observed before and during a peritoneal dialysis exchange. The Resident was sitting in a wheel chair in her room. Two surveyors were present with the Resident, LPN E (licensed practical nurse #E), and the ADON RN A (assistant director of nursing registered nurse #A). LPN E squirted a dime size amount of alcohol based hand sanitizer into her hands and briskly rubbed them together. She donned a pair of clean gloves from an open box in the Resident's room and applied them. After stating "We are going to weigh you now" to the Resident. The surveyors followed LPN E pushing Resident #308 in a wheel chair to the shower room at the nursing station where the Resident was weighed in her wheel chair. LPN E pushed electronic digital buttons on the wheel chair scale with her gloved hands to obtain the weight, while her uniform top touched the scale which was used to weigh all wheel chair bound residents. The Resident weighed 212.6 pounds in the wheel chair. LPN E then returned the Resident to the Resident's room. The nurse did not weigh the wheel chair prior to weighing the Resident. LPN E was asked what the Resident's weight was and she stated "I need to get my calculator out." LPN E removed the gloves and threw them in the regular garbage can next to the resident's bed. There were no biohazardous waste receptacles in the Resident's room. LPN E pulled the calculator out of her shirt pocket with bare hands which were now contaminated, and calculated the weight. LPN E stated "she weighs 174.6 pounds." When	F 684	standards of practice. The Director of Nursing or designee will review weights for residents receiving peritoneal dialysis during the Daily Clinical Meeting weekly x 4 weeks then monthly x 2 months to ensure the physician and responsible party have been notified of weights outside of parameters. The Director of Nursing or designee will review new admission orders, new routine orders and care plans for residents receiving peritoneal dialysis during the Daily Clinical Meeting weekly x 4 weeks then monthly x 2 months for completion and accuracy. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 684	Continued From page 53 LPN E was asked how she came to that number, she stated "I subtracted 38 pounds from 212.6 pounds for the wheel chair weight." LPN E was asked how she knew the wheel chair weight, she stated it was written on the back of the wheel chair" that Resident #308 always used. The chair was inspected, and there was no weight written on the back of the chair. It is unknown if the chair was swapped out for a different chair, and what the weight of the current chair was, as the chair was not weighed even after this discussion. The Resident's vital signs were obtained with a machine from the hallway and were "Temperature 98.0 Fahrenheit orally, blood pressure 134/75, and heart rate 80. LPN E put on a clean pair of gloves from the same container in the Resident's room without washing her hands. The room door remained open. LPN E and all observers donned masks, no gowns were used. The nurse did not check the temperature of the dialysis bag of fluid. The nurse opened a second bag containing an empty dialysis bag with 2 sets of tubing attached to it which she brushed against her uniform top and pants. The empty bag was placed on the bottom shelf of a 2 shelf push cart which was visibly dusty and soiled. LPN E did not clean the shelf nor put a barrier layer down under the empty bag which was now contaminated. The tubing was laying on top of the empty bag with a loop of the tubing hanging down in front of the cart and laying on the floor, which contaminated it. An IV (intravenous) medication pole was pulled over to hang the bag of fluids on (which was not cleaned) that would drain into the Resident, after the fluid in her abdomen was	F 684		

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F 684	Continued From page 54 drained into the empty bag on the bottom of the cart. LPN E placed 2 clamps (which had been open and laying on the cart on top of the now contaminated tubing) and closed them so as to allow no fluid to pass through either tubing. The clamps were not cleaned, and were contaminated. LPN E picked up a canister of cleaning wipes and cleaned the Resident's abdominal peritoneal dialysis tube with the wipes which were now contaminated by her contaminated gloves, allowed no time for the tubing to dry, and connected the tubing (which had been on the bottom of the cart and contaminated) and touched to the Resident after pulling a cap off of the tubing. LPN E then pulled the IV pole over closer to the Resident, hung the full bag of fluid on it, and connected the second line of tubing to it making a circuit of the 2 bags and the Resident, which were now all contaminated. The clamp for the drain bag was released and fluid began filling the bag from the Resident's abdomen. After the observation LPN E and the ADON were made aware of the breaches in infection control, and the need for aseptic technique when providing peritoneal dialysis. The ADON stated this is a clean procedure, and there are levels of aseptic techniques. The ADON was then asked what nursing standard of practice the facility followed for infection control and aseptic technique, and the reply was CDC (the centers for disease control). The ADON went on to say he taught peritoneal dialysis to staff and he was asked to provide the	F 684		

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F 684	Continued From page 55 text information used for that training, and his certificate of completion for his training. No certificate of training was produced, however, the Director of nursing provided a 3 page document entitled "Baxter CAPD Exchange Procedure" , which was not followed by LPN E, and a 2 page document entitled CAPD "Continuous Ambulatory Peritoneal Dialysis". The Director of Nursing (DON) stated the facility professional standard for nursing practice was obtained from "Potter and Perry". The documents were reviewed and the CAPD document stated "Use strict aseptic technique when performing bag exchanges.". and "As with all peritoneal dialysis procedures, aseptic technique is essential during catheter insertion, exchanges, and dressing changes to prevent peritonitis." Peritonitis is a life threatening inflammation of the sterile abdominal cavity which is often fatal. The CDC requires aseptic technique for all dialysis. The CDC definition of aseptic technique is "free from all pathogenic microorganisms, to protect from infection, and to prevent the spread of pathogens". The director of Nursing provided the policy for dialysis, and stated this is the only dialysis policy we have. The policy referred only to hemodialysis. No mention of peritoneal dialysis existed in this document. The facility did not provide hemodialysis in the facility. After the observations, the Resident's clinical record was reviewed. The review revealed signed physician orders which included the below order:	F 684		

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F 684	Continued From page 56 "4-21-18: Afternoon manual exchanges: Fill volume 2000 milliliter bags (use 1.5% solution, if blood pressure greater than 140/80 then use 2.5% solution one time a day related to end stage renal disease). On 4-24-18 the entry was not signed as administered by staff, and referred the reader to a nursing note for explanation. The nursing note stated that the supplies for the exchange were unavailable and they were waiting for delivery. The exchange was never completed. Resident #308's old admission care plan, and new admission care plans were reviewed and revealed that no specific step by step individualized instructions were ever care planned to direct nursing home staff in provision of care before, during and after peritoneal dialysis, and did not specify that strict aseptic technique must be used. There was no doctor's order, nor care plan for access site care, or aseptic technique or infection control standards to be observed for PD. No directions were care planned for pre and post dialysis weights, the care plan simply stated follow doctor's orders for weight. There were no doctor's order for weights. No intake and output amounts of fluids consumed and excreted were obtained or ordered. There was no doctor's order, nor care plan for aseptic access site care. There was no order to follow, nor care plan derived for vital signs, and how and when to stop peritoneal dialysis and or seek help when handling complications and emergencies. No guidance was care planned for handling clinical symptoms of dialysate contamination. No dwell time was specified, no specific drain time was specified in	F 684		

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F 684	Continued From page 57 orders or care planning, and no target weight during the provision of peritoneal dialysis was included in orders or care planning. The one care plan intervention "to monitor and report to doctor signs of acute renal failure with urine output of less than 400 milliliters in 24 hours" was not being measured for this Resident as she went to the toilet independently, and no device to catch urine was in the toilet. The intervention that was care planned for "Report to Doctor weight gain of over 2 pounds per day" was not followed. Resident #308 was admitted with a weight of 163 pounds per a physicians progress note dated 4-20-18, and by 4-26-18 the weight was 174.6 pounds, equaling greater than 10 pounds gained in the one week since admission. No call to the doctor had been made by 2:30 p.m. on 4-26-18 when the nursing notes were printed for surveyors. Further evidence from a physicians progress note dated 4-24-18, revealed the doctor documented a weight of 163 pounds, and was unaware of the weight gain. The Residents weight record from the Medication Administration Record (MAR) revealed the following; 4-21-18 (160 pounds), 4-22-18 (165 pounds), 4-23-18 (168.9 pounds), 4-24-18 (no weight taken nor PD administered), 4-25-18 (168 pounds), and during observation of weight on 4-26-18 (174.6 pounds). LPN E was asked if she had been trained by a dialysis certified facility trainer, and she stated "yes, they came from [name of dialysis company]	F 684		

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F 684	Continued From page 58 yesterday at 3:00 p.m. (4-25-18) to train us." She went on to say that was the first time they had trained her, and she had been providing care for a month, and for this Resident for a week. According to federal regulation, before providing peritoneal dialysis (PD), the facility staff must be trained by a qualified dialysis trainer from a certified dialysis facility. Training can not be provided by nursing home staff. That did not happen as LPN E had not been formally trained until 4-25-18, and had been providing PD for a week without training. On 4-26-18, and 4-27-18 at the end of day debrief, the Administrator and DON were made aware that PD was not being provided in accordance with federal regulations, the care plan for this Resident was not developed to adequately guide staff in the provision of care for PD, and that breaches in infection control during PD were observed by surveyors. They were made aware that their policy was for hemodialysis only, and gave no staff guidance for PD. They were also made aware that the Resident had experienced a 10 pound weight gain since admission a week ago, and no intervention by staff had been taken for the Resident, hindering her quality of care and wellbeing. No further information was provided by the facility staff.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		5/31/18

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F 688	Continued From page 59 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review the facility staff failed to prevent a decrease in range of motion, for one resident (Resident #34) of 28 residents in the survey sample. Resident #34 was never observed wearing any protective hand device to prevent the formation of contractures, and loss of range of motion. The findings included: Resident #34 was initially admitted to the facility on 11-28-12, and readmitted on 9-6-14. Diagnoses included; multiple sclerosis, gastrostomy tube for feeding, failure to thrive, aphasia, depression, anxiety, and contractures. Resident #34's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2-20-18. Resident #34 was coded with a Brief Interview of Mental Status score of unable to complete due to severe cognitive impairment. The Resident was totally	F 688	1.A referral for therapy services to evaluate for contracture management has been submitted for resident #34 and adaptive call bell has been provided. 2.Any resident has the potential to be affected staff fail to prevent a decrease in range of motion. Resident rounds will be completed to identify residents with contractures that could benefit from therapy services. A referral for therapy services will be submitted as applicable. An adaptive call bell will be provided to residents identified with hand contractures that have the functional ability to use a call bell. 3.The Director of Nursing or designee will educate the nursing staff on the policy and procedure for Contracture Prevention. 4.The QAPI Coordinator or designee will conduct random observations of 2 nursing staff members performing ADLs for 1	

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F 688	Continued From page 60 dependant on 1 to 2 staff members for all activities of daily living, such as bed mobility, toileting, bathing, and dressing. Resident #34 was observed on 4-24-18 at 6:30 p.m., during initial tour of the facility laying in her bed flat on her back with a tube feeding running into her abdomen via a gastrostomy tube at 60 ml (milliliters) per hour via a tube feeding pump. The call bell was laying next to her in the bed, but her hands were so contracted (closed) that she was unable to grasp it or to call for help. The Resident stayed this way until 8:30 p.m. when a CNA (certified nursing assistant) came into the room to administer incontinence care and sat the Resident up. Resident #34 was again observed on 4-25-18 beginning at 8:45 a.m., and the Resident was found laying in bed flat on her back with the call bell placed in the palm of her contracted hand, which she was unable to use. The observation continued until 11:00 a.m., when a nurse (LPN F) approached the surveyor and sat the Resident up. During both observation days there was no device in the palms of the Resident to prevent further contractures and possible pressure areas of her palms. Resident #34 had a physical therapy (PT) evaluation on 11-24-12, and an occupational therapy (OT) evaluation on 11-30-12. Treatment and services with both therapies continued until 1-10-13, when they were discontinued as the goals were not met. No further evaluation or treatment has occurred since that time, and for approximately 5 years. At the time of that therapy	F 688	resident at risk for contractures weekly x 4 weeks then monthly x 2 months to ensure range of motion is being performed. The QAPI Coordinator or designee will conduct resident observations weekly x 4 weeks then monthly x 2 months to ensure residents at risk for contractures receive services to prevent the development of contractures. The QAPI Coordinator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 688	Continued From page 61 the Resident was documented by both therapy groups to have had normal range of motion in her upper extremities and hands. During survey it was noted that the Resident was unable to open her hands and they were permanently frozen in a closed manner. Review of nursing notes, physicians orders, and the nursing care plan revealed no re-evaluation had been requested, nor ordered by a physician for any orthotic, or splint application to maintain the Residents previous level of range of motion, or to prevent further contracture. The Administrator, Clinical Consultant, and Director of Nursing were notified of the issue at the end of day meeting on 4-25-18. No further information was provided.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral	F 693		5/31/18

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F 693	Continued From page 62 means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to administer tube feeding per professional standards for 1 resident (Resident #34) in the survey sample of 28 residents. Facility staff failed to maintain Resident #34's head of bed elevated to prevent aspiration of tube feeding. The Findings included: Resident #34 was initially admitted to the facility on 11-28-12, and readmitted on 9-6-14. Diagnoses included; multiple sclerosis, gastrostomy tube for feeding, failure to thrive, aphasia, depression, anxiety, and contractures. Resident #34's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2-20-18. Resident #34 was coded with a Brief Interview of Mental Status score of unable to complete due to severe cognitive impairment. The Resident was totally dependant on 1 to 2 staff members for all activities of daily living, such as bed mobility, toileting, bathing, and dressing. Resident #34 was observed on 4-24-18 at 6:30 p.m., during initial tour of the facility laying in her	F 693	1.Resident #34 has been assessed relative to receiving enteral feedings and head of bed elevated. There were no negative effects. An education and counseling has been done with the nurse and the certified nursing assistant for failing to ensure the head of the bed was elevated. 2.Any resident receiving tube feeding has the potential to be affected if staff fail to maintain the head of the bed elevated in a manner that prevents aspiration. Resident rounds will be conducted to assess compliance with the head of the bed being elevated for residents receiving enteral feedings. 3.The Director of Nursing or designee will educate the nursing staff on ensuring the head of bed is elevated on residents receiving enteral feedings. 4.The Unit Manager or designee will conduct resident rounds on residents receiving enteral feedings weekly x 4 weeks then monthly x 2 months to ensure the head of the bed is elevated. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3	

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F 693	Continued From page 63 bed flat on her back with a tube feeding running into her abdomen via a gastrostomy tube at 60 ml (milliliters) per hour via a tube feeding pump. The call bed was laying next to her in the bed, but her hands were so contracted (closed) that she was unable to grasp it or to call for help. The Resident stayed this way until 8:30 p.m. when a CNA (certified nursing assistant came into the room to administer incontinence care and sat the Resident up. Resident #34 was again observed on 4-25-18 beginning at 8:45 a.m., and the Resident was found laying in bed flat on her back with the call bell placed in the palm of her contracted hand, which she was unable to use. The observation continued until 11:00 a.m., when a nurse (LPN F) approached the surveyor and sat the Resident up. The surveyor asked why the Resident was laying flat, and the nurse responded "I saw her sitting up at 8:00 a.m., and gave her meds, and I have not seen her since." CNA D was responsible for care for Resident #34 that day so she was interviewed and stated I bathed and put a clean gown on her when I first came in at 7:30 a.m., I found her flat, but I sat her up." Physician orders were reviewed and Resident #34 had an order for "Isosource 1.5 tube feeding to infuse at 60 ml (milliliters) per hour from 8:00 p.m., until 10:00 a.m., or until 840 ml had infused." The facility tube feeding policy review revealed that all residents must have their head of bed elevated during tube feeding infusions to prevent aspiration of stomach contents. The Administrator, Clinical Consultant, and	F 693	months.	

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F 693	Continued From page 64 Director of Nursing were notified of the issue at the end of day meeting on 4-25-18. No further information was provided.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who 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 and facility documentation review, the facility staff failed for 1 resident (Resident #257) of 28 residents in the survey sample to provide respiratory care in the manner to prevent the spread of infection. For Resident #257, the tubing to the nebulizer machine was on the floor and a used sterile catheter used for bronchial suctioning was kept for reuse in an open plastic bag. The findings included: Resident #257 was admitted to the facility on 4/16/18. Diagnoses included dysphagia, Pressure ulcer, Chronic Obstructive Pulmonary Disease, tracheostomy, feeding tube, catheter, and pulmonary fibrosis. As Resident #257 was new to the facility, a	F 695	1.The nebulizer tubing and suction catheter for resident #257 has been replaced. 2.Any resident receiving respiratory services has the potential to be affected if staff fail to provide care in a manner to prevent the spread of infection. Resident room observations will be conducted to assess compliance with storage of tubing and supplies in a manner that is consistent with infection prevention practices. 3.The Director of Nursing or designee will educate the nursing staff on General Infection Control Nursing Policy. The Director of Nursing or designee will educate the licensed nurses on the Oral Suction Policies.	5/31/18

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F 695	Continued From page 65 Minimum Data Set assessment had not been completed. Resident #257 had impaired communication and cognition. On 4/26/18 at 3:35 p.m., Resident #257 was observed lying in bed. The nebulizer machine was in the drawer of the bedside table. The tubing to the nebulizer machine was lying on the floor. There was a bedside table in the room near Resident #257's bed. A used suction catheter for bronchial suctioning was inside an opened gallon sized plastic bag. The suction catheter was still attached to the tubing to the suctioning machine. The suction catheter had been used to suction the lungs. This device is not a reusable piece of equipment. Suction catheters should be removed from sterile packaging before insertion into the lungs. The suction catheter on the bedside table should have been discarded after use. A nurse was requested to observe Resident #257 along with the survey team. Licensed Practical Nurse C (LPN C) entered the room. She was asked if it was ok that the nebulizer tubing was on the floor. LPN C stated that it should not be on the floor. LPN C was asked to observe the suction catheter in the plastic bag. LPN C stated that she had just used it to suction Resident #257's lungs and then put it in the bag. When asked if she was supposed to keep the suction catheter after using to perform bronchial suctioning, LPN C stated she was supposed to change it with every use. It was reviewed with LPN C that sterile equipment should be used when suctioning. The issue was reviewed with the Administrator	F 695	4.The Director of Nursing or designee will conduct resident room observations weekly x 4 weeks then monthly x 2 months for residents with nebulizer and suction machines to ensure compliance with storage of tubing and attachments in a manner that is consistent with infection prevention practices. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 695	Continued From page 66 and Director of Nursing at the end of day meeting on 4/26/18 at 4:45 p.m. The Administrator stated that the suction catheter should have been discarded after use when performing bronchial suctioning. The facility policy "Tracheostomy Care" was reviewed. The "Purpose" of the policy read "To maintain airway and prevent infection, distress and discomfort." The policy listed required "equipment". Included was "C. Suction machine and sterile catheters." No further information was provided.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to provide pain management for 1 resident (Resident #258) of 28 residents in the survey sample. For Resident #258, facility staff failed to provide physician ordered fentanyl patch for pain management. The finding included: Resident #258, a 69 year old, was admitted to the facility on 4/18/18. Diagnoses included multiple	F 697	1.Resident #258 has been discharged home. An associate education was completed with the licensed nurses assigned on the day and time the patch was due to be administered for failing to follow the process to ensure medications are available to administer as ordered. The resident had no negative effect. 2.Any resident has the potential to be affected if facility staff fail to provide physician ordered pain management. The clinical report will be reviewed for the past	5/31/18

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F 697	Continued From page 67 myeloma (cancer), dysphagia, hypertension, anemia, and critical illness myopathy (muscle weakness). Resident #258 was new to the facility and did not have a Minimum Data Set completed. Her care plan documented that she was able to make basic care decisions and express care preferences. On 4/25/18 at 8:15 a.m., Resident #258 was observed in bed with her eyes closed. The skilled nursing note dated 4/24/18 read "(Resident #258) is receiving skilled acre services for rehabilitation therapies scheduled at least 5 days/ week, daily assessment and management of pain, ." Resident #258 had the following physician orders dated 4/18/18 for pain management: 1. Dexamethasone 20 milligram by mouth in the morning for pain 2. Fentanyl patch 25 microgram/ hour every 72 hours for pain The following information about Dexamethasone was accessed on 4/30/18 at 1:53 p.m. at the website https://medlineplus.gov/druginfo/meds/a682792.html "Dexamethasone, a corticosteroid, is similar to a natural hormone produced by your adrenal glands. It often is used to replace this chemical when your body does not make enough of it. It relieves inflammation (swelling, heat, redness, and pain) and is used to treat certain forms of arthritis; skin, blood, kidney, eye, thyroid, and intestinal disorders (e.g., colitis); severe allergies;	F 697	72hrs in addition to the missed medication report to ensure medications are available and administered according to physician orders. 3.The Director of Nursing will educate the licensed nurses on the process for ensuring medications are available. 4.The Unit Manager or designee will conduct a random audit of physician□s orders for 2 resident□s receiving Fentanyl Patches compared to the medication cart weekly x 4 weeks then monthly x 2 months to ensure availability. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 697	Continued From page 68 and asthma. Dexamethasone is also used to treat certain types of cancer." The following information about Fentanyl transdermal patch was accessed on 4/30/18 at 1:53 p.m. at the website https://medlineplus.gov/druginfo/meds/a601202.html "Fentanyl patches are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Fentanyl is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." According to the April 2018 Medication Administration Record (MAR), the Fentanyl patch was applied to Resident #258 at 9:00 am. on 4/21/18. A new patch was supposed to be applied again on 4/24/18, with the previous patch to be removed. According to the MAR, the new patch was not applied on 4/24/18, as the documentation space was blank. On 4/27/18, the Director of Nursing (DON) was asked if the facility had the count sheet for the Fentanyl to determine if it had been administered on 4/24/18. On 4/27/18 at 1:05 p.m., the DON stated that the Fentanyl was never delivered from the pharmacy. It was not administered. No further information was provided.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		5/31/18

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F 698	Continued From page 69 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 observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint, the facility staff failed to provide peritoneal dialysis services consistent with professional standards of practice, the comprehensive care plan, and the Resident's goals and preferences for one Resident (Resident #308) of 28 residents in the survey sample. Resident #308 did not receive peritoneal dialysis consistent with professional standards of practice. The findings included: Resident #308 was admitted previously to the facility on 12-1-17, after amputation surgery of her left foot. The Resident was discharged home from the facility on 3-14-18. The Resident was readmitted after further amputation surgeries on 4-19-18 with the diagnoses of, but not limited to; hypertension, heart disease, chronic kidney disease with peritoneal dialysis, bilateral below the knee amputations, insulin dependant diabetes, glaucoma, and asthma. The most recent Minimum Data Set (MDS) for this admission was a quarterly assessment with an Assessment Reference Date (ARD) of 3-5-18, from the previous stay. The MDS coded Resident #308 with no cognitive impairment. The	F 698	1.Resident #308 was discharged home. The Admissions Director and Administrator reviewed pre-admission communication to identify barriers that affected the timely availability of resident #308 dialysis supplies. An associate education was completed with the licensed nurse that was responsible for failing to provide dialysis services in a manner that is consistent with professional standards of practice. The resident had no negative effects from the provision of dialysis services. 2.Any resident receiving peritoneal dialysis has the potential to be affected if services provided are not consistent with professional standards of practice. Currently there are no residents in the center receiving peritoneal dialysis. 3.The Administrator or designee will educate the Admissions Director on ensuring peritoneal dialysis supplies are available to staff the day before admission. The Director of Nursing or designee will educate the licensed nurses on the protocol for monitoring availability of peritoneal dialysis supplies. The Director of Nursing or designee will schedule peritoneal dialysis training to be completed with current licensed nurses	

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F 698	Continued From page 70 Resident needed extensive assistance from staff for toileting, hygiene, bed mobility and transferring. On 4-24-18 at 6:30 p.m. on initial tour of the facility the Resident was observed lying in bed, and when asked for an interview, she stated that tomorrow would be better, she was tired. On 4-25-18 at 10:30 a.m., the Resident was sitting on her bed and granted the request for an interview. The Resident stated she had been back at the facility for "About a week after having surgery on my legs." The Resident went on to say that her dialysis treatments were a problem, and when asked why, she stated that the staff did not know how to do them correctly, and she had to monitor them closely so they "don't mess me up and give me an infection or worse." The Resident stated that the staff don't know what they are doing, they put the wrong bags on to dialyze with, they don't use good infection practices, and they put the bags and tubing on the floor, they didn't order the right equipment bag and tubing cassettes (5 prong instead of 3 prong tubing) and she stated she has to tell them step by step what to do, and sometimes at night she is asleep and has to wake up to watch what the staff is doing so the staff doesn't "mess me up". The Resident went on to say "I have gained 10 pounds since I have been here in one week." "Weight gain is a problem, and I guess I will have to call the doctor myself, since they won't." "I never use 1.5 bags cause I gain fluid with them, I told them that but they don't listen." "Yesterday they got the wrong stuff so I didn't even get my afternoon exchange at all, I had to wait for supplies to come, that's ridiculous".	F 698	that have not been trained by a qualified dialysis trainer from a certified dialysis center prior to the employee being assigned to care for a resident receiving peritoneal dialysis. The Director of Nursing or designee will schedule peritoneal dialysis training to be completed with new hires by a qualified dialysis trainer from a certified dialysis center prior to the employee being assigned to care for a resident receiving peritoneal dialysis. The Director of Nursing or designee will educate licensed nurses on aseptic technique. The Director of Nursing or designee will educate the licensed nurses on the policy and procedure for handwashing and General Infection Control Guidelines. The Director of Nursing or designee will educate the licensed nurses on the protocol for obtaining weights for residents receiving peritoneal dialysis services to include notification to the physician and responsible party when weights are not within parameters. The Director of Nursing or designee will educate the Unit Managers and Supervisors on ensuring care plans for residents receiving peritoneal dialysis accurately reflect the resident□s current conditions and appropriate interventions for treatment and monitoring. The Director of Nursing or designee will educate the licensed nurses on ensuring residents receiving peritoneal dialysis have complete and accurate orders. 4.The Unit Manager or designee will check the availability of dialysis supplies	

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F 698	Continued From page 71 On 4-26-18 at 11:00 a.m. LPN E was observed obtaining a 1.5% dextrose dialysis bag full of fluid to instill in the Resident's abdomen after the old fluid was drained out of the Resident's abdomen. The bag was opened by LPN E with gloved hands from it's protective clear wrapper one hour prior to the planned 12:00 noon exchange, and was placed on a warming tray. There was condensation liquid on the outside of the inner bag when LPN E opened the outer protective clear wrapper and LPN E began wiping it off with a paper towel. On 4-26-18 at 12:30 p.m. Resident #308 was observed before and during a peritoneal dialysis exchange. The Resident was sitting in a wheel chair in her room. Two surveyors were present with the Resident, LPN E (licensed practical nurse #E), and the ADON RN A (assistant director of nursing registered nurse #A). LPN E squirted a dime size amount of alcohol based hand sanitizer into her hands and briskly rubbed them together. She donned a pair of clean gloves from an open box in the Resident's room and applied them. After stating "We are going to weigh you now" to the Resident. The surveyors followed LPN E pushing Resident #308 in a wheel chair to the shower room at the nursing station where the Resident was weighed in her wheel chair. LPN E pushed electronic digital buttons on the wheel chair scale with her gloved hands to obtain the weight, while her uniform top touched the scale which was used to weigh all wheel chair bound residents. The Resident weighed 212.6 pounds in the wheel chair. LPN E then returned the Resident to the Resident's room.	F 698	weekly x 4 weeks then monthly x 2 months. The QAPI Coordinator or designee will conduct random observations of the provision of peritoneal dialysis services as available for 2 licensed nurses trained to provide peritoneal dialysis services weekly x 4 weeks then monthly x 2 months to ensure services are being provided in a manner that is consistent with professional standards of practice. The Director of Nursing or designee will review weights for residents receiving peritoneal dialysis during the Daily Clinical Meeting weekly x 4 weeks then monthly x 2 months to ensure the physician and responsible party have been notified of weights outside of parameters. The Director of Nursing or designee will review new admission orders, new routine orders and care plans for residents receiving peritoneal dialysis during the Daily Clinical Meeting weekly x 4 weeks then monthly x 2 months for completion and accuracy. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 698	Continued From page 72 The nurse did not weigh the wheel chair prior to weighing the Resident. LPN E was asked what the Resident's weight was and she stated "I need to get my calculator out." LPN E removed the gloves and threw them in the regular garbage can next to the resident's bed. There were no biohazardous waste receptacles in the Resident's room. LPN E pulled the calculator out of her shirt pocket with bare hands which were now contaminated, and calculated the weight. LPN E stated "she weighs 174.6 pounds." When LPN E was asked how she came to that number, she stated "I subtracted 38 pounds from 212.6 pounds for the wheel chair weight." LPN E was asked how she knew the wheel chair weight, she stated it was written on the back of the wheel chair" that Resident #308 always used. The chair was inspected, and there was no weight written on the back of the chair. It is unknown if the chair was swapped out for a different chair, and what the weight of the current chair was, as the chair was not weighed even after this discussion. The Resident's vital signs were obtained with a machine from the hallway and were "Temperature 98.0 Fahrenheit orally, blood pressure 134/75, and heart rate 80. LPN E put on a clean pair of gloves from the same container in the Resident's room without washing her hands. The room door remained open. LPN E and all observers donned masks, no gowns were used. The nurse did not check the temperature of the dialysis bag of fluid. The nurse opened a second bag containing an empty dialysis bag with 2 sets of tubing attached	F 698		

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F 698	Continued From page 73 to it which she brushed against her uniform top and pants. The empty bag was placed on the bottom shelf of a 2 shelf push cart which was visibly dusty and soiled. LPN E did not clean the shelf nor put a barrier layer down under the empty bag which was now contaminated. The tubing was laying on top of the empty bag with a loop of the tubing hanging down in front of the cart and laying on the floor, which contaminated it. An IV (intravenous) medication pole was pulled over to hang the bag of fluids on (which was not cleaned) that would drain into the Resident, after the fluid in her abdomen was drained into the empty bag on the bottom of the cart. LPN E placed 2 clamps (which had been open and laying on the cart on top of the now contaminated tubing) and closed them so as to allow no fluid to pass through either tubing. The clamps were not cleaned, and were contaminated. LPN E picked up a canister of cleaning wipes and cleaned the Resident's abdominal peritoneal dialysis tube with the wipes which were now contaminated by her contaminated gloves, allowed no time for the tubing to dry, and connected the tubing (which had been on the bottom of the cart and contaminated) and touched to the Resident after pulling a cap off of the tubing. LPN E then pulled the IV pole over closer to the Resident, hung the full bag of fluid on it, and connected the second line of tubing to it making a circuit of the 2 bags and the Resident, which were now all contaminated. The clamp for the drain bag was released and fluid began filling the bag from the Resident's abdomen.	F 698		

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F 698	Continued From page 74 After the observation LPN E and the ADON were made aware of the breaches in infection control, and the need for aseptic technique when providing peritoneal dialysis. The ADON stated this is a clean procedure, and there are levels of aseptic techniques. The ADON was then asked what nursing standard of practice the facility followed for infection control and aseptic technique, and the reply was CDC (the centers for disease control). The ADON went on to say he taught peritoneal dialysis to staff and he was asked to provide the text information used for that training, and his certificate of completion for his training. No certificate of training was produced, however, the Director of nursing provided a 3 page document entitled "Baxter CAPD Exchange Procedure" , which was not followed by LPN E, and a 2 page document entitled CAPD "Continuous Ambulatory Peritoneal Dialysis". The Director of Nursing (DON) stated the facility professional standard for nursing practice was obtained from "Potter and Perry". The documents were reviewed and the CAPD document stated "Use strict aseptic technique when performing bag exchanges.". and "As with all peritoneal dialysis procedures, aseptic technique is essential during catheter insertion, exchanges, and dressing changes to prevent peritonitis." Peritonitis is a life threatening inflammation of the sterile abdominal cavity which is often fatal. The CDC requires aseptic technique for all dialysis. The CDC definition of aseptic technique is "free from all pathogenic microorganisms, to	F 698		

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F 698	Continued From page 75 protect from infection, and to prevent the spread of pathogens". The director of Nursing provided the policy for dialysis, and stated this is the only dialysis policy we have. The policy referred only to hemodialysis. No mention of peritoneal dialysis existed in this document. The facility did not provide hemodialysis in the facility. After the observations, the Resident's clinical record was reviewed. The review revealed signed physician orders which included the below order: "4-21-18: Afternoon manual exchanges: Fill volume 2000 milliliter bags (use 1.5% solution, if blood pressure greater than 140/80 then use 2.5% solution one time a day related to end stage renal disease). On 4-24-18 the entry was not signed as administered by staff, and referred the reader to a nursing note for explanation. The nursing note stated that the supplies for the exchange were unavailable and they were waiting for delivery. The exchange was never completed. Resident #308's old admission care plan, and new admission care plans were reviewed and revealed that no specific step by step individualized instructions were ever care planned to direct nursing home staff in provision of care before, during and after peritoneal dialysis, and did not specify that strict aseptic technique must be used. There was no doctor's order, nor care plan for access site care, or aseptic technique or infection control standards to be observed for PD. No directions were care planned for pre and post dialysis weights, the care plan simply stated	F 698		

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F 698	Continued From page 76 follow doctor's orders for weight. There were no doctor's order for weights. No intake and output amounts of fluids consumed and excreted were obtained or ordered. There was no doctor's order, nor care plan for access site care. There was no order to follow, nor care plan derived for vital signs, and how and when to stop peritoneal dialysis and or seek help when handling complications and emergencies. No guidance was care planned for handling clinical symptoms of dialysate contamination. No dwell time was specified, no specific drain time was specified in orders or care planning, and no target weight during the provision of peritoneal dialysis was included in orders or care planning. The one care plan intervention "to monitor and report to doctor signs of acute renal failure with urine output of less than 400 milliliters in 24 hours" was not being measured for this Resident as she went to the toilet independently, and no device to catch urine was in the toilet. The intervention that was care planned for "Report to Doctor weight gain of over 2 pounds per day" was not followed. Resident #308 was admitted with a weight of 163 pounds per a physicians progress note dated 4-20-18, and by 4-26-18 the weight was 174.6 pounds, equaling greater than 10 pounds gained in the one week since admission. No call to the doctor had been made by 2:30 p.m. on 4-26-18 when the nursing notes were printed for surveyors. Further evidence from a physicians progress note dated 4-24-18, revealed the doctor documented a weight of 163 pounds, and was unaware of the weight gain.	F 698		

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F 698	Continued From page 77 The Residents weight record from the Medication Administration Record (MAR) revealed the following; 4-21-18 (160 pounds), 4-22-18 (165 pounds), 4-23-18 (168.9 pounds), 4-24-18 (no weight taken nor PD administered), 4-25-18 (168 pounds), and during observation of weight on 4-26-18 (174.6 pounds). LPN E was asked if she had been trained by a dialysis certified facility trainer, and she stated "yes, they came from [name of dialysis company] yesterday at 3:00 p.m. (4-25-18) to train us." She went on to say that was the first time they had trained her, and she had been providing care for a month, and for this Resident for a week. According to this federal regulation, before providing peritoneal dialysis (PD), the facility staff must be trained by a qualified dialysis trainer from a certified dialysis facility. Training can not be provided by nursing home staff. That did not happen as LPN E had not been formally trained until 4-25-18, and had been providing PD for a week without training. On 4-26-18, and 4-27-18 at the end of day debrief, the Administrator and DON were made aware that PD was not being provided in accordance with federal regulations, the care plan for this Resident was not developed to adequately guide staff in the provision of care for PD, and that breaches in infection control during PD were observed by surveyors. They were made aware that their policy was for hemodialysis only, and gave no guidance to staff for PD. They were also made aware that the Resident had experienced a 10 pound weight gain since admission a week	F 698		

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F 698	Continued From page 78 ago, and no intervention by staff had been taken for the Resident, hindering her quality of care and wellbeing. No further information was provided by the facility staff.	F 698		
F 726 SS=D	Complaint deficiency. Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		5/31/18

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F 726	Continued From page 79 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed to ensure competent nursing staff to provide peritoneal dialysis (PD) services for one Resident (Resident #308) in a survey sample of 28 residents. The Facility failed to provide competent nursing staff for Resident #308's peritoneal dialysis care needs. The findings included; Resident #308 was admitted previously to the facility on 12-1-17, after amputation surgery of her left foot. The Resident was discharged home from the facility on 3-14-18. The Resident was readmitted after further amputation surgeries on 4-19-18 with the diagnoses of, but not limited to; hypertension, heart disease, chronic kidney disease with peritoneal dialysis, bilateral below the knee amputations, insulin dependant diabetes, glaucoma, and asthma. The most recent Minimum Data Set (MDS) for this admission was a quarterly assessment with an Assessment Reference Date (ARD) of 3-5-18, from the previous stay. The MDS coded Resident #308 with no cognitive impairment. The Resident needed extensive assistance from staff for toileting, hygiene, bed mobility and transferring. On 4-24-18 at 6:30 p.m. on initial tour of the	F 726	1.Resident #308 was discharged home. The licensed nurse that provided peritoneal dialysis to resident #308 on the day of the observation has received training by a qualified dialysis trainer from a certified dialysis center. The resident had no negative effects from the provision of dialysis services. 2.Any resident receiving peritoneal dialysis has the potential to be affected if staff are not trained to provide peritoneal dialysis. Currently there are no residents in the center receiving peritoneal dialysis. 3.The Director of Nursing or designee will schedule peritoneal dialysis training to be completed with current licensed nurses that have not been trained by a qualified dialysis trainer from a certified dialysis center prior to the employee being assigned to care for a resident receiving peritoneal dialysis. The Director of Nursing or designee will schedule peritoneal dialysis training to be completed with new hires by a qualified dialysis trainer from a certified dialysis center prior to the employee being assigned to care for a resident receiving peritoneal dialysis. 4.The QAPI Coordinator or designee will conduct random observations of the provision of peritoneal dialysis services as available for 2 licensed nurses trained to	

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F 726	Continued From page 80 facility the Resident was observed lying in bed, and when asked for an interview, she stated that tomorrow would be better, she was tired. On 4-25-18 at 10:30 a.m., the Resident was sitting on her bed and granted the request for an interview. The Resident stated she had been back at the facility for "About a week after having surgery on my legs." The Resident went on to say that her dialysis treatments were a problem, and when asked why, she stated that the staff did not know how to do them correctly, and she had to monitor them closely so they "don't mess me up and give me an infection or worse." The Resident stated that the staff don't know what they are doing, they put the wrong bags on to dialyze with, they don't use good infection practices, and they put the bags and tubing on the floor, they didn't order the right equipment bag and tubing cassettes (5 prong instead of 3 prong tubing) and she stated she has to tell them step by step what to do, and sometimes at night she is asleep and has to wake up to watch what the staff is doing so the staff doesn't "mess me up". The Resident went on to say "I have gained 10 pounds since I have been here in one week." "Weight gain is a problem, and I guess I will have to call the doctor myself, since they won't." "I never use 1.5 bags cause I gain fluid with them, I told them that but they don't listen." "Yesterday they got the wrong stuff so I didn't even get my afternoon exchange at all, I had to wait for supplies to come, that's ridiculous". On 4-26-18 at 11:00 a.m. LPN E was observed obtaining a 1.5% dextrose dialysis bag full of fluid to instill in the Resident's abdomen after the old fluid was drained out of the Resident's abdomen. The bag was opened by LPN E with gloved hands	F 726	provide peritoneal dialysis services weekly x 4 weeks then monthly x 2 months to ensure services are being provided in a manner that is consistent with professional standards of practice. The QAPI Coordinator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 726	Continued From page 81	F 726		

from it's protective clear wrapper one hour prior to the planned 12:00 noon exchange, and was placed on a warming tray. There was condensation liquid on the outside of the inner bag when LPN E opened the outer protective clear wrapper and LPN E began wiping it off with a paper towel.

On 4-26-18 at 12:30 p.m. Resident #308 was observed before and during a peritoneal dialysis exchange. The Resident was sitting in a wheel chair in her room. Two surveyors were present with the Resident, LPN E (licensed practical nurse #E), and the ADON RN A (assistant director of nursing registered nurse #A).

LPN E squirted a dime size amount of alcohol based hand sanitizer into her hands and briskly rubbed them together. She donned a pair of clean gloves from an open box in the Resident's room and applied them. After stating "We are going to weigh you now" to the Resident. The surveyors followed LPN E pushing Resident #308 in a wheel chair to the shower room at the nursing station where the Resident was weighed in her wheel chair. LPN E pushed electronic digital buttons on the wheel chair scale with her gloved hands to obtain the weight, while her uniform top touched the scale which was used to weigh all wheel chair bound residents. The Resident weighed 212.6 pounds in the wheel chair. LPN E then returned the Resident to the Resident's room.

The nurse did not weigh the wheel chair prior to weighing the Resident. LPN E was asked what the Resident's weight was and she stated "I need to get my calculator out." LPN E removed the gloves and threw them in the regular garbage can

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F 726	Continued From page 82 next to the resident's bed. There were no biohazardous waste receptacles in the Resident's room. LPN E pulled the calculator out of her shirt pocket with bare hands which were now contaminated, and calculated the weight. LPN E stated "she weighs 174.6 pounds." When LPN E was asked how she came to that number, she stated "I subtracted 38 pounds from 212.6 pounds for the wheel chair weight." LPN E was asked how she knew the wheel chair weight, she stated it was written on the back of the wheel chair" that Resident #308 always used. The chair was inspected, and there was no weight written on the back of the chair. It is unknown if the chair was swapped out for a different chair, and what the weight of the current chair was, as the chair was not weighed even after this discussion. The Resident's vital signs were obtained with a machine from the hallway and were "Temperature 98.0 Fahrenheit orally, blood pressure 134/75, and heart rate 80. LPN E put on a clean pair of gloves from the same container in the Resident's room without washing her hands. The room door remained open. LPN E and all observers donned masks, no gowns were used. The nurse did not check the temperature of the dialysis bag of fluid. The nurse opened a second bag containing an empty dialysis bag with 2 sets of tubing attached to it which she brushed against her uniform top and pants. The empty bag was placed on the bottom shelf of a 2 shelf push cart which was visibly dusty and soiled. LPN E did not clean the shelf nor put a barrier layer down under the empty bag which was now contaminated. The tubing was laying on top of the empty bag	F 726		

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F 726	Continued From page 83	F 726		

with a loop of the tubing hanging down in front of the cart and laying on the floor, which contaminated it. An IV (intravenous) medication pole was pulled over to hang the bag of fluids on (which was not cleaned) that would drain into the Resident, after the fluid in her abdomen was drained into the empty bag on the bottom of the cart. LPN E placed 2 clamps (which had been open and laying on the cart on top of the now contaminated tubing) and closed them so as to allow no fluid to pass through either tubing. The clamps were not cleaned, and were contaminated.

LPN E picked up a canister of cleaning wipes and cleaned the Resident's abdominal peritoneal dialysis tube with the wipes which were now contaminated by her contaminated gloves, allowed no time for the tubing to dry, and connected the tubing (which had been on the bottom of the cart and contaminated) and touched to the Resident after pulling a cap off of the tubing. LPN E then pulled the IV pole over closer to the Resident, hung the full bag of fluid on it, and connected the second line of tubing to it making a circuit of the 2 bags and the Resident, which were now all contaminated. The clamp for the drain bag was released and fluid began filling the bag from the Resident's abdomen.

After the observation LPN E and the ADON were made aware of the breaches in infection control, and the need for aseptic technique when providing peritoneal dialysis. The ADON stated this is a clean procedure, and there are levels of aseptic techniques. The ADON was then asked what nursing standard of practice the facility followed for infection control and aseptic technique, and the reply was CDC (the centers

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F 726	Continued From page 84 for disease control). The ADON went on to say he taught peritoneal dialysis to staff and he was asked to provide the text information used for that training, and his certificate of completion for his training. No certificate of training was produced, however, the Director of nursing provided a 3 page document entitled "Baxter CAPD Exchange Procedure" , which was not followed by LPN E, and a 2 page document entitled CAPD "Continuous Ambulatory Peritoneal Dialysis". The Director of Nursing (DON) stated the facility professional standard for nursing practice was obtained from "Potter and Perry". The documents were reviewed and the CAPD document stated "Use strict aseptic technique when performing bag exchanges.". and "As with all peritoneal dialysis procedures, aseptic technique is essential during catheter insertion, exchanges, and dressing changes to prevent peritonitis." Peritonitis is a life threatening inflammation of the sterile abdominal cavity which is often fatal. The CDC requires aseptic technique for all dialysis. The CDC definition of aseptic technique is "free from all pathogenic microorganisms, to protect from infection, and to prevent the spread of pathogens". The director of Nursing provided the policy for dialysis, and stated this is the only dialysis policy we have. The policy referred only to hemodialysis. No mention of peritoneal dialysis existed in this document. The facility did not provide hemodialysis in the facility.	F 726		

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F 726	Continued From page 85 After the observations, the Resident's clinical record was reviewed. The review revealed signed physician orders which included the below order: "4-21-18: Afternoon manual exchanges: Fill volume 2000 milliliter bags (use 1.5% solution, if blood pressure greater than 140/80 then use 2.5% solution one time a day related to end stage renal disease). On 4-24-18 the entry was not signed as administered by staff, and referred the reader to a nursing note for explanation. The nursing note stated that the supplies for the exchange were unavailable and they were waiting for delivery. The exchange was never completed. Resident #308's old admission care plan, and new admission care plans were reviewed and revealed that no specific step by step individualized instructions were ever care planned to direct nursing home staff in provision of care before, during and after peritoneal dialysis, and did not specify that strict aseptic technique must be used. There was no doctor's order, nor care plan for access site care, or aseptic technique or infection control standards to be observed for PD. No directions were care planned for pre and post dialysis weights, the care plan simply stated follow doctor's orders for weight. There were no doctor's order for weights. No intake and output amounts of fluids consumed and excreted were obtained or ordered. There was no doctor's order, nor care plan for access site care. There was no order to follow, nor care plan derived for vital signs, and how and when to stop peritoneal dialysis and or seek help when handling complications and emergencies. No	F 726		

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F 726	Continued From page 86 guidance was care planned for handling clinical symptoms of dialysate contamination. No dwell time was specified, no specific drain time was specified in orders or care planning, and no target weight during the provision of peritoneal dialysis was included in orders or care planning. The one care plan intervention "to monitor and report to doctor signs of acute renal failure with urine output of less than 400 milliliters in 24 hours" was not being measured for this Resident as she went to the toilet independently, and no device to catch urine was in the toilet. The intervention that was care planned for "Report to Doctor weight gain of over 2 pounds per day" was not followed. Resident #308 was admitted with a weight of 163 pounds per a physicians progress note dated 4-20-18, and by 4-26-18 the weight was 174.6 pounds, equaling greater than 10 pounds gained in the one week since admission. No call to the doctor had been made by 2:30 p.m. on 4-26-18 when the nursing notes were printed for surveyors. Further evidence from a physicians progress note dated 4-24-18, revealed the doctor documented a weight of 163 pounds, and was unaware of the weight gain. The Residents weight record from the Medication Administration Record (MAR) revealed the following; 4-21-18 (160 pounds), 4-22-18 (165 pounds), 4-23-18 (168.9 pounds), 4-24-18 (no weight taken nor PD administered), 4-25-18 (168 pounds), and during observation of weight on 4-26-18 (174.6 pounds).	F 726		

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F 726	Continued From page 87 LPN E was asked if she had been trained by a dialysis certified facility trainer, and she stated "yes, they came from [name of dialysis company] yesterday at 3:00 p.m. (4-25-18) to train us." She went on to say that was the first time they had trained her, and she had been providing care for a month, and for this Resident for a week. According to federal regulation, before providing peritoneal dialysis (PD), the facility staff must be trained by a qualified dialysis trainer from a certified dialysis facility. Training can not be provided by nursing home staff. That did not happen as LPN E had not been formally trained until 4-25-18, and had been providing PD for a week without training. On 4-26-18, and 4-27-18 at the end of day debrief, the Administrator and DON were made aware that PD was not being provided in accordance with federal regulations, the care plan for this Resident was not developed to adequately guide staff in the provision of care for PD, and that breaches in infection control during PD were observed by surveyors. They were made aware that their policy was for hemodialysis only, and gave no guidance to staff for PD. They were also made aware that the Resident had experienced a 10 pound weight gain since admission a week ago, and no intervention had been taken by staff for the Resident, hindering her quality of care and wellbeing. No further information was provided by the facility staff.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		5/31/18

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F 755	Continued From page 88 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure for 1 resident (Resident #258) of 28 residents in the survey sample that medication was available for administration. For Resident #258, physician ordered fentanyl patch was not administered because it had not	F 755	1.Resident #258 has been discharged home. An associate education was completed with the licensed nurses assigned on the day and time the patch was due to be administered for failing to follow the process to ensure medications are available to administer as ordered. The resident had no negative effect.	

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F 755	Continued From page 89	F 755		

been delivered by the pharmacy.

The finding included:

Resident #258, a 69 year old, was admitted to the facility on 4/18/18. Diagnoses included multiple myeloma (cancer), dysphagia, hypertension, anemia, and critical illness myopathy (muscle weakness).

Resident #258 was new to the facility and did not have a Minimum Data Set completed. Her care plan documented that she was able to make basic care decisions and express care preferences.

On 4/25/18 at 8:15 a.m., Resident #258 was observed in bed with her eyes closed.

The skilled nursing note dated 4/24/18 read "(Resident #258) is receiving skilled acre services for rehabilitation therapies scheduled at least 5 days/ week, daily assessment and management of pain, ."

Resident #258 had the following physician orders dated 4/18/18 for pain management:
1. Dexamethasone 20 milligram by mouth in the morning for pain
2. Fentanyl patch 25 microgram/ hour every 72 hours for pain

The following information about Dexamethasone was accessed on 4/30/18 at 1:53 p.m. at the website
https://medlineplus.gov/druginfo/meds/a682792.html
"Dexamethasone, a corticosteroid, is similar to a natural hormone produced by your adrenal

2.Any resident has the potential to be affected if physician ordered medication is not available for administration. A review of medication availability will be completed for current residents to assess compliance.

3.The Director of Nursing will educate the licensed nurses on the process for ensuring medications are available.

4.The Unit Manager or designee will conduct a random medication pass observation weekly x 4 weeks then monthly x 2 months to ensure availability of medications. The QAPI Coordinator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.

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F 755	Continued From page 90 glands. It often is used to replace this chemical when your body does not make enough of it. It relieves inflammation (swelling, heat, redness, and pain) and is used to treat certain forms of arthritis; skin, blood, kidney, eye, thyroid, and intestinal disorders (e.g., colitis); severe allergies; and asthma. Dexamethasone is also used to treat certain types of cancer." The following information about Fentanyl transdermal patch was accessed on 4/30/18 at 1:53 p.m. at the website https://medlineplus.gov/druginfo/meds/a601202.html "Fentanyl patches are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Fentanyl is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." According to the April 2018 Medication Administration Record (MAR), the Fentanyl patch was applied to Resident #258 at 9:00 am. on 4/21/18. A new patch was supposed to be applied again on 4/24/18, with the previous patch to be removed. According to the MAR, the new patch was not applied on 4/24/18, as the documentation space was blank. On 4/27/18, the Director of Nursing (DON) was asked if the facility had the count sheet for the Fentanyl to determine if it had been administered on 4/24/18. On 4/27/18 at 1:05 p.m., the DON stated that the Fentanyl was never delivered from the pharmacy. It was not administered.	F 755		

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F 755	Continued From page 91 No further information was provided.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure one resident (Resident # 8) in a survey sample of 28 residents was free from significant medication errors. For Resident # 8, the facility staff failed to administer insulin as prescribed by the physician. Findings included: Resident # 8 was a 66-year-old male who was admitted to the facility on 9/17/2014 with diagnoses of but not limited to: Hypertensive Heart Disease, Diabetes, End Stage Renal Disease, Hypotension, Anxiety , Bacteremia, Hyperkalemia, Pneumonia, Hyperlipidemia, and Dyspnea.. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/17/2018. The MDS coded Resident # 8 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of 1-2 staff persons with Activities of Daily Living except required supervision and set up for eating; and coded as frequently incontinent of bowel and bladder.	F 760	1.Resident #8 is receiving insulin as ordered. There were no negative effects for the resident. An associate education will be completed for the licensed nurse responsible for insulin administration on the days insulin was not administered. 2.Any resident has the potential to be affected if staff fail to administer physician ordered insulin. Medication administration records for current residents receiving insulin will be reviewed for the past 72hrs to assess compliance with insulin administration. An associate education and a medication error report will be completed with physician and responsible party notification as applicable. 3.The Director of Nursing or designee will educate the licensed nurses on ensuring insulin is administered as ordered and medication administration documentation requirements. 4.The Director of Nursing or designee will review medication administration compliance during the Daily Clinical Meeting weekly x 4 weeks and monthly x 2 months to ensure compliance with	5/31/18

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F 760	Continued From page 92 Review of the clinical record was conducted on 4/25/2018 at 3:50 PM. Review of the February 2018-April 2018 Medication Administration Records revealed missing documentation of administration of insulin several times. Below are dates with no documentation of administration of insulin as ordered by the physician. Novolog Insulin Inject as per Sliding Scale: if 150-200= 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units over 400 call md (medical doctor), subcutaneously before meals and at bedtime (Notify MD for BS (Blood Sugar) < 60 Not documented as having been administered on 4/3/2018 at 6 AM, Review of the March 2018 MAR revealed missing documentation of insulin: Novolog Insulin Inject as per Sliding Scale: if 150-200= 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units over 400 call md (medical doctor), subcutaneously before meals and at bedtime (Notify MD for BS (Blood Sugar) < 60 Not documented as having been administered on 3/4/2018 at 6 AM, 3/21/2018 at 6 AM, 3/28/2018 at 11 AM. 3/28/2018 at 9 AM-Levemir Insulin inject 6 units subcutaneously in the morning every Sunday, Monday, Wednesday and Friday	F 760	insulin administration and documentation requirements. The Director of Nursing or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 760	Continued From page 93 Review of the February 2018 MAR revealed missing documentation of insulin: Novolog Insulin Inject as per Sliding Scale: if 150-200= 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units over 400 call md (medical doctor), subcutaneously before meals and at bedtime (Notify MD for BS (Blood Sugar) < 60 Insulin was not documented as having been administered on 2/8/2018 at 6 AM and 2/26/2018 at 6 AM. Valid physicians orders were noted for the medications not documented as administered. Review of the Facility policy on Medication Administration effective 6/21/2017 revealed statements: "11. Administer medication and remain with resident while medication is swallowed. ..." "14. Return to the medication cart and document on the MAR. Note refusal or ingestion of less than 100% of dose on the MAR in the designated area. " Guidance for nursing standards for the administration of medication was provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to	F 760		

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F 760	Continued From page 94 an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." On 4/26/2018 at 3 PM, an interview was conducted with the Director of Nursing who stated the nurses should administer medications as ordered by the physician. During the end of day debriefing on 4/26/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings. The Director of Nursing stated the nurses should administer medications as ordered by the physician and document on the Medication Administration Record at the time of administration. On 4/27/2018 at 11:45 AM, the Director of Nursing stated she could find no documentation in the nurses notes or on the MAR about the medications that were not documented as having been administered. No further information was provided.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		5/31/18

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F 812	Continued From page 95 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed follow professional standards for food service safety related to hand washing between changing gloves and touching face with gloved hands. The findings included: On 4/25/18 at 12:30 while observing tray line preparation Employee D changed gloves three times without washing hands after taking off soiled gloves, also on 4/2518 during tray line observation Employee E touched her face with gloved hands and did not wash hands and change gloves. On 4/26/18 during interview with Employee C (Dietary Manager) she stated that it was an expectation that when soiled gloves are removed hands are to be washed prior to donning clean gloves, she also stated that it was an expectation	F 812	1.Employees that were involved were in-serviced on proper handwashing and changing gloves. 2.Any resident has the potential to be affected if staff fail to follow professional standards for food service safety related to handwashing and gloving. Dietary staff will have a hand washing and glove application observation completed to ensure compliance. 3.The Dietary Manager or designee will educate the dietary staff on when and how to wash their hands. Handwashing signs are posted in the kitchen at the hand sinks. The Dietary Manager or designee will have dietary staff to demonstrate competency in hand washing and changing gloves.	

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F 812	Continued From page 96 that employees not touch their faces with gloves on and if they do they need to change gloves and wash hands before continuing with food preparation. The Administrator provided a written copy of the hand washing policy that stated " Frequent and thorough hand washing is a major importance in preventing the spread of germs." During exit conference on 4/47/18 at 2:45 Administration was notified and no further information was provided.	F 812	4.Dietary Manager or designee will conduct random rounds in the kitchen to ensure compliance with handwashing and changing gloves weekly x 4 then monthly x 2. Hand washing and changing glove competencies will be completed with all new hires. Findings and recommendations will be discussed during the QA Committee Meeting monthly x 3 months.	
F 880 SS=E	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, 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;	F 880		5/31/18

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F 880	Continued From page 97 §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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 98 §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, Resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to maintain peritoneal dialysis (PD) in a manner to prevent the spread of infection for 1 resident (Resident #308) in a survey sample of 28 residents. 1. For Resident #308, the facility staff contaminated the PD exchange during multiple steps on the 4-26-18 exchange observation. 2. The facility staff failed to ensure the ice machine on 2 of 2 units had an air gap to prevent backflow of contaminated water. The Findings included: Resident #308 was admitted previously to the facility on 12-1-17, after amputation surgery of her left foot. The Resident was discharged home from the facility on 3-14-18. The Resident was readmitted after further amputation surgeries on 4-19-18 with the diagnoses of, but not limited to; hypertension, heart disease, chronic kidney disease with peritoneal dialysis, bilateral below the knee amputations, insulin dependant diabetes, glaucoma, and asthma. The most recent Minimum Data Set (MDS) for this admission was a quarterly assessment with an Assessment Reference Date (ARD) of 3-5-18, from the previous stay. The MDS coded Resident #308 with no cognitive impairment. The	F 880	1.Resident #308 was discharged home. An associate education was completed with the licensed nurse that was responsible for failing to provide dialysis services in a manner that is consistent with professional standards of practice. The resident had no negative effects from the provision of dialysis services. The drain hose for the ice machine #1 that has the splash guard has been adjusted to ensure there is a 1 inch air gap above the brim of the splash guard. The drain hose for ice machine #2 has been adjusted to ensure there is a 1 inch air gap above the drain. 2.Any resident receiving peritoneal dialysis has the potential to be affected if staff fail to maintain peritoneal dialysis in a manner to prevent the spread of infection. Any resident has the potential to be affected when the air gap to the ice machines does not prevent backflow of contaminated water. Currently there are no residents in the center receiving peritoneal dialysis. An observation of other ice machines in the center will be completed to ensure the air gap is at least 1 inch from the drain. 3.The Director of Nursing or designee will educate licensed nurses on aseptic technique. The Director of Nursing or designee will educate the licensed nurses	

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F 880	Continued From page 99 Resident needed extensive assistance from staff for toileting, hygiene, bed mobility and transferring. On 4-24-18 at 6:30 p.m. on initial tour of the facility the Resident was observed lying in bed, and when asked for an interview, she stated that tomorrow would be better, she was tired. On 4-25-18 at 10:30 a.m., the Resident was sitting on her bed and granted the request for an interview. The Resident stated she had been back at the facility for "About a week after having surgery on my legs." The Resident went on to say that her dialysis treatments were a problem, and when asked why, she stated that the staff did not know how to do them correctly, and she had to monitor them closely so they "don't mess me up and give me an infection or worse." The Resident stated that the staff don't know what they are doing, they put the wrong bags on to dialyze with, they don't use good infection practices, and they put the bags and tubing on the floor, they didn't order the right equipment bag and tubing cassettes (5 prong instead of 3 prong tubing) and she stated she has to tell them step by step what to do, and sometimes at night she is asleep and has to wake up to watch what the staff is doing so the staff doesn't "mess me up". The Resident went on to say "I have gained 10 pounds since I have been here in one week." "Weight gain is a problem, and I guess I will have to call the doctor myself, since they won't." "I never use 1.5 bags cause I gain fluid with them, I told them that but they don't listen." "Yesterday they got the wrong stuff so I didn't even get my afternoon exchange at all, I had to wait for supplies to come, that's ridiculous".	F 880	on the policy and procedure for handwashing and General Infection Control Guidelines. The Administrator or designee will educate the Maintenance Director on ensuring ice machines are maintained with an air gap of at least 1 inch to prevent back flow. 4.The QAPI Coordinator or designee will conduct random observations of the provision of peritoneal dialysis services as available for 2 licensed nurses trained to provide peritoneal dialysis services weekly x 4 weeks then monthly x 2 months to ensure services are being provided in a manner that is consistent with professional standards of practice. The Maintenance Director or designee will conduct observations of center ice machines weekly x 4 weeks then monthly x 2 months to ensure air gaps are at least 1 inch. The QAPI Coordinator or designee will report findings and recommendations during the QAPI Committee Meeting monthly x 3 months.	

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F 880	Continued From page 100 On 4-26-18 at 11:00 a.m. LPN E was observed obtaining a 1.5% dextrose dialysis bag full of fluid to instill in the Resident's abdomen after the old fluid was drained out of the Resident's abdomen. The bag was opened by LPN E with gloved hands from it's protective clear wrapper one hour prior to the planned 12:00 noon exchange, and was placed on a warming tray. There was condensation liquid on the outside of the inner bag when LPN E opened the outer protective clear wrapper and LPN E began wiping it off with a paper towel. On 4-26-18 at 12:30 p.m. Resident #308 was observed before and during a peritoneal dialysis exchange. The Resident was sitting in a wheel chair in her room. Two surveyors were present with the Resident, LPN E (licensed practical nurse #E), and the ADON RN A (assistant director of nursing registered nurse #A). LPN E squirted a dime size amount of alcohol based hand sanitizer into her hands and briskly rubbed them together. She donned a pair of clean gloves from an open box in the Resident's room and applied them. After stating "We are going to weigh you now" to the Resident. The surveyors followed LPN E pushing Resident #308 in a wheel chair to the shower room at the nursing station where the Resident was weighed in her wheel chair. LPN E pushed electronic digital buttons on the wheel chair scale with her gloved hands to obtain the weight, while her uniform top touched the scale which was used to weigh all wheel chair bound residents. The Resident weighed 212.6 pounds in the wheel chair. LPN E then returned the Resident to the Resident's room.	F 880		

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F 880	Continued From page 101 The nurse did not weigh the wheel chair prior to weighing the Resident. LPN E was asked what the Resident's weight was and she stated "I need to get my calculator out." LPN E removed the gloves and threw them in the regular garbage can next to the resident's bed. There were no biohazardous waste receptacles in the Resident's room. LPN E pulled the calculator out of her shirt pocket with bare hands which were now contaminated and calculated the weight. LPN E put on a clean pair of gloves from the same container in the Resident's room without washing her hands. The room door remained open. LPN E and all observers donned masks, no gowns were used. The nurse did not check the temperature of the dialysis bag of fluid. The nurse opened a second bag containing an empty dialysis bag with 2 sets of tubing attached to it which she brushed against her uniform top and pants. The empty bag was placed on the bottom shelf of a 2 shelf push cart which was visibly dusty and soiled. LPN E did not clean the shelf nor put a barrier layer down under the empty bag which was now contaminated. The tubing was laying on top of the empty bag with a loop of the tubing hanging down in front of the cart and laying on the floor, which contaminated it. An IV (intravenous) medication pole was pulled over to hang the bag of fluids on (which was not cleaned) that would drain into the Resident, after the fluid in her abdomen was drained into the empty bag on the bottom of the cart. LPN E placed 2 clamps (which had been open and laying on the cart on top of the now contaminated tubing) and closed them so as to	F 880		

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F 880	Continued From page 102 allow no fluid to pass through either tubing. The clamps were not cleaned, and were contaminated. LPN E picked up a canister of cleaning wipes and cleaned the Resident's abdominal peritoneal dialysis tube with the wipes which were now contaminated by her contaminated gloves, allowed no time for the tubing to dry, and connected the tubing (which had been on the bottom of the cart and contaminated) and touched to the Resident after pulling a cap off of the tubing. LPN E then pulled the IV pole over closer to the Resident, hung the full bag of fluid on it, and connected the second line of tubing to it making a circuit of the 2 bags and the Resident, which were now all contaminated. The clamp for the drain bag was released and fluid began filling the bag, traveling from the Resident's abdomen. After the observation LPN E and the ADON were made aware of the breaches in infection control, and the need for aseptic technique when providing peritoneal dialysis. The ADON stated this is a clean procedure, and there are levels of aseptic techniques. The ADON was then asked what nursing standard of practice the facility followed for infection control and aseptic technique, and he replied the CDC (the centers for disease control). The ADON went on to say he taught peritoneal dialysis to staff and he was asked to provide the text information used for that training, and his certificate of completion for his training. No certificate of training was produced, however, the Director of nursing provided a 3 page document entitled "Baxter CAPD Exchange	F 880		

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F 880	Continued From page 103 Procedure" , which was not followed by LPN E, and a 2 page document entitled CAPD "Continuous Ambulatory Peritoneal Dialysis". The Director of Nursing (DON) stated the facility professional standard for nursing practice was obtained from "Potter and Perry". The documents were reviewed and the CAPD document stated "Use strict aseptic technique when performing bag exchanges.". and "As with all peritoneal dialysis procedures, aseptic technique is essential during catheter insertion, exchanges, and dressing changes to prevent peritonitis." Peritonitis is a life threatening inflammation of the sterile abdominal cavity which is often fatal. The CDC requires aseptic technique for all dialysis. The CDC definition of aseptic technique is "free from all pathogenic microorganisms, to protect from infection, and to prevent the spread of pathogens". The director of Nursing provided the policy for dialysis, and stated this is the only dialysis policy we have. The policy referred only to hemodialysis. No mention of peritoneal dialysis existed in this document. The facility did not provide hemodialysis in the facility. After the observations, the Resident's clinical record was reviewed. The review revealed signed physician orders which included the below order: "4-21-18: Afternoon manual exchanges: Fill volume 2000 milliliter bags (use 1.5% solution, if blood pressure greater than 140/80 then use 2.5% solution one time a day related to end stage	F 880		

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F 880	Continued From page 104 renal disease). On 4-24-18 the entry was not signed as administered by staff, and referred the reader to a nursing note for explanation. The nursing note stated that the supplies for the exchange were unavailable and they were waiting for delivery. The exchange was never completed. Resident #308's old admission care plan, and new admission care plans were reviewed and revealed that no specific step by step individualized instructions were ever care planned to direct nursing home staff in provision of care before, during and after peritoneal dialysis, and did not specify that strict aseptic technique must be used. There was no doctor's order, nor care plan for access site care, or aseptic technique or infection control standards to be observed for PD. LPN E was asked if she had been trained by a dialysis certified facility trainer, and she stated "yes, they came from [name of dialysis company] yesterday at 3:00 p.m. (4-25-18) to train us." She went on to say that was the first time they had trained her, and she had been providing care for a month, and for this Resident for a week. According to federal regulation, before providing peritoneal dialysis (PD), the facility staff must be trained by a qualified dialysis trainer from a certified dialysis facility. Training can not be provided by nursing home staff. That did not happen as LPN E had not been formally trained until 4-25-18, and had been providing PD for a week without training. On 4-26-18, and 4-27-18 at the end of day debrief, the Administrator and DON were made aware that PD was not being provided in accordance with federal regulations, and staff	F 880		

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F 880	Continued From page 105 were deficient in the provision of infection control care for PD during observation by surveyors. They were made aware that their policy was for hemodialysis only, and gave no guidance for PD. No further information was provided by the facility staff. Complaint deficiency. 2. The facility staff failed to ensure the ice machine on 2 of 2 units had an air gap to prevent backflow of contaminated water. During the course of inspection of the nutrition rooms on both units the drain lines coming from the ice machine did not have air gap to prevent backflow of contaminated water into ice machine. On 4/27/18 Employee F (Maintenance Director) was notified of the lack of air gap. Employee F acknowledged that he was trying to address the problem of water draining from ice machine leaking onto floor by placing drain line from ice machine directly into the drain on floor. On 4/27/18 @ 2:45 during exit conference that administration was informed of the findings no further information was provided.	F 880		