State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0415	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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F 000	Initial Comments An unannounced biennial State licensure survey was conducted on 6/27/17 through 6/29/17. Two complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 108 at the time of the survey. The survey sample consisted of 25 residents, 19 current Resident reviews (Resident #1 through 19) and 6 closed record reviews (Resident # 20 through 25).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility staff failed to have medications available for one resident (Resident #20) in the survey sample. Findings: Resident #20 was not provided medications in accordance to 12 VAC 5-371-300 A. Cross reference to F-tag 425. 12 VAC 5-371-150. Resident Rights (A, C), Refer to F167 and F168 12 VAC 5-371-220 (B) Nursing Services Reference F-309 and F-328 12 VAC 5-371-360 (E) Clinical Records Reference F-514 12 VAC 5-371-220 B and H. Nursing Services.	F 001	Please cross reference F-tag 425. 8/9/17 12VAC 5-371-150. Refer to F167 and F168 12VAC 5-371-220. Refer to F309 and F328 12VAC 5-371-360. Reference F514 12VAC 5-371-220. Refer to F157 and F309 12VAC 371-250. Reference F280 12VAC 5-371-210. Reference F496	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/12/17

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Cross reference Tags F-157 and F-309
12 VAC 5-371-250 F. Resident Assessment and Care Planning; Cross reference Tag F-280

12 VAC 5-371-210 (F.2). Nurse Staffing.
Please Cross - Reference to F496 (i)

Based on staff interview and facility document review, the facility staff failed to meet the requirements of the Virginia Board of Nursing Regulations Governing Certified Nurse Aides (CNA) to practice as a CNA in the state of Virginia.

CNA #1 failed to submit the required application by endorsement for an out of state nurse aide certification to the Virginia Board of Nursing to practice as a CNA in the state of Virginia.

On 6/29/17 at approximately 10:00 am, the employee records were reviewed and found that CNA #1's nurse aide certification was issued in the state of Georgia. The Georgia Nurse Aide Registry verification record provided by the facility Human Resources (HR) Manager stated that CNA #1's original certification date was 6/18/04 and the expiration date was 6/18/18. There was no Virginia nurse aide registry verification record found on file. CNA #1 was hired on 10/19/16.

On 6/28/17 at 1:05 pm, an interview was conducted with the HR Manager and stated that it was an oversight on the former HR Manager entering the data into the HR system. She failed to enter the correct information on CNA #1's required certification due date of 120 days into the system. This had caused the system to not recognize CNA #1's nurse aide certification due date and consequently, was not flagged to be

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updated. She stated that she interviewed CNA #1 and according to CNA #1, she had tried to apply by endorsement for her Georgia certification but did not pursue to obtain her Virginia certification.

On 6/29/17, CNA #1 was contacted twice via phone but there was no answer each time. The last attempt to contact CNA #1 was on 6/29/17 at 2:15 pm but still unable to reach her.

On 6/29/17 at approximately 1:30 pm, the Administrator was asked regarding the facility policy for newly hired CNAs who were certified from another state and she stated that she had to refer to the HR policy.

On 6/29/17 at 2:00 pm, the Director of Nursing (DON) was interviewed and was asked about the facility process on how the facility ensured a CNA's certification was current and valid. She stated that HR usually checked the nurse aide certification status and then notified the Nursing Department. In regards to CNA #1's certification status, she stated that she was just informed "an hour ago". She stated that CNA #1 was taken off the schedule immediately.

On 6/29/17 at approximately 3:45 pm, the Administrator, DON and Corporate Nurse were made aware of the above findings and no further information was provided.

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 6/27/17 through 6/29/17. Two complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 108 at the time of the survey. The survey sample consisted of 25 residents, 19 current Resident reviews (Resident #1 through 19) and 6 closed record reviews (Resident # 20 through 25).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157	The physician/designee and resident representative of Resident #9 were notified of the discontinuation of the CPAP therapy. Current residents will be reviewed to identify those refusing physician ordered therapy and to ensure that there is documentation that the physician/designee and resident representative have been notified of the refusal.	8/9/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/12/17

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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(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on observations, resident interview, staff interviews, review of the facility's policy and clinical record review the facility staff failed to notify the physician and/or designee and the resident's representative of a change in physical, mental, or psychosocial status for 1 of 25 residents in the survey sample, Resident #9.

The facility staff failed to notify the physician and/or designee and the resident's representative that Resident #9 was not receiving the physician ordered Continuous positive airway pressure

Nurses will be educated on documenting refusals of physician ordered therapy to include notification of the physician/designee and resident representative.

A random audit of residents will be completed on a weekly basis to identify residents refusing physician ordered therapy and documentation of physician/designee and resident representative notification of the refusal. Results of the audits will be referred to the Quality Assurance Committee for review and recommendation.

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(CPAP) therapy.

The findings included:

Resident #9 was originally admitted to the facility 7/8/15 and readmitted 8/29/16 after an acute hospital visit for altered mental status and shortness of breath. The current diagnoses included; chronic obstructive pulmonary disease and obstructive sleep apnea.

Resident #9's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/6/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #9's cognitive abilities for daily decision making were moderately impaired.

The 6/6/17 quarterly MDS assessment also coded the resident as exhibiting a depressed mood and having little energy two to six days per week and exhibiting no behaviors. The resident was coded as set-up assistance of one person with eating, limited assistance with locomotion, extensive assistance of one with personal hygiene, dressing and toilet use, extensive assistance of two with bed mobility and transfers and total care of one with bathing.

On 6/28/17 at approximately 12:30 p.m., an interview was conducted with Resident #9 in his room. The resident was still in bed and had just completed a nebulizer treatment for an episode of shortness of breath and congestion. This

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surveyor observed on the floor next to the bedside dresser a nebulizer machine and a CPAP machine. The CPAP machine was covered with dust and both were uncovered/unprotected from dust and debris. The surveyor asked Resident #9 if he had received CPAP therapy last night and Resident #9 stated he had not had CPAP therapy in many months because he decided it was not beneficial. Resident #9 stated the decision was not discussed with his physician and or designee but the nursing staff was aware he decided not to receive CPAP therapy and they knew not to apply the CPAP equipment at bedtime.

Review of Resident #9's, 6/1/2017 physician's order summary revealed an order with a start date of 8/30/16 which read: "CPAP every hour of sleep at bedtime for Sleep apnea."

Review of Resident #9's treatment administration record for six months revealed the following; 1/1/17 through 1/31/17; Resident #9 refused CPAP therapy 27 nights and accepted CPAP therapy 4 nights.

2/1/17 through 2/28/17; Resident #9 refused CPAP therapy 26 nights and accepted CPAP therapy 2 nights.

3/1/17 through 3/31/17; Resident #9 refused CPAP therapy 30 nights and there was no documentation available for 3/29/17.

4/1/17 through 4/30/17; Resident #9 refused CPAP therapy 21 nights, accepted CPAP therapy 5 nights and there was no documentation available for 4 nights.

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5/1/17 through 5/31/17; Resident #9 didn't refuse CPAP therapy any nights, accepted CPAP therapy 25 nights and there was no documentation available for 3 nights.

6/1/17 through 6/28/17; Resident #9 refused CPAP therapy 4 nights, accepted CPAP therapy 21 nights, "other" was documented 1 night and there was no documentation available for 4 nights.

An interview was conducted with Registered Nurse (RN) #1, on 6/29/17 at approximately 1:35 p.m. RN #1 stated she recognized on 6/28/17 at approximately 12:00 p.m., that Resident #9 was congested and experiencing shortness of breath; therefore, the respiratory medication Albuterol Sulfate was administered to the resident to relieve the symptoms. RN #1 stated the resident was in bed when she saw him the first time for the day and she did not remove the CPAP equipment which was applied the night before. RN #1 further stated she works with the resident every other week and she has never known the resident to utilize the CPAP equipment. She stated the resident was non-compliant with use of the CPAP and she had not educated the resident on the benefits of use.

An interview was also conducted with the treating Nurse Practitioner (NP) on 6/29/17 at approximately 1:45 p.m. The NP stated she is in the facility daily and she knows Resident #9 very well. She stated, Resident #9 fluctuates with compliance of his entire program and some days he just doesn't feel like being bothered. The NP stated the resident has sleep apnea; therefore, CPAP therapy was ordered. She further stated

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without the CPAP therapy the resident is likely to feel tired, not be completely alert and have decreased cognitive abilities. The NP stated most of her visits with Resident #9 are for managing symptoms related to heart failure.

The NP also stated she couldn't say she had visited the resident recently related to the diagnosis of sleep apnea or low oxygen saturation and facility staff had not notified her the resident was rejecting CPAP therapy. The NP stated she had not personally obtained the resident's oxygen saturation or had any reason to educate the resident on the importance of compliance with CPAP therapy. The NP also stated the facility staff had not informed her the resident was rejecting the CPAP therapy.

The Corporate Nurse Consultant was asked to provide any documentation from the clinical record which stated the facility staff had notified the resident's representative and physician or physician's designee of the residents rejection of CPAP therapy and any documentation from the clinical record stating Resident #9 was educated on the benefits of CPAP therapy and the potential consequences of continuous rejection of care. The Corporate Nurse Consultant stated no documentation was available.

The facility's policy titled "Refusal of Medication/Treatment Care" with an effective date of 02/01/15 read: "A licensed nurse is to document and notify the physician and responsible party when a resident refuses

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F 157	Continued From page 6 medication(s) and or treatment. Procedure number 2; three days of patient's refusals of medication(s)/treatment/care requires the notification of the physician and responsible party. The physician will review and determine if the current drug/treatment plan is appropriate and whether discharge planning may be initiated. Procedure number 3; three days of refusals will result in a review and revision of care plan. Documentation will be placed in the medical record if patient and/or Responsible party is unable or unwilling to attend the care plan conference. Procedure number 4; Patient and/or responsible party teaching will include specifics regarding the potential for negative consequences/outcome of continued refusals." The above findings were shared with the Administrator, Director of Nursing, and Corporate Nurse Consultant on 6/29/17 at approximately 3:00 p.m. No additional information was provided.	F 157		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 167	Facility staff changed the location of the posting of the most recent survey results to a prominent and accessible place frequented by residents with large, easily readable print. The location of the posting of the most recent survey results will be discussed with residents at the next Resident Council Meeting.	8/9/17

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F 167	Continued From page 7 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on general observations, group interview, staff and resident interview, the facility staff failed to ensure the posting of the availability of the survey results was in a prominent and accessible place frequented by residents with large enough print enabling easy reading. The findings include: On 6/28/17 at 1:30 p.m., during the group interview with 6 residents that represented the facility, they were unable to identify the location in the building where the survey results were located for review. Each resident was taken to the lobby and they could not find the signage that directed them to where the survey results were located. This writer took each resident to the small print framed sign that indicated where the survey results were located and none of the residents were able to read the information in the framed sign. All of the residents stated they very rarely frequented the main lobby and spent most of their time on the unit's activities unit and day	F 167	The Activity Department will be educated on reviewing the location of the most recent survey results with newly admitted residents. The Administrator will monitor the posting of the most recent survey results on a random weekly basis to ensure that the posting is in a prominent and accessible place frequented by residents and that the posting is easily readable. Results of the monitoring will be referred to the Quality Assurance Committee for review and recommendation.	

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F 167	Continued From page 8 rooms. There was no information in these resident frequented areas, where they spent most of their time, regarding survey results or where they were located. The residents stated they had never read any of the survey results. Review of the previous 6 months Resident Council Meeting minutes did not reveal any discussions about the location of the State survey and Certification results. On 6/29/17 at approximately 3:30 p.m., the aforementioned information was shared with the Administrator, Director of Nursing (DON) and the Corporate Nurse. They presented the Resident Rights information that indicated "The resident had the right to be provided, at the time of admission, a survey summary of the most recent findings and outcomes concerning Federal requirements".	F 167		
F 168 SS=C	483.10(g)(10)(ii)(k) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES (g)(10) The resident has the right to- (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. (k) Contact with External Entities. A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any	F 168	The signs listing State Agency and Advocate telephone numbers and addresses have been moved to be easily accessible and readable if in a wheelchair. The location of the State Agency and Advocate telephone numbers and addresses will be reviewed with residents at the next Resident Council Meeting.	8/9/17

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F 168	Continued From page 9 representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action. This REQUIREMENT is not met as evidenced by: Based on general observations, group interview, staff and resident interview, the facility staff failed to ensure information regarding State agencies and other advocates were conspicuously located, as well as positioned on the wall to enable residents in wheelchairs to read the information. The findings include: On 6/28/17 at 1:30 p.m., during the group interview with 6 residents that represented the facility, they were unable to identify the location in the building where the State Agencies and Advocates telephone numbers and addresses could be accessed, and then be afforded the opportunity to contact these agencies. Each of these residents were taken to the location where the aforementioned information was posted and stated it was their first awareness of this posting. Five out of the six residents were in wheelchairs and stated they were unable to read the postings because they were too high up on the wall. Review of the previous 6 months Resident Council Meeting minutes did not reveal any discussions about location of the postings of State, Federal and local advocacy addresses and	F 168	The Activity Department will be educated on reviewing the location of State Agency and Advocate telephone numbers and addresses with newly admitted residents. The Administrator will complete a random weekly interview with residents to ensure that the resident is aware of the location of State Agency and Advocate telephone numbers and addresses and that the information is easily readable. Results of the interviews will be referred to the Quality Assurance Committee for review and recommendation.	

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F 168	Continued From page 10 telephone numbers. On 6/29/17 at approximately 3:30 p.m., the aforementioned information was shared with the Administrator, Director of Nursing (DON) and the Corporate Nurse.	F 168		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--	F 280	Resident #9's person-centered plan of care has been revised to address his current strengths and needs as well as personal and cultural preferences. Current residents were reviewed to ensure that rejection of physician ordered treatment is included in the resident's plan of care. The interdisciplinary team and charge nurses will be educated on developing and revising a resident's plan of care to include rejection of physician ordered treatments. The Director of Nursing/Assistant Director of Nursing will complete a random weekly audit of resident plans of care to ensure that the plan of care addresses the resident's strengths, needs, and personal and cultural preferences. Results of the audits will be referred to the Quality Assurance Committee for review and recommendation.	8/9/17

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

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

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's 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.

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(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 observations, resident interview, staff interviews, review of the facility's policy and clinical record review the facility staff failed to review and revise the person-centered plan of care as the resident's status changed.

The facility staff failed to review and revise Resident #9's person-centered plan of care to include rejection of the physician ordered Continuous positive airway pressure (CPAP) therapy.

The findings included:

Resident #9 was originally admitted to the facility 7/8/15 and readmitted 8/29/16 after an acute hospital visit for altered mental status and shortness of breath. The current diagnoses included; chronic obstructive pulmonary disease and obstructive sleep apnea.

Resident #9's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/6/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and

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scoring 12 out of a possible 15. This indicated Resident #9's cognitive abilities for daily decision making were moderately impaired.

The 6/6/17 quarterly MDS assessment also coded the resident as exhibiting a depressed mood and having little energy two to six days per week and exhibiting no behaviors. The resident was coded as set-up assistance of one person with eating, limited assistance with locomotion, extensive assistance of one with personal hygiene, dressing and toilet use, extensive assistance of two with bed mobility and transfers and total care of one with bathing.
Observations/date/time

On 6/28/17 at approximately 12:30 p.m., an interview was conducted with Resident #9 in his room. The resident was still in bed and had just completed a nebulizer treatment for an episode of shortness of breath and congestion. This surveyor observed on the floor next to the bedside dresser a nebulizer machine and a CPAP machine. The CPAP machine was covered with dust and both were uncovered/unprotected from dust and debris. The surveyor asked Resident #9 if he had received CPAP therapy last night and Resident #9 stated he had not had CPAP therapy in many months because he decided it was not beneficial. Resident #9 stated the decision was not discussed with his physician and or designee but the nursing staff was aware he decided not to receive CPAP therapy and they knew not to apply the CPAP equipment at bedtime.

Review of Resident #9's, 6/1/2017 physician's order summary revealed an order with a start

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date of 8/30/16 which read; CPAP every hour of sleep at bedtime for Sleep apnea.

Review of Resident #9's treatment administration record for six months revealed the following; 1/1/17 through 1/31/17; Resident #9 refused CPAP therapy 27 nights and accepted CPAP therapy 4 nights.

2/1/17 through 2/28/17; Resident #9 refused CPAP therapy 26 nights and accepted CPAP therapy 2 nights.

3/1/17 through 3/31/17; Resident #9 refused CPAP therapy 30 nights and there was no documentation available for 3/29/17.

4/1/17 through 4/30/17; Resident #9 refused CPAP therapy 21 nights, accepted CPAP therapy 5 nights and there was no documentation available for 4 nights.

5/1/17 through 5/31/17; Resident #9 didn't refuse CPAP therapy any nights, accepted CPAP therapy 25 nights and there was no documentation available for 3 nights.

6/1/17 through 6/28/17; Resident #9 refused CPAP therapy 4 nights, accepted CPAP therapy 21 nights, "other" was documented 1 night and there was no documentation available for 4 nights.

An interview was conducted with Registered Nurse (RN) #1, on 6/29/17 at approximately 1:35 p.m. RN #1 stated she recognized on 6/28/17 at approximately 12:00 p.m., that Resident #9 was congested and experiencing shortness of breath

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therefore; the respiratory medication Albuterol Sulfate was administered to the resident to relieve the symptoms. RN #1 stated the resident was in bed when she saw him the first time for the day and she did not remove the CPAP equipment which was applied the night before. RN #1 further stated she works with the resident every other week and she has never known the resident to utilize the CPAP equipment. She stated the resident was non-compliant with use of the CPAP and she had not educated the resident on the benefits of use.

An interview was also conducted with the treating Nurse Practitioner (NP) on 6/29/17 at approximately 1:45 p.m. The NP stated she is in the facility daily and she knows Resident #9 very well. She stated Resident #9 fluctuates with compliance of his entire program and some days he just doesn't feel like being bothered. The NP stated the resident has sleep apnea therefore; CPAP therapy was ordered. She further stated without the CPAP therapy the resident is likely to feel tired, not be completely alert and have decreased cognitive abilities. The NP stated most of her visits with Resident #9 are for managing symptoms related to heart failure.

The NP also stated she couldn't say she had visited the resident recently related to the diagnosis of sleep apnea or low oxygen saturation and facility staff had not notified her the resident was rejecting CPAP therapy. The NP stated she had not personally obtained the resident's oxygen saturation or had any reason to educate the resident on the importance of compliance with CPAP therapy.

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The Corporate Nurse Consultant was asked to provide any documentation from the person-centered plan of care stating Resident #9 rejected CPAP therapy and was educated on the benefits of CPAP therapy and the potential consequences of continuous rejection of CPAP therapy. The Corporate Nurse Consultant stated the person-centered plan of care did not have a plan of care specific to rejection of CPAP therapy, only a comment in the problem list stating "refusal of care" without a goal or interventions related to refusal of care.

The facility's policy titled "Care Planning" with an effective date of 02/01/15 read: "A computerized care plan will be updated by each discipline on an ongoing basis as changes in the patient occurs, and reviewed quarterly with the quarterly assessment."

The above findings were shared with the Administrator, Director of Nursing, and Corporate Nurse Consultant on 6/29/17 at approximately 3:00 p.m. No additional information was provided.

F 309 SS=E 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

F 309

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest

Resident #5 is utilizing the TED hose as ordered by the physician. The CPAP therapy has been discontinued for Resident #9.

8/9/17

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F 309	Continued From page 17 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, clinical record review and facility document review the facility staff failed to ensure 2 of 25 residents in the survey sample received the treatment and care in accordance to the person-centered care plan to maintain their highest practicable well-being, Residents #5 and #9.	F 309	Current residents with orders for TED hose were reviewed to ensure that the TED hose are in use as ordered. Current residents with orders for CPAP were reviewed to ensure that the CPAP is in use as ordered or that there is documentation of physician/designee and resident representative notification of refusals to comply with the order. Nurses will be educated on following physician/designee orders, documentation of administration of physician/designee orders, documentation of refusals of physician/designee orders, and documentation of physician/designee notification of resident refusals of orders.	

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1. The facility staff failed to follow the physician's plan of care for the use of thromboembolic disease stockings (TED-compression stockings) for the management of bilateral lower extremity edema (1) for Resident #5.

2. The facility staff failed to provide physician ordered Continuous positive airway pressure (CPAP) therapy to Resident #9.

The findings included:

1. Resident #5 was admitted to the facility on 5/11/17 with diagnoses to include history of congestive heart failure, deep vein thrombosis (DVT-blood clots) of lower extremity with IVC (inferior vena cava) filter placement and diabetes.

The admission MDS (Minimum Data Set) with an assessment reference date of 5/18/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact.

The Physician Order Summary Report included an order dated 5/31/17 that read, "TED (compression stockings) to be apply to bilateral lower extremity. If not able to tolerate they may use Ace wraps from toes to knees one time a day for edema and remove per schedule". The start date was 6/1/17.

On 6/2/17 the resident was examined by the Nurse Practitioner (NP #1) for the swelling of bilateral (both) lower extremities and continued weight gain. The physical exam evidenced the resident's lower extremities had significant edema to both lower legs with the left being greater than the right. The NP documented, "...the patient

F 309

The Director of Nursing/Assistant Director of Nursing will complete a random weekly audit of residents with orders for TED hose or with orders for CPAP therapy to ensure that the orders are followed or that the physician/designee has been notified of refusals to comply with the order. Issues noted during the audits will be referred to the Quality Assurance Committee for review and recommendation.

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states that he has not yet received compression stockings...". Impression and Plan Of Care included: 1. Bilateral lower extremity edema. Venous PVL bilateral lower extremities (Peripheral vascular lab-studies to show for presence of blood clots). Please make sure the patient has thromboembolic disease stockings on daily as ordered. Change Lasix to 40 mg (milligrams) P.O. (by mouth) daily...continue fluid restriction of 1200 ml (milliliters) per 24 hours, continue daily weights parameters.

The PVL studies results dated 6/3/17 were normal without evidence of DVT-blood clots.

On 6/5/17 the resident was re-examined by NP #1. The lower extremities had mild to moderate edema, improved from previous exam on 6/2/17. The NP documented, "He is not wearing compression stockings at this time...". The Impression and Plan Of Care included: 1. Bilateral lower extremity edema, history of congestive heart failure. Continue daily weights. We will increase Lasix to 40 mg P.O. (by mouth) b.i.d (twice a day). 5. Bilateral lower extremity edema, continue thromboembolic disease stockings as ordered please.

On 6/16/17 the resident was re-examined by NP #1. The NP documented, "He states they are weighing him daily, however, he is not wearing his compression stockings today as he states he does not have any at all." "Physical Examination: ...Extremities:...He does have mild pitting edema note to bilateral lower extremities." Impression and Plan Of Care: 1. Bilateral lower extremity edema. Continue daily weights. Please make sure the patients' TED stockings are applied daily as ordered. I did speak with his day nurse, (name

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of RN #2), today in regard to this and to ensure the patient has compression stockings on daily again. 2. Acute kidney injury. Decrease Lasix to 20 mg P.O. twice daily.

A physician order dated 6/16/17 read, "Please make sure pt's (patient's) TED hose are applied daily as ordered.

On 6/27/17 at 4:30 p.m., the resident was observed sitting in his room in a wheelchair. The resident was wearing blue socks, and presented with edema to both legs, the left greater than the right. The resident was asked about the TED hose. He stated, "I never got those". He stated the NP had also questioned him about them.

On 6/28/17 at 10:30 a.m., sitting up in the wheelchair awaiting for therapy. He did not have TED hose on. At 1:00 p.m., the resident was observed in his room, in the bed. The resident did not have TED hose on.

The TAR (Treatment Administration Record) for the month of June 2017 was reviewed. It had an entry for the daily application of the TED hose on at 9 am and the removal of the TED hose every evening at 9 pm. From 6/1/17 the day shift nursing staff had initialed daily that the TED hose were applied, to include RN #2 initials.

On 6/28/17 at 3:50 p.m., RN #2 was interviewed. She was asked how does she ensure the TED hose are on Resident #9. She stated when she goes into the room she checks for them. When asked if the resident had on TED hose today she stated, "Yes, when I went in there they were on". RN #2 had initialed on the TAR for today that the TED hose were on, when in fact they were not.

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RN #2 was asked to go and check with the resident about the TED hose. RN #2 went to the resident's room, the resident was not wearing any TED hose. RN #2 inquired about the TED hose and the Resident stated, "I never got them". RN #2 then checked all drawers in the resident's room to ensure they were not stored somewhere, there were no TED hose found. The RN and this surveyor then left the resident's room. RN #2 was asked if TED hose were available in the building, she stated, "Yes". RN #2 then went into the medical supply room. Stored inside the supply room on a shelf with a plastic bin containing multiple TED hose stockings of various sizes. RN #2 grabbed a pair of TED hose and a disposable paper measuring tape to measure the resident's calf and leg to ensure for proper size. The RN then went to the resident's room.

On 6/28/17 the above findings was shared with the Director of Nursing, the Assistant Director of Nursing and the Corporate Nurse.

On 6/29/17 at 2:15 pm, NP #1 was interviewed. She was asked about the order for the TED hose and stated, "When he first came to us he did not have any increase swelling to his legs. He then started having increased swelling and I made changes to his medication (Lasix). I spoke with (name of RN #2) about the TED hose". I would expect them (nursing staff) to have placed them on if I wrote an order for them and spoke with the nurse".

The facility staff failed to follow the Physician's Plan of Care for the application of TED stockings from 6/1/17 through 6/28/17.

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PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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1). Edema - A local or generalized condition in which the body tissues contain an excessive amount of tissue fluid. (Source Taber's Cyclopedic Medical Dictionary Edition 20).

2. Resident #9 was originally admitted to the facility 7/8/15 and readmitted 8/29/16 after an acute hospital visit for altered mental status and shortness of breath. The current diagnoses included; chronic obstructive pulmonary disease and obstructive sleep apnea (1).

Resident #9's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/6/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #9's cognitive abilities for daily decision making were moderately impaired.

The 6/6/17 quarterly MDS assessment also coded the resident as exhibiting a depressed mood and having little energy two to six days per week and exhibiting no behaviors. The resident was coded as set-up assistance of one person with eating, limited assistance with locomotion, extensive assistance of one with personal hygiene, dressing and toilet use, extensive assistance of two with bed mobility and transfers and total care of one with bathing.

On 6/28/17 at approximately 12:30 p.m., an interview was conducted with Resident #9 in his room. The resident was still in bed and had just completed a nebulizer treatment for an episode of shortness of breath and congestion. This

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surveyor observed on the floor next to the bedside dresser a nebulizer machine and a CPAP machine (2). The CPAP machine was covered with dust and both were uncovered/unprotected from dust and debris. The surveyor asked Resident #9 if he had received CPAP therapy last night and Resident #9 stated he had not had CPAP therapy in many months because he decided it was not beneficial. Resident #9 stated the decision was not discussed with his physician and or designee but the nursing staff was aware he decided not to receive CPAP therapy and they knew not to apply the CPAP equipment at bedtime.

Review of Resident #9's 6/1/2017 physician's order summary revealed an order with a start dated of 8/30/16 which read; CPAP every hour of sleep at bedtime for Sleep apnea.

Review of Resident #9's care plan revealed no care plan for sleep apnea or non-compliance/rejection of CPAP therapy.

Review of Resident #9's treatment administration record for six months revealed the following; 1/1/17 through 1/31/17; Resident #9 refused CPAP therapy 27 nights and accepted CPAP therapy 4 nights.

2/1/17 through 2/28/17; Resident #9 refused CPAP therapy 26 nights and accepted CPAP therapy 2 nights.

3/1/17 through 3/31/17; Resident #9 refused CPAP therapy 30 nights and there was no

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documentation available for 3/29/17.

4/1/17 through 4/30/17; Resident #9 refused CPAP therapy 21 nights, accepted CPAP therapy 5 nights and there was no documentation available for 4 nights.

5/1/17 through 5/31/17; Resident #9 didn't refuse CPAP therapy any nights, accepted CPAP therapy 25 nights and there was no documentation available for 3 nights.

6/1/17 through 6/28/17; Resident #9 refused CPAP therapy 4 nights, accepted CPAP therapy 21 nights, "other" was documented 1 night and there was no documentation available for 4 nights.

An interview was conducted with Registered Nurse (RN) #1, on 6/29/17 at approximately 1:35 p.m. RN #1 stated she recognized on 6/28/17 at approximately 12:00 p.m., that Resident #9 was congested and experiencing shortness of breath; therefore, the respiratory medication Albuterol Sulfate was administered to the resident to relieve the symptoms. RN #1 stated the resident was in bed when she saw him the first time for the day and she did not remove the CPAP equipment which was applied the night before. RN #1 further stated she works with the resident every other week and she has never known the resident to utilize the CPAP equipment. She stated the resident was non-compliant with use of the CPAP and she had not educated the resident on the benefits of use.

An interview was also conducted with the treating

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Nurse Practitioner (NP) on 6/29/17 at approximately 1:45 p.m. The NP stated she is in the facility daily and she knows Resident #9 very well. She stated Resident #9 fluctuates with compliance of his entire program and some days he just doesn't feel like being bothered. The NP stated the resident has sleep apnea therefore; CPAP therapy was ordered. She further stated without the CPAP therapy the resident is likely to feel tired, not be completely alert and have decreased cognitive abilities. The NP stated most of her visits with Resident #9 are for managing symptoms related to heart failure.

The NP also stated she couldn't say she had visited the resident recently related to the diagnosis of sleep apnea or low oxygen saturation and facility staff had not notified her the resident was rejecting CPAP therapy. The NP stated she had not personally obtained the resident's oxygen saturation or had any reason to educate the resident on the importance of compliance with CPAP therapy.

The Corporate Nurse Consultant was asked to provide any documentation from the clinical record which stated the facility staff had notified the resident's representative and physician or physician's designee of the residents rejection of CPAP therapy and any documentation from the clinical record stating Resident #9 was educated on the benefits of CPAP therapy and the potential consequences of continuous rejection of care. The Corporate Nurse Consultant stated no documentation was available.

The facility's policy titled "Respiratory/Oxygen

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Equipment" with an effective date of 08/04/15 read: "licensed nurses will administer and maintain respiratory equipment, oxygen administration and oxygen equipment per physician's order and in accordance with standards of practice."

The facility's policy titled "Refusal of Medication/Treatment Care" with an effective date of 02/01/15 read: "A licensed nurse is to document and notify the physician and responsible party when a resident refuses medication(s) and or treatment. Procedure number 2; three days of patient's refusals of medication(s)/treatment/care requires the notification of the physician and responsible party. The physician will review and determine if the current drug/treatment plan is appropriate and whether discharge planning may be initiated. Procedure number 3; three days of refusals will result in a review and revision of care plan. Documentation will be placed in the medical record if patient and/or Responsible party is unable or unwilling to attend the care plan conference. Procedure number 4; Patient and/or responsible party teaching will include specifics regarding the potential for negative consequences/outcome of continued refusals."

The above findings were shared with the Administrator, Director of Nursing, and Corporate Nurse Consultant on 6/29/17 at approximately 3:00 p.m. No additional information was provided.

(1) Sleep apnea is a common disorder in which you have one or more pauses in breathing or shallow breaths while you sleep.

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F 309	Continued From page 27 (https://www.nhlbi.nih.gov/health/health-topics/topics/sleepapnea) (2) Continuous positive airway pressure (CPAP) therapy is a treatment that uses mild air pressure to keep your breathing airways open ... CPAP is used to treat sleep-related breathing disorders including sleep apnea... (https://www.nhlbi.nih.gov/health/health-topics/topics/cpap/) For the treatment to work, you should use your CPAP machine every time you sleep at home, while traveling, and during naps. Getting used to using your CPAP machine can take time and requires patience. Your doctor may need to adjust your pressure settings for you. You may have to work with your sleep doctor to find the most comfortable mask that works best for you, to try the humidifier chamber in your machine, or to use a different CPAP machine that allows multiple or auto-adjusting pressure settings. Some patients notice immediate improvements after starting CPAP treatment, such as better sleep quality, reduction or elimination of snoring, and less daytime sleepiness. Equally important are the long-term benefits that you cannot notice, such as helping to prevent or control high blood pressure, lowering your risk for stroke, and improving memory and other cognitive function. (https://www.nhlbi.nih.gov/health/health-topics/topics/sleepapnea)	F 309		
F 328 SS=E	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 328		

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F 328	Continued From page 28 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (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	F 328	Resident #5 has been seen by the Podiatrist as ordered. Residents with orders for a podiatry consult were reviewed to ensure that the consult has been completed. Nurses will be educated on completion of consult orders in a timely manner. The DON/ADON will complete a random weekly audit of consults to ensure that the consult has been completed as ordered. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	8/9/17

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professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interviews, clinical record review, the facility staff failed to ensure 1 of 25 residents in the survey sample received the treatment and care in accordance to the person-centered care plan to receive Podiatry services (foot care) and assist in making appointments to maintain their highest practicable well-being, Residents #5.

1. The facility staff failed to follow the Physician's Plan Of Care for a Podiatry (1) consult to manage a foot wound for Resident #5.

The findings included:

Resident #5 was admitted to the facility on 5/11/17 with diagnoses to include history of diabetes.

The admission MDS (Minimum Data Set) with an assessment reference date of 5/18/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact.

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On 5/22/17 the resident was examined by the Nurse Practitioner (NP #2) for left great toe pain and abrasion. The resident had complained of left great toe pain for the past week with an abrasion on it and some redness. The resident had denied any specific trauma or injury to the area. The physical exam evidenced the resident's left great toe was positive for pain and redness, described as, " Left great toe with a large abrasion over the bottom of the toe with scabbed covering, surrounding mild erythema (redness), no tenderness to palpation (touch)". Impression and Plan Of Care included: "1. Started Keflex (an antibiotic) for left great toe abrasion and concern for beginning of cellulitis (2). Podiatry consulted."

The Physician Order Summary Report included an order dated 5/23/17 that read, "Podiatry consult for L (left) foot great toe wound w/ hx DM (with history of diabetes) and treatment orders. The treatment order was for Silvadene cream 1% to be applied to the affected area topically every day shift for open area to left foot great toe, apply Q-tip size amount daily to affected area with band aid."

On 6/2/17 the resident was re-examined by another NP (NP #1). The Impression and Plan Of Care included: "2. Left great toe wound, neuropathy (1). Podiatry consult as soon as possible regarding left great toe wound. Continue Keflex. Cleanse left great two with DWC (dermal wound cleanser), pat dry, apply Medihoney on wound and cover with dry sterile dressing daily and as needed."

The nurse practitioner wrote a second order for a Podiatry consult regarding the left great toe wound on 6/2/17.

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On 6/5/17 the resident was re-examined by NP #1. Under Impression and Plan of Care read: 3. Left great toe wound. X-ray was done on June 2, 2017 was negative for any acute process. Continue Medihoney local wound care daily. The patient is (blank) Podiatry consult and has finished course of Keflix.

On 6/7/17 the left great toe Medihoney dressing time was changed to every evening and as needed.

The electronic clinical record was reviewed. There was no Podiatry consult found. A request to review all consults for Resident #5 was made to the Administrator on 6/28/17. There were no consults found.

On 6/28/17 at 10:30 a.m., the resident was observed sitting up in the wheelchair awaiting for therapy. The resident was wearing blue socks and was asked about the left great toe dressing. The resident stated it was changed last evening. When asked if the Podiatrist had examined the left great toe wound he stated, "No".

The left toe dressing change was not observed during the survey as it was scheduled on the evening shift.

The wound was assessed weekly by the nursing staff. The last assessment was conducted on 6/27/17. The wound was described as a diabetic wound to the left great toe. The wound presented with pink moist tissue, and scant amount of serosanguinous drainage. The wound measured 0.8 cm (centimeters) x 0.5 cm and 0.1 cm. No inflammation was noted and the wound progress

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was stable.

On 6/28/17 at 2:30 p.m., the unit secretary was interviewed. She was asked what was the process for obtaining a Podiatry consult. She stated when a physician orders a Podiatry consult she faxes the face sheet to the Podiatrist office, she then calls the Podiatry office and speaks with the staff to confirm a consult. A log book was made available to review that included Podiatry consult visits. On 5/23/17, the Podiatrist marked through Resident #9's name who was awaiting a consult, off to side the Podiatrist hand wrote that the resident required a physician referral, as the resident was not Medicaid. The Podiatrist included a phone number to call to aid in obtaining a referral for a Podiatrist consult. The unit secretary stated the resident is managed care and they need authorization for a referral. She stated she was not aware that the resident required the referral as she had not read this handwritten note left by the Podiatrist. She stated if the resident was Medicaid she could get the Podiatrist in as soon as tomorrow. She stated nursing could have also assisted with following up on this. Later that same day, the unit secretary followed up and stated to this surveyor that the resident was Medicaid approved on 6/23/17 and she has re-faxed the face sheet to the Podiatrist office. She had not been made aware of the resident being Medicaid until today.

On 6/28/17 the above findings was shared with the Director of Nursing, the Assistant Director of Nursing and the Corporate Nurse.

On 6/29/17 at 2:15 pm, the NP was interviewed. She stated she was not quite clear if the Podiatrist had seen the resident. She stated she

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F 328	Continued From page 33 had requested the Podiatry consult as the resident was a diabetic. The NP wanted the Podiatrist to evaluate and assess the foot wound, and review the treatment plan for possible recommendations. 1). Podiatry-The diagnosis, treatment, and prevention of conditions of human feet. (Source Taber's Cyclopedic Medical Dictionary Edition 20). 2). Cellulitis-A spreading bacterial infection of the subcutaneous tissue. The extremities esp. the legs, are the most common sites. (Source Taber's Cyclopedic Medical Dictionary Edition 20).	F 328		
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides.	F 356	Daily nurse staffing information records are now maintained for review. The Staffing Scheduler is maintaining the daily nurse staffing information records in a designated location. The Staffing Scheduler has been educated on maintaining the daily nurse staffing information records for 18 months. The Administrator will complete a random weekly audit to ensure that the daily nurse staffing information records are completed and stored in a designated location. Issues noted during the audits will be referred to the Quality Assurance Committee for review and recommendation.	8/9/17

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(iv) Resident census.

(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, the facility staff failed to retain the daily nurse staffing information records for 18 months.

On 6/27/17 at approximately 11:45 am, the facility was requested copies of the daily nurse staffing records filed from January 2016 through 6/27/17. The facility provided copies of the records from June 2016 through 6/28/17. During the review of these records conducted on 6/28/17 at approximately 12:30 pm, it was found that there were missing records of the daily nursing staffing

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information as follows:
In 2016:
June 24, 25, 26
July 6, 7, 8, 9, 10, 23, 24, 25
August - 1, 5, 6, 7, 11, 12, 13, 14, 15, 16, 17, 20, 21, 25, 26, 27, 28
September - 2, 3, 4, 5, 8, 10, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 30
October - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, 31
November - 1, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 23, 26, 27
December - 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25

In 2017:
January - no record for the entire month
February - no record for the entire month
March - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 19, 28, 29, 30, 31
April - 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 30
May - 6, 12, 13, 22

On 6/28/17 at 12:55 pm, an interview was conducted with the Administrator and she stated that the former Staffing Scheduler who was responsible for keeping the nurse staffing information records no longer worked at the facility. The office was also moved to another location so they were unable to locate the missing records.

On 6/29/17 at 2:10 pm, the Corporate Nurse stated, when asked, that the facility should keep the records of the nurse staffing information for 18 months. She stated that they have searched the entire facility but failed to find the missing records.

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F 356	Continued From page 36 On 6/29/17 at 3:45 pm, the Director of Nursing (DON) provided a copy of the facility policy and procedure #410 titled, "General Documents" with an effective date of 5/1/17. The policy stated, "(Name of facility company) has established and maintains a records retention schedule for General Documents." The procedure stated, in part, "1. The following retention schedules are to be timely implemented for General Documents: ...i. Daily Nurse Staffing Report Form (CMS). (18 months). On 6/29/17 at approximately 4:15 pm, the Administrator, DON and the Corporate Nurse was made aware of the above findings and no further information was provided.	F 356		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, closed record review and staff interview, the facility staff failed to ensure medications were available for one resident (Resident #20) in the survey sample of 25 residents.	F 425	Resident #20 was discharged from the facility. Current residents will be reviewed to ensure that medications are available as ordered. Nurses will be educated on ordering of medications, use of the stat box for newly ordered medications, and reordering of medications. The Director of Nursing/Assistant Director of Nursing will complete a random weekly audit of availability of medications. Issues noted during the audits will be referred to the Quality Assurance Committee for review and recommendation.	8/9/17

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The findings included:

Resident #20 was re-admitted to the facility on 10/11/16 with diagnoses of type two diabetes, hypertension, muscle weakness, GERD (gastroesophageal reflux disease), and cardio vascular accident. The facility failed to provide Resident #20 with her insulin medication.

A review of the reentry Minimum Data Set (MDS) dated 10/18/16 indicated this resident was assessed in the area of Cognitive Patterns- Brief Interview for Mental Status (BIMS) score as a 15 indicating no cognitive impairment. In the area of Activities of Daily (ADL) this resident was assessed as requiring Extensive assistance in the area of Transfers, dressing and toilet use.

A revised Care Plan dated 9/13/16 indicated: Focus- The resident has Diabetes Mellitus. Goal- The resident will be free from any sign or symptoms of hyperglycemia. Interventions- diabetes medications as ordered by doctor.

A Physician order dated 10/11/16 indicated: lantus SoloStar Solution Pen-injector 100 unit/ML (insulin Giargine) inject 25 unit subcutaneously at bedtime related to type 2 Diabetes Mellitus without complications.

A review of the Medication Administration Record (MAR) for the month of October 2016 indicated on 10/14/16 at the 2100 hour (9:00 P.M.) hour Resident #20's insulin medication was not administered as ordered. A chart code indicated "9" which indicated other see progress notes.

A Progress Note dated 10/14/16 at 21:59 P.M.

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F 425	Continued From page 38 nursing indicated: "Lantus SoloStar solution Pen-injector 100 Unit/ML (milliliter) Inject 25 unit subcutanously at bedtime related to Type 2 Diabetes mellitus without complications. Note Text: On order." During an interview on 6/29/17 at 9:37 A.M. with the Director of Nursing, she stated, the insulin was not given as ordered because it was not available at the time." A facility policy for Receiving pharmacy products and services from pharmacy dated 2013 indicated: "Facility should ensure medications orders include medication name, strength, dose, route, frequency, indication for use (to reduce medication errors) and stop order, or administration parameters, if any." The facility staff failed to provide one resident medications as ordered by the physician.	F 425		
F 496 SS=E	Complaint Deficiency 483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or	F 496	CNA#1 is currently certified by the Virginia Board of Nursing to practice in the state of Virginia. Employee records were reviewed to ensure that all CNAs are currently certified by the Virginia Board of Nursing to practice in the state of Virginia or are within the 120-day period to obtain the Virginia certification.	8/9/17

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F 496	Continued From page 39 (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to meet the requirements of the Virginia Board of Nursing Regulations Governing Certified Nurse Aides (CNA) to practice as a CNA in the state of Virginia. CNA #1 failed to submit the required application by endorsement for an out of state nurse aide certification to the Virginia Board of Nursing to practice as a CNA in the state of Virginia.	F 496	The HR Manager will be educated on reviewing certification upon hire to ensure that certification in the state of Virginia is current or is flagged to alert staff prior to the 120 day requirement. The HR Manager will complete a random monthly audit to ensure that CNA staff are currently certified by the Virginia Board of Nursing to practice in the state of Virginia or remain within the 120-day period to obtain the Virginia certification. The Regional HR Manager will complete a random quarterly audit to ensure that CAN staff are currently certified by the Virginia Board of Nursing to practice in the state of Virginia or remain within the 120 day period to obtain the Virginia certification. Issues noted during the audits will be referred to the Quality Assurance Committee for review and recommendation.	

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On 6/29/17 at approximately 10:00 am, the employee records were reviewed and found that CNA #1's nurse aide certification was issued in the state of Georgia. The Georgia Nurse Aide Registry verification record provided by the facility Human Resources (HR) Manager stated that CNA #1's original certification date was 6/18/04 and the expiration date was 6/18/18. There was no Virginia nurse aide registry verification record found on file. CNA #1 was hired on 10/19/16.

On 6/28/17 at 1:05 pm, an interview was conducted with the HR Manager who stated that it was an oversight on the former HR Manager entering the data into the HR system. She failed to enter the correct information on CNA #1's required certification due date of 120 days into the system. This had caused the system to not recognize CNA #1's nurse aide certification due date and consequently, was not flagged to be updated. She stated that she interviewed CNA #1 and according to CNA #1, she had tried to apply by endorsement for her Georgia certification but did not pursue to obtain her Virginia certification.

On 6/29/17, CNA #1 was contacted twice via phone but there was no answer each time. The last attempt to contact CNA #1 was on 6/29/17 at 2:15 pm but still unable to reach her.

On 6/29/17 at approximately 1:30 pm, the Administrator was asked regarding the facility policy for newly hired CNAs who were certified from another state and she stated that she had to refer to the HR policy.

On 6/29/17 at 2:00 pm, the Director of Nursing (DON) was interviewed and was asked about the facility process on how the facility ensured a

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F 496	Continued From page 41 CNA's certification was current and valid. She stated that HR usually checked the nurse aide certification status and then notified the Nursing Department. In regards to CNA #1's certification status, she stated that she was just informed "an hour ago". She stated that CNA #1 was taken off the schedule immediately. On 6/29/17 at approximately 3:45 pm, the Administrator, DON and Corporate Nurse were made aware of the above findings and no further information was provided.	F 496		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided,	F 514	Resident #5's TAR is currently documented in an accurate manner. Residents with orders for TED hose were reviewed to ensure that the documentation on the TAR is accurate. Nurses will be educated on accurate documentation of completion of physician/designee orders. The DON/designee will complete a random weekly audit of documentation to ensure that physician/designee orders are accurately documented. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	8/9/17

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(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State.

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident interviews, staff interview, and clinical record review the facility staff failed to ensure 1 of 25 residents in the survey sample clinical record was accurate, Residents #5.

1. The facility staff failed to ensure the Treatment Administration Record (TAR) for June 2017 was accurate for the use of TED hose (thromboembolic disease stockings) for Resident #5.

The findings included:

Resident #5 was admitted to the facility on 5/11/17 with diagnoses to include history of congestive heart failure, deep vein thrombosis (DVT-blood clots) of lower extremity with IVC (inferior vena cava) filter placement and diabetes.

The admission MDS (Minimum Data Set) with an assessment reference date of 5/18/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact.

The Physician Order Summary Report included

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an order dated 5/31/17 that read, "TED (compression stockings) to be apply to bilateral lower extremity. If not able to tolerate they may use Ace wraps from toes to knees one time a day for edema and remove per schedule". The start date was 6/1/17.

On 6/2/17 the resident was examined by the Nurse Practitioner (NP #1) for the swelling of bilateral (both) lower extremities and continued weight gain. The physical exam evidenced the resident's lower extremities had significant edema (1) to both lower legs with the left being greater than the right. The NP documented, "...the patient states that he has not yet received compression stockings...". Impression and Plan Of Care included: 1. Bilateral lower extremity edema. Venous PVL bilateral lower extremities (Peripheral vascular lab -studies to show for presence of blood clots). Please make sure the patient has thromboembolic disease stockings on daily as ordered.

On 6/5/17 the resident was re-examined by the NP. The lower extremities had mild to moderate edema, improved from previous exam on 6/2/17. The NP documented, "He is not wearing compression stockings at this time...". The Impression and Plan Of Care included: 1. Bilateral lower extremity edema, history of congestive heart failure. Continue daily weights. We will increase Lasix to 40 mg (milligrams) P.O. (by mouth) b.i.d (twice a day). 5. Bilateral lower extremity edema, continue thromboembolic disease stockings as ordered please.

On 6/16/17 the resident was re-examined by the NP. The NP documented, "He states they are weighing him daily, however, he is not wearing his

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compression stockings today as he states he does not have any at all." "Physical Examination: ...Extremities:...He does have mild pitting edema note to bilateral lower extremities." Impression and Plan Of Care: 1. Bilateral lower extremity edema. Continue daily weights. Please make sure the patients' TED stockings are applied daily as ordered. I did speak with his day nurse, (name of RN #2), today in regard to this and to ensure the patient has compression stockings on daily again.

A physician order dated 6/16/17 read, "Please make sure pt's (patient's) TED hose are applied daily as ordered.

On 6/27/17 at 4:30 p.m., the resident was observed sitting in his room in a wheelchair. The resident was wearing blue socks, and presented with edema to both legs, the left greater than the right. The resident was asked about the TED hose. He stated, "I never got those". He stated the NP had also questioned him about them.

On 6/28/17 at 10:30 a.m., sitting up in the wheelchair awaiting for therapy. He did not have TED hose on. At 1:00 p.m., the resident was observed in his room, in the bed. The resident did not have TED hose on.

The TAR (Treatment Administration Record) for the month of June 2017 was reviewed. It had an entry for the daily application of the TED hose on at 9 am and the removal of the TED hose every evening at 9 pm. Each day from 6/1/17 through 6/28/17 the day shift nursing staff had initialed that the TED hose were applied, to include RN#2 initials. The evening shift nursing staff signed that the TED hose were removed twenty two out

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of twenty eight days.

On 6/28/17 at 3:50 p.m., RN #2 was interviewed. She was asked how does she ensure the TED hose are on Resident #9. She stated when she goes into the room she checks for them. When asked if the resident had on TED hose today she stated, "Yes, when I went in there they were on". RN #2 had initialed on the TAR for today that the TED hose were on, when in fact they were not. RN #2 went to the resident's room, the resident was not wearing any TED hose. RN #2 inquired about the TED hose and the Resident stated, "I never got them". RN #2 then checked all drawers in the resident's room to ensure they were not stored somewhere, there were no TED hose found. The RN and this surveyor then left the resident's room. RN #2 was asked if TED hose were available in the building, she stated, "Yes". RN #2 then went into the medical supply room. Stored inside the supply room on a shelf with a plastic bin containing multiple TED hose stockings of various sizes. RN #2 grabbed a pair of TED hose and a disposable paper measuring tape to measure the resident's calf and leg to ensure for proper size. The RN then went to the resident's room.

On 6/28/17 the above findings was shared with the Director of Nursing, the Assistant Director of Nursing and the Corporate Nurse.

The facility staff failed to follow the Physician's Plan of Care for the application of TED stockings and inaccurately documented from 6/1/17 through 6/28/17 in the TAR that the TED hose were in use.

1. Edema-A local or generalized condition in

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