STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/23/16 through 08/25/16. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated. The Life Safety code report will follow. The census in this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents # 1 through 20) and 3 closed record reviews (Residents # 21 through 23).	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to follow physician orders for two of 23 residents in the survey sample: Residents # 8 and # 11. 1. Resident # 8 did not have TED (compression stockings) applied per physician orders. 2. Resident # 11's leg protectors were not applied per physician order.	F 309	1) Res #8 TEDs obtained and placed on resident #8 8/25/2016. Res #11 leg protectors obtained and applied per MD order 8/24/2016. 2) 100% audit by DON/designee of resident orders to identify those having TEDs and/or skin protectors. Visual inspection of 100% of those identified to ensure they are available and applied per MD order.	10/4/16

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

Electronically Signed | 09/12/2016

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F 309	Continued From page 1 Findings include: 1. Resident # 8's TED hose were not applied as ordered by the physician. Resident # 8 was admitted to the facility 3/4/16 with diagnoses to include, but were not limited to: anemia, high cholesterol level in the blood, Alzheimer's disease, and anorexia. The most recent MDS (minimum data set) was a quarterly review dated 7/12/16 and had Resident # 8 with severe impairment in cognition with a total summary score of 05 out of 15. The clinical record was reviewed 8/24/16 beginning at 10:55 a.m. The August 2016 POS (physician order sheet) included an order carried forward from 6/29/16 for "BLE (bilateral lower extremity) knee high ted hose 2 times per day during Day, Evening, Special Instructions: on in am and off in pm..." On 8/24/16 at 3:50 p.m. Resident # 8 was observed standing in her room with 2 CNA's (certified nursing assistants) present. This surveyor knocked on the door, and after being given permission to enter the room, went in to speak to Resident # 8. CNA # 2 stated they had heard the resident's alarm sounding and went to the room. The CNA's were getting the resident back to bed after toileting. This surveyor asked if the resident's legs could be observed once she was back in bed. CNA # 2 asked the resident if we could look at her legs, and the resident stated we could. CNA # 2 then pulled up Resident # 8's pants legs to her knees. Resident # 8 had on regular tan knee stockings on. This surveyor	F 309	3) Implementation of EHR task list functionality allowing linkage of care planned interventions to task list accessed by C.N.A.□s and shahbazim. *Review by DON/designee of current resident care plans to identify care planned interventions to maintain skin integrity that are unique and specific to the resident, and that are assigned to C.N.A. or shahbazim. *Education by DON/designee of every C.N.A., shahbaz and nurse on every shift to EHR added functionality. Education to include review of role responsibilities added in this plan of correction. *Review by charge nurse of unreported task report by every shift during that shift. Variance investigated and corrective action taken by the charge nurse. *Ongoing creation by DON/designee of orders linked to tasks for care plan interventions to maintain skin integrity that are unique and specific to the resident, and that are assigned to a C.N.A. or shahbazim. *Audit by Social Services Manager of resident care plans provided to private duty caregiver to ensure updated care plans are present. *The DON/designee will educate the private duty caregiver to changes to the plan of care when it is updated. 4) *Audit by DON/designee of incomplete task list report generation and review by charge nurse for every shift for 6 weeks. *Audit by DON/designee of	

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F 309	Continued From page 2 asked about the TED hose. CNA # 2 and CNA # 3 looked at each other and stated "We didn't know she was to have TED hose on." This surveyor informed both CNA's of the order for Resident # 8, and also asked how they knew what care and services to provide for residents on their shift. CNA # 3 stated "Usually it's on the paper what the resident needs. I'll go get it and show you." CNA # 3 left the room, and returned a few moments later with an oblong sheet of paper with resident names and divided columns of what treatments and/or services each resident was to receive each shift. CNA # 3 stated "There isn't anything on here about [name of resident] having TED hose." On 8/24/16 during a meeting with facility staff beginning at 4:30 p.m. the DON (director of nursing) and the administrator were informed of the above observation. No further information was provided prior to the exit conference. 2. Resident #11 did not have physician ordered leg protectors in place. Findings include: Resident # 11 was admitted to the facility originally on 09/15/15. Diagnoses for Resident # 13 included, but were not limited to: Dementia, anemia (low blood count), and edema.	F 309	uncompleted tasks and of care plan to ensure that all orders to maintain skin integrity that are unique and specific to a resident are linked to a task. Audit to include 2 residents ordered TED hose/skin protectors per neighborhood per week, scheduled across all shifts, for task completion for 6 weeks, then every two weeks for another 6 weeks, then monthly for another three months. *Audits will include one resident per week with a private duty caregiver. *Audits will also include visual verification of the residents to ensure task completion. *Variances to be investigated and corrected by the DON/designee. *The DON/designee will verify audit completion and will analyze audit results to identify trends and patterns. *Audits to be reviewed by QAPI monthly. 5) 10/4/2016	

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F 309	Continued From page 3	F 309		

The most current full MDS (minimum data set) was a quarterly assessment dated 06/21/16. Resident #11 had long and short-term memory loss with severe cognitive impairment in daily decision making skills.

Resident # 11's physician's orders were reviewed on 08/23/16 and revealed an order dated 6/30/16 that read "Leg Protectors to Bilateral Legs ON 1 Time per day during Day, For skin integrity [sic]."

Resident #11's care plan was then reviewed and revealed a care plan titled "Potential for altered skin integrity [...]" An intervention with a date of 6/26/16 documented "Use leg protectors to promote skin integrity and prevent injury."

On 8/24/16 at 10:10 a.m. Resident #11 was observed sitting in a wheelchair in a common area and without leg protectors in place.

At this time an interview with a certified nursing aide (CNA #1) was conducted concerning the observation. CNA #1 verbalized that she did not see the leg protectors when she was getting Resident #11 out of bed. This surveyor and CNA #1 then went to Resident #11's room to look for the leg protectors, but were unable to locate them.

CNA #1 then verbalized that she (CNA #1) knew that Resident #11 was supposed to be wearing the leg protectors during the day.

Resident #11's legs were then assessed by this surveyor and CNA #1. Resident #11 had some scattered bruising throughout both lower extremities, but no open areas.

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F 309	Continued From page 4 The above finding was brought to the attention of the director of nursing (DON) and the administrator on 8/24/16 at 4:30 p.m. No other information was presented prior to exit conference on 8/25/16.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure physician ordered heel boots were in place as ordered for one of 23 residents in the survey sample: Resident # 3. Findings include: Resident # 3, who had a history of pressure ulcers on his heels, was observed in bed without the heel boots as ordered by the physician for prevention. Resident # 3 was admitted to the facility 1/3/16 with diagnoses to include, but not limited to: Alzheimer's disease, high blood pressure, and	F 314	1) Heel boots were identified and applied per MD orders for resident #3 on 8/24/2016. 2) 100% audit of resident orders to identify those having heel boots. Audit to include visual inspection of identified residents to ensure ordered heel boots are available and applied per MD order. 3) Implementation of EHR task list functionality allowing linkage of care planned interventions to task list accessed by C.N.A.□s and shahbazim. *Review by DON/designee of current resident care plans to identify care planned interventions to maintain skin integrity that are unique and specific to the	10/4/16

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F 314	Continued From page 5 heart disease. The most recent MDS (minimum data set) was a significant change assessment dated 8/9/16. Resident # 3 was coded as having short term and long term memory problems, and moderately impaired in daily decision making ability. The clinical record was reviewed 8/23/16 at 1:45 p.m. It was noted the August POS (physician order sheet) included an order for "Bilateral (both) heel boots when in bed." The care plan was then reviewed, and interventions for skin integrity included the bilateral heel boots when in bed. On 8/24/16 during an interview with OS (other staff) # 1 (a private sitter for the resident) Resident # 3 was observed in bed with eyes closed. Heel boots were observed lying on the extra bed in the resident's room, and OS # 1 was asked about the heel boots, and why the resident did not have them on. OS # 1 stated "He only wears them when he's in bed." This surveyor acknowledged the resident was in bed at that time. OS # 1 then stated "Oh, I mean when he's in bed for the night; like for the night." This surveyor informed OS # 1 the order and care plan did not indicate only at night, but when the resident was in bed. OS # 1 stated "Oh, well, I just know that I think that's when the nurses put the boots on him. He doesn't have any sores on his heels right now; do you want to see?" This surveyor stated "Yes." OS # 1 then gently informed the resident of looking at his feet, and proceeded to lift each heel up for this surveyor to observe. Resident # 3's right heel had a slight reddened area on the heel approximately the size of a dime, but the skin was intact. The area was brought to OS # 1's attention, and he stated he	F 314	resident, and that are assigned to C.N.A. or shahbazim. *Education by DON/designee of every C.N.A., shahbaz and nurse on every shift to EHR added functionality. Education to include review of role responsibilities added in this plan of correction. *Review by charge nurse of unreported task report by every shift during that shift. Variances investigated and corrective action taken by the charge nurse. *Ongoing creation by DON/designee of orders linked to tasks for care plan interventions to maintain skin integrity that are unique and specific to the resident, and that are assigned to a C.N.A. or shahbazim. *Audit by Social Services Manager of resident care plans provided to private duty caregiver to ensure updated care plans are present. *The DON/designee will educate the private duty caregiver to changes to the plan of care when it is updated. 4) *Audit by DON/designee of incomplete task list report generation and review by charge nurse for every shift for 6 weeks. *Audit by DON/designee of uncompleted tasks, and of care plan to ensure that all orders for heel boots are linked to a task. Audit to include 2 residents ordered heel boots per neighborhood per week, scheduled across all shifts, for task completion for 6 weeks, then every 2 weeks for another 6 weeks, the monthly for 3 months.	

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F 314	Continued From page 6 did not realize the area was there. On 8/24/16 during a meeting with facility staff beginning at 4:30 p.m. the DON (director of nursing) and the administrator were informed of the above observation. No further information was provided prior to the exit conference.	F 314	*Audits will include one resident per week with a private duty caregiver. *Audits will also include visual verification of the residents to ensure task completion. *Variance to be investigated and corrected by the DON/designee. *The DON/designee will verify audit completion and will analyze audit results to identify trends and patterns. *Audits to be reviewed by QAPI monthly. 5) 10/4/2016	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure safety interventions for the prevention of falls for two of 23 residents in the survey sample, which resulted in harm for Resident # 4 and Resident # 3. 1. The facility failed to ensure two staff members were at Resident # 4's bedside, when the resident was being transferred via lift, as a result the resident fell off the side of the bed and incurred	F 323	1) All C.N.A.□s assigned to provide care for resident #4 were educated on her plan of care including the level of assistance needed during transfers, on 02/05/2016. The private duty caregiver providing care to resident #3 was educated to his plan of care, including the need for supervision during toileting, on 08/24/2016. 2) 100% audit by DON/designee of resident orders to identify those at risk of falling. Audit to include visual inspection of	10/4/16

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F 323	Continued From page 7 left zygomatic bone fracture (zygomatic arch or cheek bone is formed by the zygomatic process of temporal bone) with left eye/ left facial bruising and subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover the brain) and a subdural hematoma (usually the result of a serious head injury, with a collection of blood outside the brain). 2. The facility staff failed to ensure Resident # 3 had appropriate supervision during toileting, as a result the resident fell off the toilet and incurred a hip fracture. Findings include: 1. The facility failed to ensure two staff members were at Resident # 4's bedside, when the resident was being transferred via lift, as a result the resident fell off the side of the bed and incurred left zygomatic bone fracture (zygomatic arch or cheek bone is formed by the zygomatic process of temporal bone) with left eye/ left facial bruising and subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover the brain) and a subdural hematoma (usually the result of a serious head injury, with a collection of blood outside the brain). Resident # 4 was admitted to the facility on 9/04/15, with the most current readmission on 01/28/16. Diagnoses for Resident # 4 included, but were not limited to: history of a CVA (cerebrovascular accident/stroke) with left side paralysis and left side neglect (Left side neglect is a perceptual disorder frequently after a stroke where the resident ignores the left side of their body, things or people on the left side), dementia,	F 323	residents identified to ensure that ordered interventions to reduce the risk of falling are in place. 3) Implementation of EHR task list functionality allowing linkage of care planned interventions to task list accessed by C.N.A.□s and shahbazim. *Review by DON/designee of current resident care plans to identify care planned interventions to prevent falls that are unique and specific to the resident, and that are assigned to C.N.A. or shahbazim. *Education by DON/designee of every C.N.A., shahbaz and nurse on every shift to EHR added functionality. Education to include review of role responsibilities added in this plan of correction. *Review by charge nurse of unreported task report by every shift during that shift. Variance investigated and corrective action taken by the charge nurse. *Ongoing creation by DON/designee of orders linked to tasks for care plan interventions to prevent falls that are unique and specific to the resident, and that are assigned to a C.N.A. or shahbazim. *Audit by Social Services Manager of all resident care plans provided to private duty caregivers to ensure updated care plans are present. *The DON/designee will educate the private duty caregiver to changes to the plan of care when it is updated. 4) *Audit by DON/designee of	

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F 323	Continued From page 8 HTN (high blood pressure), Myasthenia Gravis (a chronic autoimmune (neuromuscular) disease characterized by fluctuating weakness of voluntary muscles), and narcolepsy (a chronic sleep disorder that causes overwhelming drowsiness). The most current full MDS (minimum data set) was a significant change assessment dated 02/03/16. This MDS assessed the resident with a cognitive score of "9", indicating the resident had moderate impairment in daily decision making skills. This MDS also assessed the resident as requiring extensive to total assistance for bed mobility and transfers, with two staff members for physical assistance. This MDS also assessed that the resident had a fall with major injury in the last month. The resident triggered for falls in the CAAS (care area assessment summary) and the area was marked to be addressed in the resident's CCP (comprehensive care plan). The quarterly MDS assessment dated 01/20/16, just prior to the fall assessed the resident with a cognitive score of 9 and requiring extensive assistance from staff for most ADL's, with two staff assist. The most recent MDS assessment was a quarterly, reviewed for comparison dated 07/19/16. This MDS assessed the resident with a cognitive score of "9" and as requiring total assistance from staff for all ADL's (activities of daily living), with two staff member assist. During clinical record review on 08/23/16 through 08/25/16, Resident # 4's nursing notes were reviewed and documented that on 01/28/16 at approximately 7:30 a.m. Resident # 4 fell off the	F 323	incomplete task list report generation and review by charge nurse for every shift for 6 weeks. *Audit by DON/designee of uncompleted tasks and of care plan to ensure that all orders to prevent falls that are unique and specific to a resident are linked to a task. Audit to include 2 residents with such orders per neighborhood per week, scheduled across all shifts, for task completion for 6 weeks, then every 2 weeks for another 6 weeks, then monthly for three months. *Audits will include one resident with private duty caregivers. *Audits will include visual verification of the residents to ensure task completion. *Variances will be investigated and corrective action taken by DON/designee. *The DON/designee will verify audit completion and will analyze audit results to identify trends and patterns. *Audits to be reviewed by QAPI monthly. 5) 10/4/2016	

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side of the bed, and was sent out to the hospital for evaluation.

On 08/24/16 at approximately 9:40 a.m., the fall investigation for Resident # 4 was requested.

The fall investigation for Resident # 4 was presented and reviewed and documented the following in summary:

Resident # 4 was admitted on 09/04/15 following a hospitalization for a stroke. The resident's fall occurred on 01/23/16 at approximately 7:30 a.m. and there were two witnesses. CNA (certified nursing assistant) # 5 and RN (Registered Nurse) # 4, both were interviewed and provided statements. CNA # 5 was providing morning care to Resident # 4 and sat the resident on the side of the bed, with feet on floor and then the CNA used her radio to call for assistance with transferring. The lift was in the hallway outside of the resident's room, the resident asked CNA # 5 for facial cream and the CNA turned to get it off the bedside table and at that point RN # 4 was in the doorway of the resident's room and the resident fell forward from the sitting position on the bed to the floor. The resident was sitting on the side of the bed for a few minutes at most before the fall happened. The resident has a history of narcolepsy and had been noted in the past to fall asleep prior to receiving her morning medications and at the time of the fall the resident had only received eye drops, no medication for narcolepsy or any others. The resident hit her left side of her head hard on the floor. The patient was rolled onto her back and placed in a position of comfort, patient was alert and oriented prior to fall. The resident was in an unconscious state, with her eyes rolling around in her head. Resident # 4

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was transported to the local hospital following a fall in her room at the facility, the resident was positive for a subdural hematoma and zygomatic fracture, she was admitted to the hospital and was discharged back to the facility on 01/28/16.

Resident # 4's CCP was then reviewed and documented the following: "Start date 10/06/15 [under falls]...2 staff members to be with patient when sitting on side of bed prior to lift transfer...does not walk...keep bed at appropriate height for safe transfer...[ADL section] Transfers with mechanical lift and 2 assists..."

Resident # 4's physician's orders were reviewed for 01/01/16 through 01/23/16 (date of resident discharge to hospital) and documented the resident was on "Fall Precautions."

The resident's current physician's orders were reviewed for 08/01/16 through 08/31/16 and documented the resident was on "Fall Precautions."

On 08/24/16 at 1:25 p.m., the DON (director of nursing) and ADON (assistant director of nursing) were interviewed in a meeting with the survey team. The DON and ADON were made aware of serious concerns regarding Resident # 4 falling and being seriously injured. The DON and ADON were asked about the resident's CCP fall interventions to have two staff members present while at the bedside for transfers. The DON and ADON agreed that interventions were not followed. The DON and ADON were asked if residents have a kardex or care sheet that staff go by for specific care information on residents. The DON stated, no. The DON was asked where do staff (Nurses and/or CNA's) get information

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regarding their resident's specific needs. The DON stated that, we encourage them to look at the care plans, but they don't have any kind of kardex or care sheet. The DON was asked, what does 'Fall Precautions' mean, as indicated on the physician's order sheets from January 2016 and current (August 2016). The DON stated that is a 'term' that the hospital uses and puts on there when a resident is readmitted. The DON was made aware that this was an actual current physician's order for Resident # 4, as an active order here at the facility. The DON stated that they (facility staff) did not actually know what that means and again stated that is something that comes from the hospital and did not have a definition or description of what 'fall precautions' mean.

A facility policy on fall prevention was presented and reviewed. The policy documented, "Falls Prevention Protocol...early identification of risk factors and staff intervention can reduce the potential for falls...It is the responsibility of all staff to assist in identifying risk factors and carrying out established plans to minimize falls...identify residents at high risk of falling and to minimize or prevent any injury that occurs due to a fall...The resident will be consider [sic] at risk if the: score is 10 or greater on fall risk assessment..."

Resident # 4 had a fall risk assessment completed on admission 09/04/15, which gave the resident a score of 22. A fall risk assessment dated 01/20/16 gave the resident a score of 14.

Resident # 4's hospital records were reviewed.

A CT (computed tomography) of the brain and head dated 01/24/16, documented: "...acute

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hemorrhage within the interhemispheric fissure...3.3 cm [centimeters] in length, 1.5 cm in maximal thickness...related to subdural and subarachnoid hemorrhage with possible small amount of parenchymal hemorrhage...evidence of developing subdural hematoma..acute blood as well as more low attenuation fluid...developed from 01/23/16...this measures approximately 5 mm [millimeters] in thickness...small subdural hematoma with subarachnoid hemorrhage...small amount of intraventricular hemorrhage..left zygomatic arch fracture..."

On 08/25/16 at approximately 11:20 a.m., in a meeting with the survey team, the administrator and DON were informed of serious concerns related to Resident # 4 being harmed during a transfer, which resulted in a fall with extensive injuries. The administrator and DON were made aware that facility staff did not follow the resident's CCP (comprehensive care plan) for transfers, as indicated in the resident's plan of care. The administrator and DON agreed and were then asked if they had any additional information and/or documentation regarding the above. The DON stated, no and further stated that they (staff) presented all information. The administrator stated that all information has been presented to the survey team regarding Resident # 4's fall with injury and it had been reviewed by the facility's administrative team and they (staff) agreed that there was actual harm. The administrator stated that, the adminsitrative staff had provided all the information.

No further information and/or documentation was presented prior to the exit conference on 08/25/16 at 12:45 p.m. to evidence that the facility staff implemented appropriate and/or adequate

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safety interventions in place for Resident # 4, to prevent a fall with major injury.

2. The facility staff failed to ensure Resident # 3 had appropriate supervision during toileting, as a result the resident fell off the toilet and incurred a hip fracture.

Resident # 3 was admitted to the facility 1/3/16 with diagnoses to include, but not limited to: Alzheimer's disease, high blood pressure, and heart disease.

The most recent MDS (minimum data set) was a significant change assessment dated 8/9/16. Resident # 3 was coded as having short term and long term memory problems, and moderately impaired in daily decision making ability. This MDS also assessed the resident as requiring extensive to total assistance for bed mobility, transfers, and toileting with two staff members for physical assistance. The resident triggered for falls in the CAAS (care area assessment summary) and the area was marked to be addressed in the resident's CCP (comprehensive care plan).

Section G0300 "Balance During Transitions and Walking" has Resident # 3 coded for "Moving from seated to standing position" and "Surface-to-surface transfer" as a "2. Not steady, only able to stabilize with human assistance."

The clinical record was reviewed 8/23/16 at 1:45 p.m. It was noted Nursing notes dated 5/25/16 and 5/26/16 documented the following:

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5/25/16 17:00 (5:00 p.m.) -" Comments: General Quick Comments= Resident had unwitnessed fall from toilet. Nursing in to evaluate. VS (vital signs) obtained and found to be wnl (within normal limits). Residents wife was contacted with news of the fall and requests that he be sent to the ER for evaluation. [Name of physician assistant] contacted and informed of the fall and the request by family that he be sent out. [Name of transport company] called for transport to hospital. Ambulance arrived at approximately 1700 [5:00 p.m.] and transported resident to the emergency room. His wife states she will meet the resident at the ER."

5/26/16 11:37 a.m. "Comments: General Quick Comments= Patient discussed in IDT [interdisciplinary team] meeting regarding fall. Private caregiver was present, and fell from toilet. Nurse provided education to caregiver regarding not leaving pt. unattended in bathroom. Pt. sent to ER and admitted."

The CCP was then reviewed. The care plan was dated 1/27/16 for the identified areas of ADL (activities of daily living) and Falls. For the ADL section, under "Problem" was documented "Resident needs ext-total [extensive to total] assistance with ADL care due to cognition impairment..." Under "Approach" was included "Start Date: 1/27/16- During transfers and/or position changes, maintain arms reach control for safety and stability." Under the section for Falls dated 1/27/16 was documented "...has had a fall with fx [fracture]; is at risk d/t [due to] poor safety awareness associated with dementia, unsteady gait/balance, pain meds." Under "Approach" was documented "Start date 1/27/16- sitter to remain in bathroom with resident (5/25/16)."

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F 323	Continued From page 15 On 8/24/16 at approximately 8:30 a.m. the ADON (assistant director of nursing) was asked for a copy of the fall investigation for Resident # 3. The investigation was presented and reviewed, and included the following documentation in summary: Incident Details 5/25/16 : Details of the incident- Resident was placed on toilet by his sitter and 1 staff member when the sitter left the bathroom and returned to sit in the residents room. The sitter states he heard a loud noise, and went to the bathroom and found the resident on the floor. The sitter states he got him up and placed him back on the toilet. One of our staff members then entered the bathroom and the sitter informed her of what happened and she immediately informed nursing of the incident. Nursing in to assess patient. He was very agitated and aggressive with those trying to assist and thorough assessment could not be performed. Staff attempted to determine if he was injured but he became combative at that point. Additional staff came into the room and it was determined that he would be transferred over to his wheelchair so he could be assessed more thoroughly. Staff attempted to stand the patient up but he was unable to bear weight. At that point he was seated back on the toilet. [Name of physician assistant and wife] were notified of the incident and [wife] requests he be sent out to the ER for evaluation. Private ambulance in to pick hip [sic] up but unfortunately he is still on the toilet. He was successfully transferred to the stretcher and talked to the hospital. Staff called to check on his status and were told he had fractured his right hip.	F 323		

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F 323	Continued From page 16 On 08/24/16 at 1:25 p.m., the DON (director of nursing) and ADON (assistant director of nursing) were interviewed in a meeting with the survey team. The DON and ADON were made aware of serious concerns regarding Resident #3 falling from the toilet and being seriously injured. The facility staff were asked about the resident's CCP fall interventions to maintain arms reach for control and stability. The facility staff agreed that interventions were not followed. The DON and ADON were asked if residents have a kardex or care sheet that staff go by for specific care information on residents. The DON stated, no. The DON was asked where do staff (Nurses and/or CNA's, including the residents private sitter) get information regarding their resident's specific needs. The DON stated that, we encourage them to look at the care plans, but they don't have any kind of kardex or care sheet. The ADON was asked if the private sitter and/or the company for the sitter had any type of agreement or contract. The ADON stated that there was a contract that, on admission, was signed by the resident/POA (power of attorney) and a representative of the company as well as the facility. The ADON further stated that this contract had not been signed by the residents wife/POA until June 2016, after the fall. The DON stated that the intervention dated 5/25/16 on the resident's care plan had been an added as a result of the fall with injury for the sitter to remain in the bathroom with the resident. On 8/24/16 at 11:15 a.m. during an interview with Resident # 3's wife, she stated that the fall incurred by the resident had really upset the private sitter. She further stated "I didn't have to hire a private sitter; I feel confident that the facility staff would take good care of him, but I can so I	F 323		

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did. I know the sitter was so upset when that happened; he's been with him since he was admitted and this really caused him to be upset. I wasn't here when it happened, so I can't say exactly what happened, but the sitter will be here this afternoon."

On 8/24/16 at 3:15 p.m. the private sitter was interviewed. The sitter was asked about the incident on 5/25/16 when the resident fell from the toilet and broke his hip. The sitter stated "Everything about that day was normal; I got one of nurses to help me get him on the toilet. The wipes were over here on his bedside table, and I could smell that he had a bowel movement so I got up to get the wipes and then I heard a loud noise; he had attempted to get up, which he never does..... he usually won't stand up and will fight me but that day he got up. I learned a valuable lesson that day.....I learned that even if somebody does something the same way for 20 years, on year 21 they may do something unexpected. It kills me that this happened on my watch." The sitter was then asked how he received information on the resident's care. The sitter stated "I usually get information from the nursing staff; I don't normally look at the care plan."

On 08/25/16 at approximately 11:20 a.m., in a meeting with the survey team, the administrator and DON were informed of serious concerns related to Resident # 3 being harmed while unattended on the toilet, which resulted in a fall with a fractured hip. The administrator and DON were made aware that facility staff did not follow the resident's CCP (comprehensive care plan) for the intervention to maintain arms reach for control and stability, as indicated in the resident's plan of

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F 323	Continued From page 18 care. The administrator and DON agreed and were then asked if they had any additional information and/or documentation regarding the above. The DON stated, no and further stated that they (staff) presented all information. The administrator stated that all information has been presented to the survey team regarding Resident # 3's fall with injury and it had been reviewed by the facility's administrative team and they (staff) agreed that there was actual harm. The administrator stated that, we (staff) provided all the information and think you all (survey team) have identified an issue for us. No further information and/or documentation was presented prior to the exit conference on 08/25/16 at 12:45 p.m.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		10/4/16

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F 431	Continued From page 19 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, facility staff failed to properly label a medication and ensure an expiration date was legible on the Massanutten unit. Facility staff failed to date an opened bottle of liquid Lorazepam stored in the locked box in the medication refrigerator. Also, the manufacturer expiration date was illegible. Findings included: On 08/24/2016 at approximately 2:55 p.m. this surveyor entered the medication room on Massanutten unit with RN #1 (registered nurse). A bottle of liquid Lorazepam was noted inside the locked box affixed inside the refrigerator. Upon inspection of the opened bottle of Lorazepam 2mg/ml (milligrams per milliliter) for a total of 30 ml, only 10 ml was left in the bottle. The bottle was not	F 431	1) The liquid Lorazepam identified by the survey team was discarded on 8/24. A replacement was ordered the same date. 2) All refrigerated medications examined by DON/designee to ensure recorded and legible open dates as well as expiration dates. 3) Education provided by DON/designee to all nurses re: recording of open and expiration dates, use of waterproof marker to record, use of containers for refrigerated medications to keep them upright. 4) Weekly audit by DON/designee of all refrigerated medications to include review of recorded open date and legible expiration date. Audits to be reviewed monthly by QAPI for trends and patterns. 5) 10/4/16	

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dated when it was opened and no expiration date was visible on the bottle. The box with the pharmacy label for the Lorazepam was noted also. The manufacturer expiration date was illegible. It had rubbed off of the label.

RN #1 inspected the Lorazepam bottle and packaging box and agreed the open bottle had not been dated and there was no visible expiration date on the bottle or the pharmacy label.

RN #1 was interviewed regarding labeling of opened medications. RN #1 stated, "Yes ma'am, I date any medications when opened. If there isn't a place on the bottle I will write on a piece of tape and attach to the bottle."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 08/25/2016 at approximately 11:30 a.m. The DON stated, "My expectation is that any medication should be dated when opened."

The facility policy for "Storage and Expiration of Medications, Biologicals, Syringes and Needles...Effective Date: 12/01/07 Revision Date: 01/01/13..." stated, "...4. Facility should ensure that medications and biologicals: 4.1 Have an Expiration Date on the label;...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 5.1 Facility staff may record the calculated expiration date based on date

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F 431	Continued From page 21 opened on the medication container. 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels..." No further information was received prior to the exit conference on 08/25/2016.	F 431		