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	495105	A. BUILDING _____ B. WING _____	C 08/02/2018

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LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/31/18 through 8/2/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/31/18 through 08/02/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 162 at the time of the survey. The survey sample consisted of 32 current Resident reviews and four closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		8/29/18

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

Electronically Signed | 08/10/2018

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview and clinical record review, the facility staff failed to ensure one of 36 resident in the survey sample, was treated with dignity and respect (Resident # 109). The facility staff failed to provide timely call bell response and toileting for Resident # 109, as a result Resident # 109 became incontinent of stool and was not provided assistance with toileting. Findings include: Resident # 109 was admitted to the facility on	F 550	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain incompliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.	

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F 550	Continued From page 2 06/23/18. Diagnoses for Resident # 109 included, but were not limited to: right hip fracture with surgical repair, diabetes mellitus, barretts esophagus without dysplasia, muscle weakness, and congestive heart failure. The most current, full MDS (minimum data set) with CAAS (care area assessment summary) was a five day assessment dated 06/29/18. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision makings skills. The resident was additionally assessed on this MDS as requiring extensive assistance with two people for transfers and supervision with one person assist for toileting and eating. The resident's CAAS section triggered for ADL's (activities of daily living), urinary, and pressure. A 14 day MDS assessment, dated 07/06/18 was reviewed for comparison and documented, the resident required limited assistance with one person physical assistance for ambulation, toileting and hygiene. The most current MDS was a 30 day assessment dated 7/20/18, which documented, the resident had a cognitive score of 15, indicating the resident is cognitively intact for daily decision making skills. The resident was also assessed as limited assistance with assistance of one person for bed mobility, locomotion on unit, dressing, toilet use, and personal hygiene. The resident was assessed for supervision with one person assist for walking in room. Resident uses a walker/w/c (wheelchair) for mobility. The resident was coded as occasionally incontinent for bladder and always incontinent of stool on this MDS.	F 550	F550 1. Call bell was answered within five minutes and needs were met for R109 while surveyors were onsite. 2. Residents who use the call bell are at risk. 3. Staff development coordinator or designee will educate nursing staff on answering call bells within 5 minutes and needs are met at that time. 4. Unit manager or designee will randomly audit call bell times to ensure call bells are answered within five minutes and needs are met at that time. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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On 08/01/18 at 10:01 AM, Resident # 109 was interviewed regarding call bell response and toileting assistance. The resident stated, "It takes time for them to get to you, when calling to go to the bathroom." The resident stated that it has been going on from the beginning, when she first came into the facility. The resident stated that she didn't think that it should take over 10-15 minutes, but there are times it takes longer. The resident was asked what had been the longest time to wait for assistance and the resident stated, 'The longest has been over 15 minutes." The resident then stated, that she can now get up and go to the bathroom on her own, and that all of that is behind her now. The resident then stated that sometime this past week she had an accident with stool in my brief, no one came to help her and she had to go, she "just couldn't hold it." The resident stated that she had a barium swallow, which required her to drink "that chalky stuff" and the resident stated that really messed up her stomach. The resident stated that the night she had an accident in her brief, she put on her light and no one came, the resident stated that it was around 2 or 3 in the morning and she ended up having to get up by herself and go to the bathroom and clean herself up. The residents stated, "I was a mess." The resident stated that when staff finally did come, she told them what happened and that she cleaned her self up and the staff member told her, "well it's good you can do it," the resident stated that she was guessing the staff member meant it was good she could clean herself up.

A nursing note dated 07/02/18 (timed 3:48 p.m.) documented, "...spoke with...daughter, concerns about dressing changes...Call bell time, advised

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F 550	Continued From page 4 that is addressed all concerns [sic] with nursing staff and that dressing will be changed daily as ordered..." A nursing note dated 07/03/18 (timed 8:32 a.m.) documented, "...spoke with...daughter, reassured that call bell being answered in a timely manner and that right hip dressing is being changed daily..." The resident's CCP (comprehensive care plan) documented, "...keep skin clean and dry...pericare with incontinent episodes...TOILET USE: Resident requires assistance...TRANSFER: Resident requires assistance...encourage resident to use call bell for assistance...[all above created on 06/23/18]...Resident has incontinence related to impaired mobility...monitor/document/report...any possible causes of incontinence...[created on 07/10/18]..." A nursing note dated 07/03/18 documented, "...patient continent of bowel and bladder..." The DON (director of nursing) and administrator were made aware in a meeting with the survey team on 08/02/18 at 12:15 p.m.. No comments were made regarding the above information. No further information and/or documentation was presented prior to the exit conference on 08/02/18 at 2:00 p.m. to evidence that Resident # 109's call bell was answered timely and/or that the resident was toileted in a timely manner to prevent incontinence episodes.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		8/29/18

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F 561	Continued From page 5 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to ensure opportunity to exercise personal preferences for one of 23 residents in the survey sample, Resident #27. Resident #27 was not afforded the opportunity to go outside when requested.	F 561	F561 1. R27 was provided opportunity for outside activity while surveyors were onsite, resident declined. 2. Current residents are at risk. 3. Staff development coordinator or designee will educate activities department on honoring personal	

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F 561	Continued From page 6 The findings Include: Resident #27 was admitted to the facility on 6/2/15 with a readmission on 9/14/17. Diagnoses for Resident #27 included: Malignant neoplasm of prostate, diabetes, major depression. Resident #27 was currently on hospice because of prostate cancer. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/6/18. Resident #27 was assessed with a cognitive score of 10, indicating moderate cognitive impairment. On 07/31/18 at 11:51 AM, Resident #27 was interviewed. When asked about choices, Resident #27 verbalized that he would like to go outside, but staff will not take him when he asks. Review of Resident #27's comprehensive activities assessment dated 2/14/18, documented: "How important is it for you to go outside to get fresh air when the weather is good." Resident #27 answered "Very important." This was also documented on a comprehensive MDS under section "F" with an ARD date of 2/14/18. On 8/1/18 the activities director (other staff, OS #5) was asked for documentation to evidence that Resident #27 was being afforded the opportunity to go outside. On 08/01/18 at 4:53 PM, OS #5 provided documentation of Resident #27's activities and verbalized that activities were reviewed for a time period of March through July 2017 and indicate	F 561	preferences for activities. 4. Activities director or designee will audit two residents activities assessment and verify with resident that activity preferences noted are being honored. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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F 561	Continued From page 7 Resident #27 did not go outside or was offered to go outside and refused. OS #5 verbalized that she did ask Resident if he wanted to go outside today (after being brought to her attention) but Resident #27 refused at this time because his brother was visiting. OS #5 verbalized that she would make a plan to ensure resident is offered to go outside. Review of Resident #27's progress notes from March through July 2018 were also reviewed and did not evidence that Resident #27 was offered to go outside. On 08/02/18 at 12:34 PM, the above information was presented to the DON (director of nursing) and administrator, the DON verbalized that the facility has reached out to hospice volunteers to help engage Resident #27 to go outside. No other information was provided prior to exit conference on 8/2/18.	F 561		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		8/29/18

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F 657	Continued From page 8 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for three of 36 residents in the survey sample, Resident # 109, # 134 and # 46. 1. The facility staff failed to reassess the effectiveness of interventions and review and revise the CCP to meet the needs of Resident # 109; Resident # 109 was being weighed weekly, but did not get weighed for the two weeks, the resident lost additional weight during this time and was not happy with her diet/food choices. 2. The facility staff failed to reassess the effectiveness of interventions and review and revise the CCP to meet the needs of Resident # 134. Resident # 134 lost 13 lbs (pounds) on just over two months time. 3. Resident #46 was NPO (nothing by mouth) with continuous tube feeding. Her CCP was not updated to reflect that area of care.	F 657	F657 1. Careplans were updated related to weight loss interventions accordingly for R109, R134, and R46 while surveyors were onsite. 2. Current residents with weight loss are at risk. 3. Staff development coordinator or designee will educate the licensed nursing staff and registered dietician on updating careplans appropriately with weight loss interventions. 4. Registered dietician or designee will audit residents with weight loss to ensure careplans are updated to include interventions for weight loss. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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F 657	Continued From page 9	F 657		

Findings include:

1. Resident # 109 was admitted to the facility on 06/23/18. Diagnoses for Resident # 109 included, but were not limited to: right hip fracture with surgical repair, diabetes mellitus, barretts esophagus without dysplasia, muscle weakness, and congestive heart failure.

The most current, full MDS (minimum data set) with CAAS (care area assessment summary) was a five day assessment dated 06/29/18. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision makings skills. The resident was additionally assessed on this MDS as requiring extensive assistance with two people for transfers and supervision with one person assist for toileting and eating. The resident's CAAS section triggered for, but not limited to: ADL's (activities of daily living) and nutrition.

A 30 day MDS assessment, dated 07/20/18 was reviewed for comparison and documented, the resident required supervision with setup only for meals.

On 08/01/18 at 10:31 AM, Resident # 109 was interviewed regarding the food. The resident stated that she has lost weight, (she didn't know how much) and that staff were serving her pureed food. The resident stated that she had a test that indicated her esophagus was sluggish, but stated she can eat regular food and that she does not like the pureed food at all. The resident stated that she has complained about it on a number of occasions and that staff have not got back to her on what the plan is or when she can eat regular

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food. The resident stated that it (the food) looks and smells like cat food. The resident again stated that staff have not got back with her to let her know anything and the meals "just aren't good," everything is pureed and she hasn't had a regular meal since she has been here. The resident stated that she can eat regular texture, even though she has had some issues with some foods, but she knows what they are and gave corn as an example.

Clinical record review revealed that the resident had a cookie swallow test at the hospital prior to admission and again on 07/11/18. The resident then had a barium swallow test on 07/26/18.

Resident # 109's physician's orders were reviewed and documented the resident had an order for a heart healthy diabetic diet level 4 pureed texture with regular liquids (06/23/18) and an order for med plus 2.0 120 ml (milliliters) after meals and to document consumption.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...nutrition risk related to recent hospitalization/new admission...avoid significant weight change...weekly weights...RD (registered dietitian) to evaluate and make change recommendations PRN [as needed]..."

The resident's dietary/RD notes were then reviewed. A note dated 06/28/18 documented, "...65" 162.1 # (pounds)...met with pt (patient) who was able to answer all questions. Appetite is 'very poor' because of pureed texture..."

A weight warning note dated 07/19/18 documented, "...met with pt regarding weight loss.

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Pt stated that she continues to hate the pureed diet but has and appointment today and fully expects that her diet will be advanced. Pt agreed to med plus three times a day after meals...weekly weights and routine monitoring..."

A note dated 07/31/18 documented, "...met with pt regarding diet dissatisfaction. Diet not advanced following appointment last week...Pt continues to eat poorly and have poor tolerance to mech [mechanical soft] altered diet because she is tired of it and is angry about the lack of progress towards diet advancement."

A nursing note dated 07/23/18 at 3:33 p.m. documented "Gastro called and made an appointment for follow up for resident 08/02/18 at 9:00 a.m. to discuss the results of the barium swallow. Resident is to planned for discharge home on 8/7/18."

On 08/01/18 at approximately 4:40 p.m., the resident was in her room with her daughter. The resident was asked if she had a follow up appointment tomorrow (08/01/18). The resident and daughter both stated that they were unaware of any follow up appointment. The resident stated they (the facility) don't tell me this stuff and stated that she would like to know these things in advance. The resident was asked if she had been on any other diet and the resident stated that she had only been on the puree diet since she has been here on 06/23/18.

At approximately 4:45 p.m. the unit manager was interviewed and stated that the resident did not have an appointment tomorrow for anything. The nurse was asked to look at the residents nursing notes. The unit manger stated, "yes, she does

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have an appointment tomorrow, that's the first I knew of that." The unit manager then went to the resident and informed her of the follow up appointment scheduled for the next morning.

On 08/02/18 at 07:45 AM, Resident # 109 observed in her room sitting in her wheelchair, dressed for the follow up appointment with gastroenterology. The resident stated that she had not had breakfast yet and the CNA (certified nursing assistant) stated that the resident should have had an early breakfast scheduled.

On 8/02/18 at 07:50 AM, the unit manager was informed that this resident had not been weighed for the last two weeks (per documentation) and was informed that the resident had been being weighed every week. The unit manager stated she did not know why the resident was not weighed and stated, "we can get a weight on the resident." The resident was then weighed. The resident weighed 152.3 pounds, for a total weight loss of 9.8 pounds(6.05%) from 06/23/18 to 08/02/18.

At approximately 8:20 a.m., the DON (director of nursing) was asked how often residents are weighed, and informed the DON that this resident had been weighed weekly, but has not been weighed for the last two weeks. The DON stated that skilled resident's are weighed weekly. Resident # 109 is a skilled resident.

The DON was asked to see the RD to discuss this resident.

On 08/02/18 at 10:15 AM, the RD was interviewed regarding this resident's weight loss. The RD stated that the resident was on a diuretic

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(lasix 40 mg on Monday, Wednesday, and Friday) and that the resident is not happy with the puree meals. The RD was made aware that the resident had not been weighed for the last two weeks and had lost an additional two pounds. The RD was made aware that the resident was documented as being fairly consistent in consuming the med plus most of the time at 100%. The RD was made aware of the concerns regarding the lack of interventions for this resident, after the resident voiced on multiple occasions that she was dissatisfied with the puree meals and the resident was not weighed for two weeks. The RD did not have any other comments.

No further information and/or documentation was presented prior to the exit conference at 2:00 p.m. on 08/02/18 to evidence that the resident's interventions were reassessed for effectiveness and/or reviewed and revised to incorporate new interventions.

2. Resident # 134 was admitted to the facility on 05/21/18. Diagnoses for Resident # 134 included, but were not limited to: fracture of the pelvis, history of falls, high blood pressure, osteoporosis, chronic kidney disease, anemia, vitamin D deficiency, and PVD (peripheral vascular disease).

The most current, full MDS with CAAS (care area assessment summary) was a 5 day admission dated 05/28/18. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills. The resident was also coded as requiring supervision with setup only for meal consumption. The resident triggered in the CAAS section of this

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MDS for ADL's (activities of daily living), nutrition and dental.

On 07/31/18 at 4:19 PM, Resident # 134 was interviewed. The resident stated that she has a healthy appetite and probably eats too much, but enjoyed eating and sometimes get full fast. The resident was asked if she had lost any weight and the resident stated that she didn't think so.

On 08/01/18 at 08:00 AM, Resident # 134 was laying in bed, covered with lights off. No breakfast trays were on the unit at this time.

On 08/01/18 at 08:42 AM, Resident # 134 was sitting up in bed with her bedside table over the bed, with the resident's meal tray set up. The resident had scrambled eggs, cream of wheat, a banana and coffee. The resident was asked how she was doing this morning. The resident stated, "I need some sugar," which was located behind the resident's tray, out of her sight. The resident was given the sweetener packet, the resident opened it and poured it into the cream of wheat. The resident then stated, "The main thing I need is my teeth." The resident was asked where her teeth were and the resident stated, that she didn't know. The resident looked around and the dentures were on the kitchen sink in a closed denture holder.

This surveyor went to the hall and asked CNA (certified nurses' assistant) # 14 for assistance. The CNA stated that this was not her resident today and didn't know why the CNA assigned would not have given the resident her teeth, but did not mind to get the resident's dentures for her. The CNA cleaned the resident's dentures and gave them to the resident. The resident put them

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in her mouth and ate her 100% breakfast.

CNA # 14 was asked to find the resident's assigned CNA. CNA # 10 came to this surveyor and stated that she was the resident's CNA. The CNA was asked if she had set the resident up for breakfast this morning and the CNA responded, yes. The CNA was asked why the resident didn't have her dentures in and the CNA responded that she (the CNA) thought that the resident already had them in and that she (the resident) usually has her teeth in when I go in, and "that was my honest mistake."

The resident's physician's orders were reviewed and documented, an order for a heart healthy diet Level 7-Regular texture, regular liquids on 05/22/18. The resident also had an order for med plus 2.0 after meals for supplement 120 ml document consumption (06/05/18).

The resident's CCP documented, "...nutrition risk related to hospitalization/new admission...provide and serve diet as ordered, monitor intake and record every meal...provide and serve supplements as ordered, Med Plus...RD (registered dietitian) to evaluate and make diet change recommendations PRN...weekly weights..."

A dietary/RD noted dated 06/05/18 documented, "...med plus TID (three time a day) after meals...history of weighing 161...subsequent gradual weight loss, pt (patient) consuming 50-100% of meals. Goal is to arrest wt loss...med plus initiated per daughter's request...signature of RD."

An RD note dated 06/12/18 documented,

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"Daughter came to RD office yesterday and agreed to paper menus which she completed w (with)/her mother's input. Goal is to maximize satisfaction and intake...signature of RD."

A weight warning note dated 07/03/18 documented, "...143.4...completes paper menus w/daughter to maximize satisfaction and intake. Med plus TID ongoing...met with pt who stated appetite "couldn't be better"...observed finishing 100 % of her lunch...per pt glad about weight loss...no changes at this time..."

A weight warning note dated 07/19/18 documented, "...139.9...making her own menu choices with assistance at times...Med plus TID...met with pt who stated she "feels full" after each meal. Regarding wt (weight) loss pt stated "that's fine"...doesn't bother her...will continue to monitor for intake adequacy...signature of RD."

On 08/02/18 at 8:20 AM, the DON (director of nursing) was asked how often are resident's weighed, and informed the DON that this resident has been weighed weekly, but has not been weight for the last two weeks. The DON stated that skilled resident's are weighed weekly.

On 08/02/18 at 8:58 AM, Resident # 134 was observed eating breakfast in her room, sitting up in her wheelcahir. The resident had eaten all of her egg with ketchup, and had a small bowl of oatmeal with butter and raisins that she was getting ready to eat. The bowl of oatmeal was approximately 4 ounces. The resident stated that she was enjoying her lunch, but really would like some milk. The resident stated that she had already called for it twice. The unit manger then entered the room and was informed of the milk,

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by the resident and this surveyor. The unit manger stated that she would get the resident some milk. The unit manager returned with one carton of whole milk and assisted the resident with pouring some milk on the oatmeal. The resident stated that she would drink the rest. The resident stated that she didn't know why they (staff) didn't bring her more milk that she really liked milk. The resident's meal ticket was observed. The meal ticket had oatmeal checked, butter checked, coffee-decaf, one scrambled egg, and ketchup. There was a milk selection for 2% or whole milk, neither were marked.

The unit manager was made aware that the resident did not have weights for the last two weeks and had been getting weighed weekly and has had weight loss, the unit manager stated that they (staff) would get the resident's weight after she finished eating. The resident was asked if it was ok for her to be weighed after she eats and the resident stated, "Yes, I don't mind."

On 08/02/18 at 09:15 AM, CNA # 14 took the resident down to be weighed. The CNA stated, we weighed the wheelchair and it weighs 41.6 lbs. The CNA rolled Resident # 134 up onto the scale in the wheelchair. The resident stated, "now you all have to do some math." The weight total weight was 184.2 pounds. The resident's weight was 142.6 pounds after the wheelchair weight deduction. The resident had a total weight loss of 13.0 lbs (8.35%) since 05/21/18 (less than 10 weeks).

On 08/02/18 at 10:15 AM, the RD was interviewed regarding this resident's weight loss, and the fact the resident had been being weighed weekly and had not been weighed for two weeks.

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The RD was made aware that the resident had weight loss and no other interventions have been implemented. The RD stated that another intervention was implemented (not on the resident's care plan) that the resident's daughter was helping with the menu choices. The RD was then showed the meal slip for breakfast on 08/02/18 and was informed that the resident did not get milk this morning and the RD stated, she fills out her own meals slips maybe she needs help. The RD then stated, Oh no, her daughter helps with her with the meal slips." The RD was made aware that the resident stated that she liked milk and voiced that she did not understand why the facility staff were not giving her more milk. The RD made no further comments.

No further information and/or documentation was presented prior to the exit conference on 08/02/18 at 2:00 p.m. to evidence that Resident # 134's interventions were reassessed for effectiveness or reviewed and revised to include additional interventions for Resident # 134.
3. Resident #46 was originally admitted to the facility on 11/15/17 and readmitted on 07/15/18 with diagnoses including, but not limited to: CVA (cerebrovascular accident), Aphasia, Dementia, Diabetes, Seizures, Pneumonia and Gastrostomy Tube (feeding tube).

The most recent MDS (minimum data sheet) was a quarterly assessment with an ARD (assessment reference date) of 05/23/18. Resident #46 was assessed as severely impaired in her short and long term memory and moderately impaired in her daily decision making skills.

Resident #46's clinical record was reviewed on

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08/01/18 at approximately 10:00 a.m. During the record review this resident's CCP was noted to include the following interventions.

Under the focus area of Diabetes, "Created on : 11/15/2017, Revision on: 07/15/2018, ...Discuss meal times, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen."

Under the focus area of Dysphagia, "Created On: 12/19/2017, Revision on: 07/15/2018, ...Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 200 cc [cubic centimeters] aspirate."

Under the focus area of GERD, "Created on: 11/15/17, Revision on: 07/15/18, Avoid activities that involve bending, lifting. Avoid overeating. Provide small frequent meals rather than 3 large ones. Encourage the resident to take their time eating. Alternate food with sips of fluids. Dietary: Avoid foods or beverages that tend to irritate esophageal lining..."

Review of the current physician order sheet, dated 07/01/18-07/31/18 included, "NPO diet, ...Enteral Feed Order every shift Vital AF 1.2 55ml/hr [milliliters per hour]..."

The DON (director of nursing) and Corporate Nurse #5 were interviewed on 08/02/18 at 11:25 a.m. regarding care plan updates. Corporate Nurse #5 stated, "Nursing updates the care plans. MDS updates them also with their MDS assessments. Any nurse can update the care plan at any time." The DON concurred with Corporate Nurse #5. Both agreed Resident #46's

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F 657	Continued From page 20 care plan was not individualized to her specific needs and level of care. No further information was received by the survey team prior to the exit conference on 08/02/18.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow professional standards of care for two of 36 residents in the survey sample. 1. Nurses held insulin administration for Resident #15 without a clinical rationale and without prior notification or order to/from the physician. 2. A nurse failed to clarify medication orders prior to administration during a medication pass observation with Resident #51. The medication administration information on the medication card did not match the physician orders in the electronic medical record. The findings include: 1. Resident #15 was admitted to the facility on 4/9/18 with a re-admission on 7/20/18. Diagnoses for Resident #15 included diabetes, seizures, high blood pressure, cerebral infarction, irritable bowel syndrome, gastroesophageal reflux	F 658	F658 1. MD was notified of insulin being held on R15 while surveyors were onsite with no new orders. MD was notified that nurse pulled Depakote 500mg out of evening card versus morning card while surveyors were onsite with no new orders. 2. Current residents who are prescribed insulin and Depakote are at risk. 3. Staff development coordinator or designee will educate licensed nursing staff on obtaining orders for holding insulin per MD and only pulling medications from cards that match the electronic medical record. 4. Unit manager or designee will audit two residents per unit with insulin orders to ensure insulin was given as ordered, as evidenced by being signed off on the MAR, weekly for four weeks. Unit manager or designee will audit med pass for one resident a week to ensure Depakote is pulled from accurate card	8/29/18

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F 658	Continued From page 21 disease, dysphagia and hyperlipidemia. The minimum data set (MDS) dated 4/25/18 assessed Resident #15 with severely impaired cognitive skills. Resident #15's clinical record documented a physician's order dated 5/1/18 for NPH insulin, 10 units to be administered every 12 hours for treatment of diabetes. The resident's medication administration record (MAR) for July 2018 documented NPH insulin was not administered on 7/28/18 at 9:00 a.m. and on 7/29/18 at 9:00 a.m. and 9:00 p.m. A nursing note dated 7/28/18 at 9:03 a.m. documented the resident's blood sugar was 77. A note dated 7/29/18 at 9:03 a.m. stated, "...blood sugar...96." A nursing note dated 7/29/18 at 8:52 p.m. documented, "Orders -Administration Note...none available at this time." The clinical record documented no clinical rationale for why the NPH insulin was not administered on 7/28/18 and 7/29/18. There was no notification to the physician regarding the held insulin or the unavailable insulin on 7/29/18 at 9:00 p.m. There was no documented assessment of the resident other than the listed blood sugar readings. The clinical record documented a physician's order dated 7/3/18 to check the resident's blood sugar as needed and notify the physician for readings less than 60 or greater than 400. The clinical record documented no physician ordered parameters for holding the scheduled insulin. Resident #15's plan of care (revised 7/30/18) documented the resident had diabetes.	F 658	matching the electronic medical record weekly. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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Interventions to prevent diabetic complications included, "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness."

On 8/1/18 at 2:43 p.m., the registered nurse unit manager (RN #1) was interviewed about Resident #15's insulin not administered as ordered. RN #1 stated there were no ordered parameters to hold the insulin. RN #1 stated the protocol was to notify the physician of blood sugar readings below 60 or above 400. RN #1 stated Resident #15 was ordered scheduled insulin doses and doses were not adjusted based on blood sugar readings (sliding scale).

On 8/2/18 at 7:48 a.m., RN #1 was interviewed again about any further information regarding the missed insulin for Resident #15. RN #1 stated she did not know why the insulin was not given as ordered. RN #1 stated if not given, there should have been an assessment and notification to the physician. Regarding the insulin not available on 7/29/18 at 9:00 p.m., RN #1 stated the medication was not re-ordered in time.

On 8/2/18 at 12:08 p.m., the director of nursing (DON) was interviewed about nurses holding Resident #15's insulin without an order or rationale. The DON stated there were no physician orders to hold the resident's insulin. The DON stated if nurses did not give a scheduled medication they were supposed to let the physician know the reasons for holding the medicine and get an order for the hold. The DON stated nurses should have documented an assessment indicating the need to hold the medication and a physician's order. The DON stated there were no ordered parameters for

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holding Resident #15's insulin.

The Nursing 2017 Drug Handbook on page 783 describes NPH insulin as an intermediate-acting antidiabetic used for management of type 1 and type 2 diabetes. Page 785 of this reference includes in nursing considerations, "Assess patient for signs and symptoms of hypoglycemia (seizures, sweating, shaking, trembling, confusion) and hyperglycemia (drowsiness, fruity breath odor, frequent urination, thirst). Notify prescriber if any of these signs or symptoms occur." (1)

The Lippincott Manual of Nursing Practice 10th edition on page 16 states, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reason for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." (2)

The Lippincott Manual of Nursing Practice 10th edition on pages 16 and 17 states regarding professional standards of care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered...Failure to administer medications properly and in a timely fashion or to report and administer omitted doses

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appropriately..." (2)

These findings were reviewed with the administrator and director of nursing during a meeting on 8/2/18 at 12:30 p.m.

(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.

(2) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.
2. A medication pass and pour observation was conducted on 08/01/2018 beginning at approximately 8:00 a.m. LPN (licensed practical nurse) #1 was observed preparing medications for Resident #51.

Resident # 51 was admitted to the facility on 07/01/2016. His diagnoses included but were not limited to: Unspecified psychosis not due to substance or known psychological condition, benign prostate hyperplasia, unspecified mood disorder, bipolar disorder, convulsions (seizures), pulmonary hypertension and alcohol induced persisting dementia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/30/2018. Resident # 51 was assessed with a cognitive summary score of "04", indicating severe impairment in his cognitive status.

During the preparation of medications for Resident #51, the medication card for Divalproex Sodium (Depakote), was pulled by LPN #1. Directions on the card were listed as: "Divalproex

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F 658	Continued From page 25	F 658		

Sodium 500 mg 2 tabs [tablet] PO [by mouth] in the evening dose to equal 1250 mg". LPN #1 removed one tablet and placed it in the medication cup. The rest of the morning medications were prepared and administered to Resident #51. After the administration of the medications, LPN #1 was asked about the dosage and instructions for the Divalproex. She looked at the card and pointed to the computer screen and stated, "The order on here [the computer] is for one 500 mg tablet in the morning." LPN #1 was asked how she knew which was correct, the information on the medication card or the computer. She stated, "I know that he gets 500 mg in the morning, that's the order on the computer, I go by that, and I've given him meds before." LPN #1 was asked if there was normally a medication card with the instructions for the morning dose. She stated, "I don't know I think we use the same card and just go by what the computer says." She pulled up a different screen on the computer and stated, "Yes, he has a separate card for the mornings...it looks like it was reordered on the 28th [07/28/2018]...I don't know why it isn't here."

On 08/01/18 at approximately 11:00 a.m. the pharmacist came to the conference room to speak with the survey team. He was asked how long it took a medication to arrive from the pharmacy after being ordered. He stated that usually the medications arrive that evening or the next day, depending on when it was ordered and the medication. The medication pass was discussed with him. He stated, "The resident's insurance may have kicked back the refill for the morning dose...they'll only approve so many of the same dosage of medications." He was asked what the nurse's should do if the medication card

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F 658	Continued From page 26 didn't match the dosage on the computer and the refill wasn't here. He stated, "They have a sticker that says "See MAR [medication administration record]. They put that over the instructions and they know to look at the orders...they should be on every cart." The DON (director of nursing) was interviewed at approximately 12:15 p.m., regarding the medication pass and pour observation and the conversation with the pharmacist. She stated, "They should check to make sure the computer is right and then use the stickers on the cards." At approximately 1:20 p.m. LPN #1 was interviewed regarding the stickers described by the pharmacist. She pulled the Divalproex medication card from the drawer and stated, "We put this sticker on it." The card was observed with a sticker, "Directions changed refer to chart" over the previous dosage instructions. The letters "AM" were handwritten on the card. She stated, "This is the card we are going to use for the morning dose now." She was asked if the stickers had been in her cart. She stated, "No...I got them from another nurse's cart." The above information was discussed during meeting with the DON and the administrator on 08/01/2018 at approximately 5:00 p.m. No further information was obtained prior to the exit conference on 08/02/2018.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		8/29/18

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F 684	Continued From page 27 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview and clinical record review, the facility staff failed to follow physician's orders for one of 36 residents in the survey sample, Resident 109. The facility staff failed to follow physician's orders for Resident # 109 regarding daily dressing changes to a surgical wound of the hip. Findings include: Resident # 109 was admitted to the facility on 06/23/18. Diagnoses for Resident # 109 included, but were not limited to: right hit fracture with surgical repair, diabetes mellitus, barretts esophagus without dysplasia, muscle weakness, and congestive heart failure. The most current, full MDS (minimum data set) with CAAS (care area assessment summary) was a five day assessment dated 06/29/18. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision makings skills. The resident was additionally assessed on this MDS as requiring extensive assistance with two people for transfers and supervision with one person assist for toileting and eating. The resident's CAAS section triggered for ADL's (activities of daily living), urinary, and pressure.	F 684	F684 1. Surgical site For R109 had been healed on a previous date when surveyors were onsite. 2. Current residents with surgical sites are at risk. 3. Staff development coordinator or designee will educate licensed nursing staff on changing surgical dressings per physician order. 4. Unit manager or designee will audit two electronic treatment records for residents with surgical incisions to ensure dressings are being changed per physician order, as evidenced by being initialed off in the electronic treatment record. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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Resident # 109 was interviewed on 08/01/18 at approximately 8:00 a.m., the resident stated that when she came into the facility, staff were not checking and/or assessing her surgical wound. The resident stated that when she came to the facility there was a dressing on her hip incision and that the staff "were not even looking at it." The resident stated that her daughter had concerns regarding the dressing being changed and was worried about infection.

The resident's clinical record was reviewed and nursing notes revealed that on 06/25/18, "... daughter in the room visiting and concerned about the dressing to right hip and how saturated it was...nurse explained to daughter that we had orders not to remove the dressing...nurse called ...spoke with the on call MD [medical doctor]...explained situation...MD gave orders to send to ER to evaluate the surgical incision..."

A nursing note dated 06/26/18 documented, "...dry dressing to right hip not to be removed by nursing staff, MD only per MD orders...."

A nursing note dated 06/27/18 (timed 2:30 p.m.) documented, "...return call to [name of doctor] for new orders for right hip surgical incision site. Dressing change daily-cleanse with hibiclens, apply dry gauze and tape..."

A nursing note dated 06/27/18 (timed 6:47 p.m.) documented, "...dry dressing to right hip not to be removed by nursing staff, MD only...."

A nursing note dated 06/28/18 (timed 2:42 a.m.) documented, "...dry dressing to right hip not to be removed by nursing staff, MD only...."

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A nursing note dated 06/29/18 (timed 2:45 a.m.) documented, "...dry dressing to right hip not to be removed by nursing staff, MD only...."

A nursing note dated 06/29/18 (timed 6:59 p.m.) documented, "...dressing to right hip changed on 7-3 shift...."

A nursing note dated 06/30/18 (timed 2:46 a.m.) documented, "...dry dressing to right hip not to be removed by nursing staff, MD only...."

A nursing note dated 07/01/18 (timed 2:46 a.m.) documented, "...dry dressing to right hip not to be removed by nursing staff, MD only...."

A nursing note dated 07/02/18 (timed 2:47 a.m.) documented, "...dry dressing to right hip not to be removed by nursing staff, MD only...."

A nursing note dated 07/02/18 (timed 3:48 p.m.) documented, "...spoke with...daughter, concerns about dressing changes and infection to right hip. Call bell time, advised that is addressed all concerns with nursing staff and that dressing will be changed daily as ordered..."

A nursing note dated 07/03/18 (timed 2:47 a.m.) documented, "...dry dressing to right hip not to be removed by nursing staff, MD only...."

A nursing note dated 07/03/18 (timed 8:32 a.m.) documented, "...spoke with...daughter, reassured that call bell being answered in a timely manner and that right hip dressing is being changed daily by this writer as ordered..."

The resident's physician's orders were reviewed

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F 684	Continued From page 30 and documented, "...Dressing to right hip surgical incision to be changed daily-cleanse with hibiclens, apply dry gauze and tape...06/27/18 [order date/start date]..." The resident's MARs/TARs (medication administration records/treatment administration records) were reviewed for June and July 2018. The TARs documented that the order for the dressing change was not put on the TAR until June 29. The TAR revealed a start date for the dressing change to begin on June 30th. The dressing was not changed on June 30th, July 1st, 2nd, 3rd, 4th, and July 10th. The resident's CCP (comprehensive care plan) documented, "...keep skin clean and dry...monitor/documented/report PRN [as needed] any s/sx [signs/symptoms] of hip fracture complications...infection at surgical site...[created on 06/23/18]..." The DON (director of nursing) and administrator were made aware in a meeting with the survey team on 08/02/18 at 12:15 p.m., the DON stated that she did not know about the above information. No further information and/or documentation was presented prior to the exit conference on 08/02/18 at 2:00 p.m.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		8/29/18

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F 692	Continued From page 31 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to maintain nutritional parameters for two of 36 resident in the survey sample, Resident # 109 and # 134. 1. Resident # 109 experienced a 9.8 lb (pound), 6.05 %, unintentional weight loss in approximately one month (from 06/23/18 to 08/02/18). The resident continued to recieved a pureed diet even though she did not like or want pureed food. The resident was not weighed for 2 weeks during which time she lost additional weight without any additional nutrition interventions or changes to her diet. 2. Resident # 134 experienced a 13.0 lb, 8.35 %, unintentional weight loss in approximately 2 months (from 05/21/18 to 08/02/18). The resident continued to lose weight during the first 3	F 692	F692 1. R109 and R134 were weighed while surveyors were onsite. 2. Current residents with weekly weight orders are at risk. 3. Staff development coordinator or designee will educate nursing staff on the importance of obtaining weekly weights. 4. Unit manager or designee will ensure weekly weights are obtained and documented in the electronic medical record. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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weeks of July with no new nutrition interventions to prevent further weight loss. She was not weighed for the last week in July or first week in August until requested by the surveyor.

Findings include:

1. Resident # 109 was admitted to the facility on 06/23/18. Diagnoses for Resident # 109 included, but were not limited to: right hip fracture with surgical repair, diabetes mellitus, barretts esophagus without dysplasia, muscle weakness, and congestive heart failure.

The most current, full MDS (minimum data set) with CAAS (care area assessment summary) was a five day assessment dated 06/29/18. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision makings skills. The resident was additionally assessed on this MDS as requiring extensive assistance with two people for transfers and supervision with one person assist for toileting and eating. The resident's CAAS section triggered for, but not limited to: ADL's (activities of daily living) and nutrition.

A 30 day MDS assessment, dated 07/20/18 was reviewed for comparison and documented, the resident required supervision with setup only for meals.

On 08/01/18 at 10:31 AM, Resident # 109 was interviewed regarding the food. The resident stated that she has lost weight, (she didn't know how much) and that staff were serving her pureed food. The resident stated that she had a test that indicated her esophagus was sluggish, but stated she can eat regular food and that she does not

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like the pureed food at all. The resident stated that she has complained about it on a number of occasions and that staff have not got back to her on what the plan is or when she can eat regular food. The resident stated that it (the food) looks and smells like cat food. The resident again stated that staff have not gotten back with her to let her know anything and the meals "just aren't good," everything is pureed and she hasn't had a regular meal since she has been here. The resident stated that she can eat regular texture, even though she has had some issues with some foods, but she knows what they are and gave corn as an example.

Clinical record review revealed that the resident had a cookie swallow test at the hospital prior to admission and again on 07/11/18. The resident then had a barium swallow test on 07/26/18.

Resident # 109's physician's orders were reviewed and documented the resident had an order for a heart healthy diabetic diet level 4 pureed texture with regular liquids (06/23/18) and an order for med plus 2.0 120 ml (milliliters) after meals and document consumption.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...nutrition risk related to recent hospitalization/new admission...avoid significant weight change...weekly weights...RD (registered dietitian) to evaluate and make change recommendations PRN [as needed]..."

The resident's dietary/RD notes were then reviewed. A note dated 06/28/18 documented, "...65" 162.1# (pounds)...met with pt (patient) who was able to answer all questions. Appetite is

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'very poor' because of pureed texture..."

A weight warning note dated 07/19/18 documented, "...met with pt regarding weight loss. Pt stated that she continues to hate the pureed diet but has an appointment today and fully expects that her diet will be advanced. Pt agreed to med plus three times a day after meals...weekly weights and routine monitoring..."

A note dated 07/31/18 documented, "...met with pt regarding diet dissatisfaction. Diet not advanced following appointment last week...Pt continues to eat poorly and have poor tolerance to mech [mechanical soft] altered diet because she is tired of it and is angry about the lack of progress towards diet advancement."

A nursing note dated 07/23/18 at 3:33 p.m. documented "Gastro called and made an appointment for follow up for resident 08/02/18 at 9:00 a.m. to discuss the results of the barium swallow. Resident is to planned for discharge home on 8/7/18."

On 08/01/18 at approximately 4:40 p.m., the resident was in her room with her daughter. The resident was asked if she had a follow up appointment tomorrow (08/01/18). The resident and daughter both stated that they were unaware of any follow up appointment. The resident stated they (the facility) don't tell me this stuff and stated that she would like to know these things in advance. The resident was asked if she had been on any other diet and the resident stated that she had only been on the puree diet since she has been here on 06/23/18.

At approximately 4:45 p.m. the unit manager was

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interviewed and stated that the resident did not have an appointment tomorrow for anything. The nurse was asked to look at the residents nursing notes. The unit manger stated, "yes, she does have an appointment tomorrow, that's the first I knew of that." The unit manager then went to the resident and informed of the follow up appointment scheduled for the next morning.

On 08/02/18 at 7:45 AM, Resident # 109 observed in her room sitting in her wheelchair dressed for the follow up appointment with gastroenterology. The resident stated that she had not had breakfast yet and the CNA (certified nursing assistant) stated that the resident should have had an early breakfast scheduled.

On 08/02/18 at 07:50 AM, the unit manager was informed that this resident has not been weighed for the last two weeks (per documentation) and was informed that the resident had been being weighed every week. The unit manager stated she did not know why the resident was not weighed and stated, "we can get a weight on the resident." The resident was then weighed. The resident weighed 152.3 for a total weight loss of 9.8 lbs (6.05%) from 06/23/18 to 08/02/18.

At approximately 8:20 a.m., the DON (director of nursing) was asked how often are residents weighed, and informed the DON that this resident had been weighed weekly, but had not been weighed for the last two weeks. The DON stated that skilled resident's are weighed weekly. This resident is a skilled resident.

The DON was asked to see the RD to discuss this resident.

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On 08/02/18 at 10:15 AM, the RD was interviewed regarding this resident's weight loss. The RD stated that the resident was on a diuretic (lasix 40 mg on Monday, Wednesday, and Friday) and that the resident is not happy with the puree meals. The RD was made aware that the resident had not been weighed for the last two weeks and had lost an additional two pounds. The RD was made aware that the resident was documented as being fairly consistent in consuming the med plus most of the time at 100%. The RD was made aware of the concerns regarding the lack of interventions for this resident, after the resident voiced on multiple occasions that she was dissatisfied with the pureed meals and the resident was not weighed for two weeks. The RD did not have any other comments.

No further information and/or documentation was presented prior to the exit conference at 2:00 p.m. on 08/02/18 to evidence that this resident's nutritional parameters were maintained.

2. Resident # 134 was admitted to the facility on 05/21/18. Diagnoses for Resident # 134 included, but were not limited to: fracture of the pelvis, history of falls, high blood pressure, osteoporosis, chronic kidney disease, anemia, vitamin D deficiency, and PVD (peripheral vascular disease).

The most current, full MDS with CAAS (care area assessment summary) was a 5 day admission dated 05/28/18. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills. The resident was also coded as requiring supervision with setup only for meal consumption.

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The resident triggered in the CAAS section of this MDS for ADL's (activities of daily living), nutrition and dental. Her admission weight was documented as 156 pounds.

On 07/31/18 at 4:19 PM, Resident # 134 was interviewed. The resident stated that she has a healthy appetite and probably eats too much, but enjoyed eating and sometimes get full fast. The resident was asked if she had lost any weight and the resident stated that she didn't think so.

On 08/01/18 at 08:00 AM, Resident # 134 was laying in bed, covered with lights off. No breakfast trays were on the unit at this time.

On 08/01/18 at 08:42 AM, Resident # 134 was sitting up in bed with her bedside table over the bed, with the resident's meal tray set up. The resident had scrambled eggs, cream of wheat, a banana and coffee. The resident was asked how she was doing this morning. The resident stated, "I need some sugar," which was located behind the resident's tray, out of her sight. The resident was given the sweetener packet, the resident opened it and poured it into the cream of wheat. The resident then stated, "The main thing I need is my teeth." The resident was asked where her teeth were and the resident stated, that she didn't know. The resident looked around and the dentures were on the kitchen sink in a closed denture holder.

This surveyor went to the hall and asked CNA (certified nurses' assistant) # 14 for assistance. The CNA stated that this was not her resident today and didn't know why the CNA assigned would not have given the resident her teeth, but did not mind to get the resident's dentures for her.

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The CNA cleaned the resident's dentures and gave them to the resident. The resident put them in her mouth and ate her 100% breakfast.

CNA # 14 was asked to find the resident's assigned CNA. CNA # 10 came to this surveyor and stated that she was the resident's CNA. The CNA was asked if she had set the resident up for breakfast this morning and the CNA responded, yes. The CNA was asked why the resident didn't have her dentures in and the CNA responded that she (the CNA) thought that the resident already had them in and that she (the resident) usually has her teeth in when I go in, and "that was my honest mistake."

The resident's physician's orders were reviewed and documented, an order for a heart healthy diet Level 7-Regular texture, regular liquids on 05/22/18. The resident also had an order for med plus 2.0 after meals for supplement 120 ml document consumption (06/05/18).

The resident's CCP documented, "...nutrition risk related to hospitalization/new admission...provide and serve diet as ordered, monitor intake and record every meal...provide and serve supplements as ordered, Med Plus...RD (registered dietitian) to evaluate and make diet change recommendations PRN...weekly weights..."

A dietary/RD noted dated 06/05/18 documented, "...med plus TID (three time a day) after meals...history of weighing 161...subsequent gradual weight loss, pt (patient) consuming 50-100% of meals. Goal is to arrest wt loss...med plus initiated per daughter's request...signature of RD."

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An RD note dated 06/12/18 documented, "Daughter came to RD office yesterday and agreed to paper menus which she completed w (with)/her mother's input. Goal is to maximize satisfaction and intake...signature of RD."

A weight warning note dated 07/03/18 documented, "...143.4...completes paper menus w/daughter to maximize satisfaction and intake. Med plus TID ongoing...met with pt who stated appetite "couldn't be better"...observed finishing 100 % of her lunch...per pt glad about weight loss...no changes at this time..."

A weight warning note dated 07/19/18 documented, "...139.9...making her own menu choices with assistance at times...Med plus TID...met with pt who stated she "feels full" after each meal. Regarding wt (weight) loss pt stated "that's fine"...doesn't bother her...will continue to monitor for intake adequacy...signature of RD."

On 08/02/18 at 8:20 AM, the DON (director of nursing) was asked how often are resident's weighed, and informed the DON that this resident has been weighed weekly, but has not been weight for the last two weeks. The DON stated that skilled resident's are weighed weekly.

On 08/02/18 at 8:58 AM, Resident # 134 was observed eating breakfast in her room, sitting up in her wheelcahir. The resident had eaten all of her egg with ketchup, and had a small bowl of oatmeal with butter and raisins that she was getting ready to eat. The bowl of oatmeal was approximately 4 ounces. The resident stated that she was enjoying her lunch, but really would like some milk. The resident stated that she had

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already called for it twice. The unit manger then entered the room and was informed of the milk, by the resident and this surveyor. The unit manger stated that she would get the resident some milk. The unit manager returned with one carton of whole milk and assisted the resident with pouring some milk on the oatmeal. The resident stated that she would drink the rest. The resident stated that she didn't know why they (staff) didn't bring her more milk that she really liked milk. The resident's meal ticket was observed. The meal ticket had oatmeal checked, butter checked, coffee-decaf, one scrambled egg, and ketchup. There was a milk selection for 2% or whole milk, neither were marked.

The unit manager was made aware that the resident did not have weights for the last two weeks and had been getting weighed weekly and has had weight loss, the unit manager stated that they (staff) would get the resident's weight after she finished eating. The resident was asked if it was ok for her to be weighed after she eats and the resident stated, "Yes, I don't mind."

On 08/02/18 at 09:15 AM, CNA # 14 took the resident down to be weighed. The CNA stated, we weighed the wheelchair and it weighs 41.6 lbs. The CNA rolled Resident # 134 up onto the scale in the wheelchair. The resident stated, "now you all have to do some math." The weight total weight was 184.2 pounds. The resident's weight was 142.6 pounds after the wheelchair weight deduction. The resident had a total weight loss of 13.0 lbs (8.35%) since 05/21/18 (less than 10 weeks).

On 08/02/18 at 10:15 AM, the RD was interviewed regarding this resident's weight loss,

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F 692	Continued From page 41 and the fact the resident had been being weighed weekly and had not been weighed for two weeks. The RD was made aware that the resident had weight loss and no other interventions have been implemented. The RD stated that another intervention was implemented (not on the resident's care plan) that the resident's daughter was helping with the menu choices. The RD was then showed the meal slip for breakfast on 08/02/18 and was informed that the resident did not get milk this morning and the RD stated she fills out her own meals slips maybe she needs help. The RD then stated, "Oh no, her daughter helps with her with the meal slips." The RD was made aware that the resident stated that she liked milk and voiced that she did not understand why the facility staff were not giving her more milk. The RD made no further comments. No further information and/or documentation was presented prior to the exit conference on 08/02/18 at 2:00 p.m.	F 692		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		8/29/18

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F 693	Continued From page 42 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, facility staff failed to obtain physician orders for care of a Gastrostomy Tube (G-Tube) for one of 36 residents in the survey sample, Resident #46. Facility staff did not obtain physician orders to check for G-tube placement and residual volumes during care of Resident #46's tube feedings and G-tube. Findings included: Resident #46 was originally admitted to the facility on 11/15/17 and readmitted on 07/15/18 with diagnoses including, but not limited to: CVA (cerebrovascular accident), Aphasia, Dementia, Diabetes, Seizures, Pneumonia and Gastrostomy Tube (feeding tube). The most recent MDS (minimum data sheet) was a quarterly assessment with an ARD (assessment reference date) of 05/23/18. Resident #46 was assessed as severely impaired in her short and long term memory and moderately impaired in her daily decision making skills.	F 693	F693 1. An order was obtained and entered to check residual volumes from G-tube on R46 while surveyors were onsite. 2. Current residents with G-tubes are at risk. 3. Staff development coordinator or designee will educate licensed nursing staff on obtaining an order to check residual volume for any resident that has feeding through a G-tube site. 4. Unit manager or designee will audit orders for new residents with G-tubes to ensure there is an order to check residual volume. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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Resident #46's clinical record was reviewed on 08/01/18 at approximately 10:00 a.m. During the record review this resident's care plan was noted to include the following: "Focus: The resident requires tube feeding r/t [related to] dysphagia. Created on: 12/19/2017, Revision on: 07/15/2018, ...Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 200 cc [cubic centimeters] aspirate..."

Subsequent review of the physician order sheet dated 07/01/18-07/31/18 did not include any orders to check for gastrostomy tube placement and residual volumes for Resident #46. No documentation of placement or residuals were noted on the MAR (medication administration sheet) or TAR (treatment administration sheet). No Tube Feeding Record was located in the clinical record.

Facility policy for "Care of the Patient with a Feeding Tube, Effective Date: 02/01/15, included the following: "...assess for placement and residual amounts...Procedure: General Principles related to Enteral Feedings: ...5. Verify placement of feeding tube PRIOR to infusion of formula. DO NOT GIVE FEEDING IF UNABLE TO VERIFY PLACEMENT. If residual gastric content measures > [greater than] 200cc, hold the feeding and notify the physician for direction to decrease risk of aspiration...6. Residual amounts are to be recorded on the Tube Feeding Record..."

Corporate Nurse #5 and the DON (director of nursing) was interviewed on 08/02/18 at 11:25 a.m. regarding Resident #46's G-tube. Corporate Nurse #5 stated, "We don't have an order to

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F 693	Continued From page 44 check. It was missed on her readmission. Policy doesn't specify how often to check. We will look on her old records to see her prior orders." At approximately 12:15 p.m. the DON stated, "Her previous orders were to check placement and residuals Q [every] shift. We will contact the doctor and get an order." No further information was received by the survey team prior to the exit conference on 08/02/18.	F 693		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		8/29/18

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F 755	Continued From page 45 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration to one of 36 residents in the survey sample. Resident #15 missed eight doses of physician ordered medications in a 3-week period because medications were not available from the pharmacy. The findings include: Resident #15 was admitted to the facility on 4/9/18 with a re-admission on 7/20/18. Diagnoses for Resident #15 included diabetes, seizures, high blood pressure, cerebral infarction, irritable bowel syndrome, gastroesophageal reflux disease, dysphagia and hyperlipidemia. The minimum data set (MDS) dated 4/25/18 assessed Resident #15 with severely impaired cognitive skills. Resident #15's clinical record documented current physician orders for the following medications listed with the order date. 5/01/18 - Insulin NPH 10 units every 12 hours for diabetes 6/14/18 - Olmesartan Medoxomil 40 mg (milligrams) once daily for high blood pressure 6/14/18 - Keppra 1000 mg two times per day for	F 755	F755 1. MD was notified that medications were not onsite for R15 and obtained order to administer on arrival while surveyors were onsite. 2. Current residents are at risk. 3. Staff development coordinator or designee will educate licensed staff on the process for ordering medication timely to ensure it is available for administration as ordered. 4. Unit manager or designee will audit electronic medical records for two residents per unit to ensure medications are available for administration, as evidenced by being initialed in the electronic medical record. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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seizures
7/20/18 - Carvedilol 25 mg two times per day for high blood pressure
7/20/18 - Hydrochlorothiazide 25 mg each day for high blood pressure
7/20/18 - Loratadine Syrup 10 mg each day for allergies

Resident #15's medication administration record (MAR) documented the above medications were not available and not administered as follows.

Olmesartan Medoxomil 40 mg - not given on 7/16/18 at 6:00 a.m.
Keppra 1000 mg - not given on 7/16/18 at 6:00 a.m. and on 7/28/18 at 6:00 a.m.
Carvedilol 25 mg - not given on 7/28/18 at 6:00 a.m. and on 8/2/18 at 8:00 a.m.
Insulin NPH 10 units - not given on 7/29/18 at 9:00 p.m.
Hydrochlorothiazide 25 mg - not given on 8/2/18 at 8:00 a.m.
Loratadine Syrup 10 mg - not given on 8/2/18 at 8:00 a.m.

Nursing notes and the medication records documented these medications were not given because they were not available and were "waiting on pharmacy."

On 8/1/18 at 2:38 p.m., the licensed practical nurse (LPN #3) administering medications to Resident #15 was interviewed about the unavailable medications. LPN #3 stated she was an agency nurse and this was her first day. LPN #3 reviewed the clinical record and stated notes indicated the medications were not available and they were waiting on pharmacy for delivery.

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F 755	Continued From page 47 On 8/2/18 at 7:48 a.m., the registered nurse unit manager (RN #1) was interviewed about the unavailable medications for Resident #15. RN #1 stated the medications were not available because they were not re-ordered in time. RN #1 stated nurses were supposed to notify pharmacy when running low so medications could be delivered before the supply was depleted. On 8/2/18 at 10:03 a.m., LPN #5 caring for Resident #15 was interviewed about the three medications not available on 8/2/18 at 8:00 a.m. LPN #5 stated she had no Hydrochlorothiazide, Loratadine or Carvedilol for Resident #15 in the medication cart this morning (8/2/18). LPN #5 stated these medications were ordered on 8/1/18 but had not arrived from the pharmacy. The facility's policy titled Reordering Medications (undated) documented, "...staff should review all on-demand medications daily and re-order when a 5-day supply of the medication is remaining...Emergency refills must be called to the Pharmacy indicating the date and time the medications is needed." These findings were reviewed with the administrator and director of nursing during a meeting on 8/2/18 at 12:30 p.m.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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	F 761		8/29/18

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F 761	Continued From page 48 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) 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 documentation, the facility staff failed to ensure expired medications were not readily available for distribution on one of 3 units. Three expired Cefepime intravenous (antibiotic) bags were observed in the medication refrigerator on the South Wing. The findings include: Medication storage observation was conducted on 08/01/18 at 07:50 AM on the South Wing with the ADON (assistant director of nursing). Three bags of IV cefepime 2 GM (grams) for a resident currently in the facility were out of date with an expiration date of 7/26/18.	F 761	F761 1. Expired medication was removed from refrigerator while surveyors were onsite. 2. Medication refrigerators on each unit were audited by the director of nursing to ensure no expired medications were present. 3. Staff development coordinator or designee will educate licensed staff to check medication refrigerators for expired medications every shift. 4. Unit manager or designee will ensure there is no expired medication in the medication refrigerator. This will be completed five times a week for four weeks, then weekly for one month, then monthly for three months. Discrepancies	

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F 761	Continued From page 49 The ADON also observed the expired medication and was interviewed. The ADON verbalized staff are supposed to check medication rooms and carts for expired medications on every shift and place expired medications and medications for Residents that have been discharged into a collection box for the pharmacy to pick up. The ADON presented a facility policy that instructed the staff to place all discontinued or expired medications in a designated secure location in a container or box for a disposable company to pick up. On 08/02/18 12:34 PM the above information was presented to the DON (director of nursing) and administrator. No other information was provided prior to exit conference on 8/2/18.	F 761	will be brought to the QA committee and addressed as needed.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		8/29/18

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LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

(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 842	Continued From page 50 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F 842		

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F 842	Continued From page 51 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of 36 residents in the survey sample (Resident # 31) to accurately document the administration of medications. Resident # 31 had six medications that were not documented as having been administered on 7/23/18 and 7/29/18. The findings were: Resident # 31 was admitted to the facility on 5/2/18 with diagnoses that included coronary artery disease, hypertension, gastroesophageal reflux disease, hyperlipidemia, hemiplegia and hemiparesis, respiratory failure with tracheostomy, muscle wasting and atrophy, dysphagia, metabolic encephalopathy, and PEG tube placement. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 5/9/18, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired skills for daily decision making. Review of the Electronic Medication	F 842	F842 1. Medications for R31 had been administered prior to surveyors being onsite. 2. Current residents are at risk. 3. Staff development coordinator or designee will educate licensed staff to initial electronically in medication administration record when medications are administered. 4. Unit manager or designee will audit electronic medication records to ensure medications are initialed as administered, to ensure they have been administered as ordered. This will be completed five times a week for four weeks, then weekly for one month, then monthly for three months. Discrepancies will be brought to the QA committee and addressed as needed.	

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F 842	Continued From page 52	F 842		

Administration Record (EMAR) for the month of July 2018, contained in the resident's Electronic Health Record, revealed the following medications were not documented as having been administered on 7/23/18 and 7/29/18:

Aspirin Tablet 81 mg (milligram). Give 1 tablet via PEG Tube one time a day related to Hemiplegia and Hemiparesis. The dose scheduled for 8:00 a.m. was not signed off as having been given.

Clopidogrel (Plavix) Tablet 75 mg. Give 1 tablet via PEG Tube one time a day for prophylaxis related to Hemiplegia and Hemiparesis. The dose scheduled for 6:00 a.m. was not signed off as having been given.

Protonix Packet 40 mg. Give 1 packet via Peg Tube one tame a day for GERD (Gastroesophageal Reflux Disease). The dose scheduled for 6:00 a.m. was not signed off as having been given.

Heparin Sodium Solution 5000 unit/ml (unite per milliliter). Subcutaneously every 12 hours for clotting prevention. The scheduled administration times were 6:00 a.m. and 6:00 p.m. The 6:00 a.m. dose was not signed off as having been given.

Metoprolol Tablet 25 mg. Give 1 tablet via PEG tube two times a day for HTN. The scheduled administration times were 6:30 a.m. and 4:00 p.m. The 6:30 a.m. dose was not signed off as having been given.

Sodium Chloride tablet 1 gm (gram). Give 2 tablet via PEG tube three times a day for supplement. The scheduled administration times

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F 842	Continued From page 53 were 6:00 a.m., 2:00 p.m., and 8:00 p.m. The 6:00 a.m. dose was not signed off as having been given. At 9:00 a.m. on 8/2/18, the ADON (Assistant Director of Nursing) was asked about the missing entries on Resident # 31's July EMAR. The ADON said she would look into the matter. At 9:20 a.m. the ADON returned to the surveyor and said she was able to verify the listed medications were administered, but went on to say that the nurse who administered the medications failed to document they were administered. The findings were discussed during a meeting at 12:30 p.m. on 8/2/18 that included the Administrator, Director of Nursing, Assistant Director of Nursing, Corporate Nurse Consultant, and the survey team.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		8/29/18

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F 883	Continued From page 54 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview,	F 883	F883	

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F 883	Continued From page 55 and facility document review, the facility staff failed to accurately assess and document the immunization status for one of 5 resident records reviewed: Resident # 61. Resident # 61 did not have influenza vaccine documented as given or refused since 11/16/16. Findings include: Resident # 61 was admitted to the facility 4/24/18 with diagnoses to include but not limited to: history of stroke, muscle weakness, feeding tube, GERD (gastroesophageal reflux disease), diabetes, and urinary retention. The most recent MDS (minimum data set) was a quarterly review dated 6/6/18 and the resident was assessed as having short term and long term memory problems with moderate impairment in cognition. On 08/01/18 at 3:59 p.m. the clinical record was reviewed for the immunization status of influenza (flu) and pneumococcal vaccines. The most current flu vaccine documented was 11/16/16. At that time further information was requested from the DON (director of nursing) and ADON (assistant director of nursing). The facility policy was also reviewed at that time. The facility policy "Influenza and Pneumococcal Vaccinations" directed "3.h. Patient Influenza Vaccine Tracking/Surveillance Log(s) will be maintained by the Infection Preventions. All patient's names are to be included on the vaccine tracking/surveillance log(s) (sic)." On 8/2/18 at 7:45 a.m. the DON informed this	F 883	1. The immunization record for R61 was updated while surveyors were onsite. 2. Current residents are at risk. 3. Staff development coordinator or designee will educate licensed nursing staff on entering immunization records in the medical record. 4. Staff development coordinator or designee will audit five residents to ensure immunization record is current and accurate. This will be completed weekly for four weeks, then monthly for three months thereafter. Discrepancies will be brought to the QA committee and addressed as needed.	

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F 883	Continued From page 56	F 883		

surveyor "[name of resident] was in the hospital when we were doing the flu shots in October 2017, and he got his there." The DON was then asked for the documentation, and why the vaccine was not current in clinical record. She stated she would find out what happened. At 8:00 a.m. the ADON told this surveyor "We had requested the information from the hospital, but didn't get it. We finally got it yesterday and put in the system." The ADON was asked who maintained the tracking log per the policy. ADON stated "We didn't have an SDC (staff development coordinator) who is also the infection control nurse...that is who keeps the log. The new SDC nurse has only been here three weeks..."

On 8/2/18 at 8:15 a.m. the DON was asked about the tracking log. She stated "[name of resident] was written in to the side on the tracking log that he was in the hospital at that time. We did get the information yesterday and put it in the system..."

On 8/2/18 beginning at 12:26 p.m. during a meeting with facility staff the administrator, DON, ADON, and corporate nursing staff were informed of the above findings. The DON stated "Actually, I found out the SDC nurse was here during that time; she did not leave until some time in January 2018." The DON was then asked who would have been responsible for the tracking log and follow up to assure complete documentation. The DON did not answer.

No further information was provided prior to the exit conference.