STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/2/18 through 10/4/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under the State and Federal law. This plan of correction will serve as the facility's allegation of substantial compliance.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/2/18 through 10/4/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 196 certified bed facility was 132 at the time of the survey. The survey sample consisted of 46 Resident reviews.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582	Medicaid/Medicare coverage/liability notice 1. Resident #232 was discharged on 9/7/18. Resident #233 was discharged on 8/27/18. 2. Business Office Manager / Designee conducted a quality review of residents discharged from skilled services within past 30 days to ensure form CMS 10055 notification was provided. Follow-up based on findings. 3. Business Office staff has been re-educated by Executive Director on ensuring residents are notified timely when care needed does not meet Medicare coverage requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kourtney Richards | TITLE: Administrator | (X6) DATE: 10/25/2018

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

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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to	F 582	4. Executive Director or Designee to conduct quality improvement monitoring of ABN notification weekly x 4 weeks, monthly x 3, then quarterly and as needed. he results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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F 582	Continued From page 2 ensure two residents (Resident #232 and 233) of 46 sampled residents was given a form CMS-10055 before discharge from skilled nursing. The findings include: Resident #232 was discharged from skilled nursing on 09/05/2018. A review of the record showed no form CMS-10055 was provided to the resident. Resident #233 was discharged from skilled nursing on 07/08/2018. A review of the record showed no form CMS-10055 was provided to the resident. On 10/04/2018 at 11:15 am, an interview was conducted with employee D who issues the forms to the residents who are discharging from skilled nursing. Employee D stated that she did not know she was supposed to use form CMS-10055 but instead was using form CMS-R-131 The facility was informed of the findings during a briefing on 10/03/2018.	F 582		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		

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F 600	Continued From page 3 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed for 1 resident (Resident # 92) of the survey sample of 46 residents, to ensure that resident #92 was free from verbal abuse. For Resident #92, the facility staff failed to ensure that she was free of verbal abuse by facility staff on 2 occasions. The Findings included: Resident #92 was a 63 year old who was admitted to the facility on 12/13/16. Resident #92's diagnosis included Obesity, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Obstructive Pulmonary Disease, Low Back Pain, Major Depressive Disorder, Anxiety Disorder, Chronic Pain Syndrome, and Generalized Muscle Weakness. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 8/24/18, coded Resident #92 as having a Brief Mental Status Score of 15, indicating that she was independent in daily decision making ability. Resident #92 was coded as requiring the physical assistance of 2 persons for transfers and toilet use. In addition, she was coded as requiring the physical assistance of 1 person for personal	F 600	Free from Abuse and Neglect 1. Resident #92 was interviewed on 10/17/18 and reports no additional concerns. Employee identified in allegation was terminated on 10/09/18. 2. Executive Director or Designee to complete resident interviews, (responsible party if resident not interviewable) to ensure that they are free from abuse. Follow up based on findings. 3. Facility staff has been re-educated on Resident Abuse by Executive Director or Designee to ensure residents are free from abuse. 4. Executive Director or Designee to complete random resident interviews to ensure residents are free from abuse weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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F 600	Continued From page 4 hygiene. On 10/3/18, at 11:00 A.M. an interview was conducted with Resident #92. The facility Liaison (Employee F) was present. Resident #92 stated that a staff member (Certified Nursing Assistant C) had "frequently yelled and screamed at me and bullied me." Resident #92 stated that CNA C was abusive to her whenever she entered the room in response to the call bell, and had become intolerable to work with. She further stated that CNA C had repeated the abusive behavior on 10/2/18. Resident #92 stated that she usually used the call bell to receive incontinence care assistance. She further stated that she hadn't complained about her previously "because she is the only one who will come in to work on the weekends". In addition, she stated that she had recently reported another CNA (CNA F) for calling her "a liar" when she stated that incontinence care had not been provided. On 10/3/18, a review was conducted of facility documentation. On 2/6/18, CNA C had received a written warning. The Employee Corrective Action Form read, "Failure to comply with company's policies and procedures: eating, sitting, taking unauthorized breaks in residents' rooms, not answering call bells." According to the staff schedule, CNA C did work with Resident #92 on 10/2/18. On 9/27/18 the facility submitted a late follow-up to a Facility Reported Incident that occurred on 8/6/18. The incident involved a staff member (CNA F) who was reported for verbal abuse toward Resident #92. The follow-up report stated	F 600		

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F 600	Continued From page 5 that CNA F would be re-educated on the abuse policy. On 10/3/18 at 11:33 A.M., The Administrator (Administration A) reported that CNA C had been suspended, and that the allegation had been reported to the Virginia Department of Health-Office of Long Term Care. No further information was received.	F 600		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed to	F 606	Not Employ/Engage Staff w/ Adverse Actions 1. Employee B background check was obtained on 10/18/18. Employee G background check was obtained on 10/18/18. 2. Human Resource Manager or Designee conducted a quality review of new hires in last 60 days to ensure background checks were completed. Follow-up based on findings. 3. Human Resources Manager has been re-educated on obtaining background checks on employees prior to employment by Executive Director or Designee. 4. Executive Director/ Designee to complete Quality Improvement Monitoring of new hire files prior to start date weekly x8 weeks, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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F 606	Continued From page 6 screen employees for convictions of abuse, neglect, exploitation, misappropriation of property, or mistreatment. The facility staff failed to screen two employees prior to hire (Employee G, Employee B). The Findings included: On 10/3/18 at 11:45 A.M., an observation was completed of the facility kitchen. Employee G, and Employee B were working in the kitchen during lunch preparation and service. On 10/3/18 an interview was conducted with the Human Resources Manager (Employee J). The Human Resources Manager stated that the facility did not have any documentation on Employee G, or Employee B. She stated that they were sent by a food service agency. When asked if the facility had verified if they had been found guilty of abuse, neglect, or exploitation, the Human Services Manager stated that a background check had not been obtained by the facility prior to allowing them to work in the facility. They had worked in the facility for several months prior to the survey. On 10/3/18 a review was conducted of facility documentation. The Background Check Policy, dated 9/1/17 read, "It is the policy of The Company to conduct background checks to include criminal background checks...An outside contractor is a person, group and/ or company who substantially perform the same services as an employee, such as agency personnel. Employees, contractors, agency personnel or volunteers whose background checks reveal convictions for formal action of the type prohibited	F 606		

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F 606	Continued From page 7 by law or company policy from being employed in a health care center shall be discharged from employment." On 10/3/18 the facility Administrator was notified of the findings.	F 606		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622	Transfer and Discharge Requirements 1. Resident #132 was discharged on 5/10/18. Resident #80 received no adverse action and remains in the facility. 2. Quality Review of resident discharges for the last 30 days has been completed by Social Worker or Designee to ensure resident's plan of care was sent with resident upon transfer to hospital. Follow-up based on findings. 3. Licensed nursing staff and social services staff has been re-educated by Executive Director or Designee on facilitating discharges and ensuring proper documentation is available to support discharge. 4. Social Worker or Designee to conduct Quality Improvement Monitoring of discharges for transfer/ discharge requirements per regulation weekly x4 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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F 622	Continued From page 8 (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	F 622		

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F 622	Continued From page 9 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility record review, and staff interview, the facility staff failed to send a plan of care to the receiving hospital for one Resident (Resident #80) upon discharge to the hospital. For Resident #80, the facility staff failed to send a care plan to the emergency department with the Resident upon discharge. The findings included: Resident #80 was admitted to the facility on 2-12-18. Diagnoses included: Stroke with left side weakness, encephalitis, depression, and dialysis. Resident #80's most recent Minimum Data Set (MDS), was a significant change assessment, with an assessment reference date of 8-22-18. The document coded the Resident as severely cognitively impaired. The document also coded	F 622		

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F 622	Continued From page 10 Resident #80 as requiring total assistance from one to two staff members to complete all activities of daily living. The Resident was sent out to the hospital on 7-3-18 with seizure activity, according to the nursing progress notes, and Registered pharmacist's medication regimen review. Review of the social work, and physician's progress notes, revealed no indication that they were aware that the Resident had been hospitalized. Further there was no documentation indicating the Ombudsman had been notified of Resident #80's hospitalization. On 10-4-18 at 12:00 p.m., an interview was conducted with the Social Services representative, and the Director of Nursing. Both stated when asked for documentation that the ombudsman had been notified, "We fax the Ombudsman, and produced the document, which had also been faxed to the doctor. When asked what documents were sent to the hospital with the Resident they stated "the face sheet, DNR, and Meds." They were asked if a care plan denoting the Residents care needs was sent with him, they responded "we didn't know we needed to." "Nursing reaches out to RP by phone for the most part. " There was no documentation of discharge to hospital to the RP in writing. On 10-4-18 at 2:00 p.m., the Administrator and DON (director of nursing) were notified of the findings.	F 622		
F 641	Accuracy of Assessments	F 641		

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F 641 SS=D	Continued From page 11 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure an accurate assessment for 1 of 46 residents sampled (Resident #54). Specifically, the facility staff coded on the BIMS a 99 and also did the staff assessment when in fact the resident scored a 5 on the BIMS and the facility staff assessment should not have been completed. The findings included: Resident #54 was admitted 1/30/2017 with diagnoses: anxiety, depression, diabetes, and stroke. Her most recent assessment was a Quarterly Minimum Data Set (MDS) dated 8/8/2018. This MDS had a score of 99 for the Brief Interview of Mental Status (BIMS), located in Section C. This interview generates an assessment of the resident's cognitive ability. Resident #54 provided responses to 3 of the 7 questions in the BIMS interview (repeating three words, correct year, and recall of one prior item spoken by the interviewer). She provided incorrect responses to the remaining 4 questions. These questions are in MDS fields C0200-C0400. Her responses generated the following codes: 1. C0200 was coded as a "3", showing the resident repeated three words correctly 2. C0300 was coded as a "1" for the year, showing the resident missed the correct year by 2	F 641	Accuracy of Assessments 1. Modification was made to resident #54 MDS to reflect an accurate account of the BIMS score. 2. MDS Coordinator/Designee conducted a quality review of current facility residents for MDS accuracy in section C. Follow up based on findings. 3. Regional Case Mix Coordinator provided re-education to Social Service Director on coding section C of the MDS. 4. Social service and MDS to conduct quality improvement monitoring of MDS section C for accuracy 3 x/ week x 4 weeks, weekly x 4 weeks, then monthly x 3 and as needed. All findings will be reported to Quality Assurance Performance Improvement (QAPI)Committee monthly and updated as indicated. Monitoring schedule modified based on findings. 5. Date of compliance: 11/06/18	

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	495423	A. BUILDING _____ B. WING _____	C 10/04/2018

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F 641	Continued From page 12 -5 years. The resident did not report the month or day of the week, resulting in a score of "0" for those questions 3. C0400 was coded as a "1", showing that the resident remembered one of the words provided earlier in the interview. The resident could not recall the other items, resulting in a score of "0" for those questions However, C0500 was coded as a "99", which indicates that the resident was unable to complete the interview and the facility staff completed the staff assessment of mental status (fields C0600 through C1000). Per the Resident Assessment Instrument (RAI) Manual for v 1.14 of the MDS (effective 10/1/2016), page C-15: C0500: BIMS Summary Score Steps for Assessment After completing C0200-C0400: 1. Add up the values for all questions from C0200 through C0400. 2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview. Coding Instructions Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15. o If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and a staff assessment is completed. o To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included	F 641		

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F 641	Continued From page 13 in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips on page C-4 for residents who choose not to participate at all. o Code 99, unable to complete interview: if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a dash. - Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items. Page C-17: C0600: Should the Staff Assessment for Mental Status (C0700-C1000) Be Conducted? Steps for Assessment 1. Review whether BIMS Summary Score item (C0500), is coded 99, unable to complete interview. Coding Instructions o Code 0, no: if the BIMS was completed and scored between 00 and 15. Skip to C1310. o Code 1, yes: if the resident chooses not to participate in the BIMS or if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response. Continue to C0700-C1000 and perform the Staff Assessment for Mental Status. Note: C0500 should be coded 99. Coding Tips o If a resident is scored 00 on C0500,	F 641		

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F 641	Continued From page 14 C0700-C1000, Staff Assessment, should not be completed. 00 is a legitimate value for C0500 and indicates that the interview was complete. To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to four or more BIMS items. At 10/03/18 04:37 PM an interview was conducted with Admin C, the corporate MDS consultant. When asked to review the BIMS coding for this MDS, Admin C replied "I can see it already- they coded it a 99 and did the staff assessment." When asked what the correct code for C0500 would be, Admin C replied "it should have been a 5, and not do the staff assessment. I will modify this MDS." When asked what the facility policy was for MDS accuracy, Admin C replied "We follow the RAI Manual." No further information was provided prior to exit.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		

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F 644	Continued From page 15 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure an accurate PASARR assessment for 1 of 46 residents sampled (Resident #54). The findings included: Resident #54 was admitted 1/30/2017 with diagnoses: anxiety, depression, diabetes, and stroke. Her most recent assessment was a Quarterly Minimum Data Set (MDS) dated 8/8/2018. This MDS showed a diagnosis of Anxiety, Depression, and Psychotic disorder in fields I5700, I5800, and I5950 respectively. Her prior assessments dated 5/9/2018, 2/6/2018, 11/8/2017, 8/10/2017, 5/10/2017, and 2/7/2017 did not have Psychotic disorder coded, but did list Anxiety and Depression. Her Admission History and Physical, dated 1/30/2017, did not list schizophrenia, psychosis, or dementia as active diagnoses. Her PASARR Level I, done 1/30/2017, showed that the field asking "Does the resident have a major mental disorder diagnosable under DSM-IV (e.g. schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead	F 644	Coordination of PASARR and Assessments 1. Resident #54 received no adverse reaction and remains in the facility. Resident #54 PASARR was updated on 10/04/18. 2. Social Worker or Designee will complete quality review of residents on antipsychotic medication within the past 30 days will be reviewed to ensure PASARR and assessments have been completed timely. Follow up based on findings. 3. Social Services Director has been re- educated on ensuring PASARR form is completed by Executive Director. 4. Social Services Director/Designee to complete Quality Improvement Monitoring of residents receiving antipsychotic medications for PASARR completed/updated as indicated weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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F 644	Continued From page 16 to a chronic disability)" was not checked, and the comprehensive question "Does the individual have a current serious mental illness (MI)?" was checked "NO". A review of the "Diagnosis Report" for the resident, dated 10/3/2018, shows a diagnosis of Bipolar Disorder, onset date 8/6/2018. On 10/4/2018 at 8:25 AM, an interview was held with Admin B, the Director of Nursing. When asked what the facility PASARR process was when a resident is newly diagnosed with a mental illness, Admin B replied "Let me find out." On 10/4/2018 at 3:00 PM, a copy of the "Pre-Admission screening for Serious Mental Illness (SMI) and Intellectually Disabled (ID) Individuals [PASARR], revised September 2017 was left for the surveyor. This policy states: 4. If it is learned after admission that a Serious Mental Illness (SMI) or Intellectually Disabled (ID) Level II screening is indicated, it will be the responsibility of Social Services to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results. No further information was provided prior to exit.	F 644		
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--	F 657		

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F 657	Continued From page 17 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to, for one Resident, Resident #104, in a survey sample of 46 residents, to ensure the care plan had targeted behaviors and non pharmacological interventions for the use of an antipsychotic medication. Resident #104's care plan had no targeted behaviors or non pharmacological interventions for the twice daily use of Geodon. The findings included: Resident #104 was admitted to the facility on 6-8-16. Diagnoses included anemia, Alzheimer's dementia and psychosis.	F 657	Care Plan timing and revision 1. Resident #104's Care plan has been updated to reflect non-pharmacological interventions and behaviors. 2. Regional MDS Coordinator or Designee will conduct quality review of current facility residents with behaviors to ensure the care plan is updated appropriately and timely. Follow up based on findings. 3. Re-education was provided to Social Services on updating behavioral care plans and the use of non-pharmacological interventions by Regional MDS Coordinator. 4. MDSC and IDT to ensure care plans reflect residents current status related to behaviors/ non-pharmacological interventions utilizing Morning Clinical Meeting process. DON/designee to conduct quality improvement monitoring of care plans ensuring reflective of residents current status related to behaviors and non-pharmacological interventions 3x/ week x 4 weeks, weekly x 4, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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F 657	Continued From page 18 The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9-5-18. Resident #104 was coded as having short and long term memory impairments and was severely impaired in daily decision making. There were no behaviors coded for the last seven days of the ARD. On 10/2/18 at 1:01 PM, Resident #104 was observed eating in her room. She had a regular diet, eating well. On 10/03/18 at 10:38 AM, Review of the clinical record revealed the pharmacy requested on 6-1-18 a GDR (gradual dose reduction) for the use of Geodon (antipsychotic) 60 mg twice daily. The MD declined the recommendation with the statement, "Continued use is in accordance with the current standard of practice" However, Resident #104 had no diagnosis on record for the use of an antipsychotic and no documented behaviors (for over a year) that indicated the continued use of the antipsychotic medication. In addition, the physician had declined an earlier request for a GDR with the same rationale. On 10/04/18 at 9:20 AM, the facility presented a physician note dated 9-25-18 which stated, "Recommend to continue with all current medications, including ferrous sulfate (iron), Vitamin D, oxybutynin (for bladder spasms), Donepezil (dementia) memantine (dementia) and Zyprexa (antipsychotic)." However, Resident #104 was not taking Zyprexa, she was taking Geodon. On 10/04/18 at 9:24 AM, review of the PASARR-prescreening for mental illness, mental	F 657		

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F 657	Continued From page 19 retardation, intellectual disability or related conditions, dated 6-21-16 revealed: "No serious mental illness Schizophrenia, mood disorders, paranoid, panic or other serious anxiety disorder." Review of the admission orders (dated 6-8-16) revealed the resident was admitted with a Geodon order of 60 MG twice daily for psychotic disorder with delusions due to known physiological condition. The review showed there has been no GDR since with admission. Review of the care plan dated 9-20-18 revealed the following interventions for the use of antipsychotic medications: * Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. * Consult with pharmacy, MD to consider dose reduction when clinically appropriate at least quarterly. * Monitor/document/report prn (as needed) any adverse reactions of psychotropic medications. * Monitor/record occurrence of for target behaviors symptoms. There were no targeted behaviors on the care plan nor any non pharmacological interventions on the plan of care. Review of Nursing Drug Handbook, 2019, pages 1604-1607 revealed the following information for Geodon: "Indications for use: symptomatic treatment for schizophrenia, acute bipolar mania." There is a black box warning for elderly patients with dementia related psychosis, "drug isn't indicated for use because of increased risk of death from CV (cardiovascular) events of infection."	F 657		

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F 657	Continued From page 20 On 10/04/2018 at 2:50 PM: An interview was conducted regarding QAPI (quality assurance performance improvement) program. The Regional Administrator was asked about the residents who were receiving antipsychotic medications without GDR's stated, ..."If the Physician does not agree with Pharmacy Recommendations/making changes to the order, there's nothing much that can be done"... On 10/4/18 at 5:20 PM, the Administrator and DON (director of nursing) were notified of the above findings.	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 ensure professional standards of nursing for medication administration were followed for 1 residents (#83) of 46 residents in the survey sample. 1. For Resident #83 the facility staff failed to administer calcium per physician order. The findings included: Resident #83, an 80 year old, was admitted to the facility on 3/24/18. Diagnoses included reflux, hypertension, hyperlipidemia, anemia, and	F 658	Services Provided Meet Professional Standards 1. Resident #83 MD was notified of Calcium administration on 10/03/18. Resident # 83 was assessed licensed nurse and was found with no adverse reactions to medication. Resident #83 is receiving medications according to physician orders. 2. Residents that reside in the facility have the potential to be affected; therefore, the DON/designee has performed medication pass competency demonstration of licensed nursing staff to ensure that are administering medications per MD order. Follow up based on findings.	

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F 658	Continued From page 21 depression. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8/29/18. The resident was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. On 10/3/18 at 9:30 a.m., a medication pour and pass observation was conducted with Licensed Practical Nurse F (LPN F). LPN F was observed to prepare medications for Resident #83. LPN F was observed to administer the medications to Resident #83. LPN F administered one tablet of Calcium 600 milligrams to Resident #83 during the observation. Resident #83's physician orders were reviewed. A physician order dated 9/25/18 read. "Calcium Carbonate tablet Give 500 mg (milligram) by mouth two times per day." This means an incorrect dose of calcium was administered to Resident #83 by LPN F. On 10/3/18 at 2:30 p.m., the Administrator and Director of Nursing were notified of the error observed during the medication pour and pass observation. The Director of Nursing stated that the facility used Mosby's as their nursing standards reference. Fundamentals of Nursing, 6th Edition, Potter-Perry, p. 841, provides the following guidance for standards of medications administration. "To ensure safe medication administration the nurse should be aware of a nursing standard called the six rights of	F 658	3. DON/designee provided re-education for Licensed Nurses regarding proper administration of medications and following MD orders. DON/designee will perform random Quality Improvement Monitoring of medication administration to ensure medication administered per physician order weekly x 8weeks, monthly x 3, then quarterly and as needed. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance 11/06/18	

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F 658	Continued From page 22 medication administration. All medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation"	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 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 staff interview and facility documentation review, the facility staff failed to develop a comprehensive, collaborative care plan with the hospice agency for 1 of 46 residents sampled (Resident #81). The findings included: Resident #81 was admitted 8/7/2018 with diagnoses of: adult failure to thrive, schizophrenia, pressure ulcers, contractures, and dysphagia. She was admitted to hospice services on 8/21/2018.	F 684	Quality of Care 1. Resident #81 is receiving collaborative treatment and care by the facility and hospice agency. 2. Hospice residents that reside in the facility have the potential to be affected; therefore, the DON/ designee has conducted a quality review of hospice residents to ensure care plans are in place and appropriate collaboration with hospice agency. Follow up based on findings. 3. The DON/designee provided re- education for care plan team regarding updating care plans timely and the inclusion of hospice agency for care plan meetings.	

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F 684	Continued From page 23 Resident #81 had an Admission Minimum Data Set (MDS) on 8/14/2018 which did not show hospice services in field O0100k. On 8/22/18, the provider completed a significant change in status (SCSA) MDS, which did record hospice services. This SCSA assessment is required when a resident enrolls or dis-enrolls from hospice services. Per the RAI (Resident Assessment Instrument) Manual, v 1.14 (effective 10/1/2016), page 2-23: A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home ....A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing. From the RAI Manual, v 1.14, page 2-27: If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a	F 684	4. DON/designee to conduct Quality Improvement Monitoring to ensure care plan meetings are being held; care plans are being revised and updated as necessary weekly x 8 weeks, monthly x3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance 11/06/18	

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F 684	Continued From page 24 care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident. Resident # 81 had a facility care plan in the provider software that had no problem or goal that addressed hospice. She had a single intervention in her skin care plan that stated "Notify physician and Hospice for change in condition". She had a hospice care plan in the hospice folder which had interventions for the nursing facility staff to carry out, but no signatures of provider staff other than the physician. It should be noted that by the end of the survey, Resident #81's care plan had extensive revisions for hospice services. Although requested several times, the facility staff did not produce any documentation that hospice staff attended the care plan meeting.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility documentation and clinical record review the facility failed to ensure the environment was free of accident hazards for 1 Resident (Resident	F 689		

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F 689	Continued From page 25 # 122) in a survey sample of 46 Residents resulting in harm. For Resident #122, the facility failed to provide a safe raised commode seat resulting in a fall requiring hospitalization for 3 fractured ribs. Resident #122, a 68 year old woman, was admitted to the facility on 10/02/2017 with diagnoses of but not limited to Anemia, Hypertension, history of knee replacement, unsteady gait, Osteoarthritis, Chronic Pain, Low back Pain. Her most recent (Minimum Data Set) MDS (a screening tool) had the Resident coded as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. Resident #122 was coded as needing physical assistance of 1 staff member for all transfers and toileting. On 10/3/18 a review of the clinical record for Resident # 122 was conducted and it was found that on 8/30/18 at 11:45 PM, Resident #122 yelled out and was found on the floor of her bathroom (an unwitnessed fall) resulting in serious injury. According to the fall investigation dated 8/30/18 the Resident was assessed by nursing staff and denied any unusual pain. She was assisted back to her wheelchair where she stayed throughout the night because she refused to get into bed. According to the Medication Administration Record, Resident #122 was medicated with her routine Oxycodone 15 milligrams (mg), a Narcotic Pain Medication, at 12:00 AM and again at 4:00 AM on 8/31/18. In the morning of 8/31/18, Resident #122 was sent out to the Emergency	F 689	Free of Accident Hazards/Supervision/Devices 1. Resident # 122 currently stable and has sturdy assistive device to her toilet. 2. Residents that reside in the facility have the potential to be affected; therefore, a quality review of residents at risk of falls has been conducted to ensure appropriate interventions and assistive devices are in place as indicated. Follow up based on findings 3. Regional Director of Clinical Services (RDCS)provided re-education for nursing management team regarding prevention of accidents and incidents to include evaluation and usage of assistive devices. DON/designee provided re-education for Licensed Nurses regarding prevention of accidents and incidents to include evaluation and usage of assistive devices. 4. DON/Designee to complete Quality Improvement Monitoring of interventions implemented to ensure effective and no changes are necessary to the plan of care weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings.	

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F 689	Continued From page 26 Room for complaints of Shortness of breath and rib pain and was found to have 3 fractured ribs. On 10/04/2018 at 10:35 AM during an interview with Resident #122 she stated, "They know I take myself to the toilet, they never want to help if you put the call light on someone comes in turns it off and tells you someone else will be in to help you soon. Then they never come back so you put the light on again, but if that toilet wasn't wobbling I would not have fallen." She also stated, "They have fixed it a few times, if you call that fixing it." According to facility documentation in the Maintenance Log Book the "Raised commode seat" was fixed in Room 336 (Resident #122's room) on 8/22/18. A raised commode seat is a device that fits over the toilet which raises the toilet seat about 5 inches and is clamped to the toilet to keep it in place. On 10/4/18 at 6:30 PM, during an interview with Employee C, a maintenance tech. Employee C stated that he tightened the toilet seat several times. He stated that Resident #122 would stop him in the hall and ask him to tighten the toilet seat. On 10/4/18 at 6:40 pm, in an interview, Administration D (the former administrator) stated that Maintenance was aware that the toilet seat was not fitting properly and that it had been adjusted several times. Administration D stated they educated Maintenance on 8/31/18 that if a piece of equipment has to be repaired several times then it should probably be removed until it can be replaced. Administration D stated the raised	F 689	5. Date of Compliance: 11/06/18	

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F 689	Continued From page 27 commode seat was removed after the fall on 8/30/18 but the facility could provide no evidence that the seat was ever removed on 8/30/18. However, according to the Maintenance Log the raised commode seat was not removed until 09/04/18 when the Resident returned from the hospital and once again complained the raised seat was not sturdy. On 10/4/18 at 6:40 PM during interview Administration D and Employee C both stated they did not know how the raised commode seat ended up back in the Resident's bathroom. On 10/4/18 an observation showed the raised seat was replaced with a bedside commode frame with handrails, placed over the existing toilet to add height but also to add stability with the handrails and legs that have nonskid tips that reach the floor. There was no further information provided.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to administer	F 695		

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F 695	Continued From page 28 oxygen per physician order. For Resident #108, the facility staff failed to administer the correct amount of oxygen per physician order. The Findings included: Resident #108 was admitted to the facility on 8/24/18. Resident #108's diagnoses included Generalized Muscle Weakness, Unspecified Dementia without Behavioral Disturbance, Altered Mental Status, Hypertension, and Chronic obstructive Pulmonary Disease. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 9/20/18 coded Resident #108 as requiring the use of oxygen therapy. On 10/2/18 a tour was conducted of the facility. Resident #108's oxygen was being administered at 3 liters per minute. On 10/3/18 at 1:55 P.M., Resident #108's oxygen was being administered at 3 liters per minute. On 10/2/18 a review was conducted of Resident #108's clinical record, revealing a signed physician's order that read, "10/1/18. Oxygen 2 liters per minute continuously." On 10/02/18 at 1:58 P.M., an interview was conducted with Licensed Practical Nurse A. She stated that she had set the Resident's oxygen at 3 liters per minute because she was told to do via the morning verbal report at the beginning of her shift. She was asked to inform the surveyor of what the physician's order stated. She looked at the order and stated, "Oh wow, it's supposed to	F 695	Respiratory/Tracheostomy care and Suctioning 1. Resident # 108 settings were corrected during survey along with resident assessment and no adverse reaction was noted. 2. Residents that reside in the facility receiving oxygen have the potential to be affected; therefore, a quality review of residents receiving oxygen has been conducted to ensure oxygen is being administered per MD order. Follow up based on findings. 3. DON/designee will educate nursing staff on following MD orders to include oxygen administration. 4. DON/designee to complete Quality Improvement Monitoring to ensure oxygen is being administered per MD order weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance 11/06/18	

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F 695	Continued From page 29 be 2 liters per minute." On 10/2/18 a review was conducted of facility documentation, revealing an Oxygen Therapy Policy dated 8/28/17. It read, "Start O2 (oxygen) flowrate at the prescribed liter flow." On 10/3/18 at 3:00 P.M. the Administrator (Administration A) was informed of the findings. No further information was received.	F 695		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility failed to, for one Resident, Resident #104 in a survey sample of 46 residents, to ensure the resident received care and services for dementia care. Resident #104 has been taking Geodon 60 mg (milligrams) twice daily with no appropriate diagnosis or behaviors since her admission (6-8-16). There are no care plan interventions to address behaviors or for the continued use of an antipsychotic. The findings included: Resident #104 was admitted to the facility on 6-8-16. Diagnoses included anemia, Alzheimer's	F 744		

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F 744	Continued From page 30 dementia and psychosis. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9-5-18. Resident #104 was coded as having short and long term memory impairments and was severely impaired in daily decision making. There were no behaviors coded for the last seven days of the ARD. On 10/2/18 at 1:01 PM, Resident #104 was observed eating in her room. She had a regular diet, eating well. On 10/03/18 at 10:38 AM, Review of the clinical record revealed the pharmacy requested on 6-1-18 a GDR (gradual dose reduction) for the use of Geodon (antipsychotic) 60 mg twice daily. The MD declined the recommendation with the statement, "Continued use is in accordance with the current standard of practice" However, Resident #104 had no diagnosis on record for the use of an antipsychotic and no documented behaviors (for over a year) that indicated the continued use of the antipsychotic medication. In addition, the physician had declined an earlier request for a GDR with the same rationale. On 10/04/18 at 9:20 AM, the facility presented a physician note dated 9-25-18 which stated, "Recommend to continue with all current medications, including ferrous sulfate (iron), Vitamin D, oxybutynin (for bladder spasms), Donepezil (dementia) memantine (dementia) and Zyprexa (antipsychotic)." However, Resident #104 was not taking Zyprexa, she was taking Geodon. On 10/04/18 at 9:24 AM, review of the PASARR-	F 744	Treatment/Services for Dementia 1.Resident #104 has had GDR implemented as of 10/17/18. Resident is free from any acute behaviors. 2. Residents that reside in the facility receiving antipsychotic medications have the potential to be affected; therefore, the DON/designee conducted a quality review of residents receiving antipsychotic medications to ensure proper diagnosis and ensure care plans are in place. Follow up based on findings. 3. Regional Director of Clinical Services provided re- education for physicians and clinical team regarding usage/management of antipsychotic medications for residents with dementia. DON/designee will educate the nursing and MDS staff on updating care pans to include behaviors and implementing nonpharmacological interventions as necessary. 4. IDT team complete Quality Improvement Monitoring of antipsychotic medication usage/ management utilizing weekly Standards of Care meeting process to ensure proper diagnosis, care plans, nonpharmacological interventions, and review for possible GDR as indicated weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.	

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F 744	Continued From page 31 prescreening for mental illness, mental retardation, intellectual disability or related conditions, dated 6-21-16 revealed: "No serious mental illness Schizophrenia, mood disorders, paranoid, panic or other serious anxiety disorder." Review of the admission orders (dated 6-8-16) revealed the resident was admitted with a Geodon order of 60 MG twice daily for psychotic disorder with delusions due to known physiological condition. The review showed there has been no GDR since with admission. Review of the care plan dated 9-20-18 revealed the following interventions for the use of antipsychotic medications: * Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. * Consult with pharmacy, MD to consider dose reduction when clinically appropriate at least quarterly. * Monitor/document/report prn (as needed) any adverse reactions of psychotropic medications. * Monitor/record occurrence of for target behaviors symptoms. There were no targeted behaviors on the care plan nor any non pharmacological interventions on the plan of care. Review of Nursing Drug Handbook, 2019, pages 1604-1607 revealed the following information for Geodon: "Indications for use: symptomatic treatment for schizophrenia, acute bipolar mania." There is a black box warning for elderly patients with dementia related psychosis, "drug isn't indicated for use because of increased risk of death from CV (cardiovascular) events of	F 744	Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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F 744	Continued From page 32 infection." On 10/04/2018 at 2:50 PM: An interview was conducted regarding QAPI (quality assurance performance improvement) program. The Regional Administrator was asked about the residents who were receiving antipsychotic medications without GDR's stated, ..."If the Physician does not agree with Pharmacy Recommendations/making changes to the order, there's nothing much that can be done"... On 10/4/18 at 5:20 PM, the Administrator and DON (director of nursing) were notified of the above findings.	F 744		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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F 758	Continued From page 33 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff interview, clinical record review, and facility documentation review, the facility staff failed for 6 residents (131, 71, 122, 104, 81, 65) of the survey sample of 46 residents, to ensure that they were free from unnecessary psychotropic medications. 1. For Resident #131, the facility staff failed to ensure that he was free of unnecessary psychotropic medication (Seroquel).	F 758	Free from Unnec Psychotropic Meds/PRN Use 1. Residents # 131, #71, #122, #104, #81, and #65 were referred to psych services for evaluation of antipsychotic medication usage and diagnosis, and GDR approved and implemented as indicated. Residents receiving prn antipsychotic medications #65 & #71 was discontinued during survey. 2. Residents that reside in the facility receiving antipsychotic medication have the potential to be affected; therefore, DON/designee has completed a Quality Review of residents receiving antipsychotic medications to ensure proper diagnosis and documented behaviors. Follow up based on findings. 3. The Regional Director of Clinical Services (RDCS) has provided re-education for physicians and clinical team on usage/ management of antipsychotic medications per standard/regulation. DON/designee provided re-education for Licensed Nurses regarding proper usage of antipsychotic medications. 4. IDT team to complete Quality Improvement Monitoring of antipsychotic medication usage/ management utilizing weekly Standards of Care meeting process to ensure proper diagnosis, care plans, nonpharmacological interventions, and review for possible GDR as indicated weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality	

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F 758	Continued From page 34 2. For Resident #71 the facility administered antipsychotic medication without proper diagnosis and without attempting at Gradual Dose Reduction. 3. For Resident #122 the facility failed to perform a gradual dose reduction (GDR) on psychotropic medications in spite of Pharmacy recommendations and hospital warning that it was dangerous to give Ambien and narcotic pain medicine. 4. Resident #104 did not have an appropriate diagnosis for the use of Geodon (antipsychotic) as well as having no documented behaviors for over a year. The pharmacist issued two recommendations for a GDR (12-12-17 and 6-7-18) but the physician declined the recommendations. 5. For Resident #81, the facility staff failed to ensure the resident was free from unnecessary PRN (as needed) psychotropic medications. 6. For Resident #65 the facility staff failed to ensure the resident was free from unnecessary PRN (as needed) psychotropic medications. The Findings included: 1. For Resident #131, the facility staff failed to ensure that he was free of unnecessary psychotropic medication (Seroquel). Resident #131 was an 86 year old who was admitted to the facility on 9/7/18. Resident #131's diagnoses included Unspecified Dementia without Behavioral Disturbance, Lower Urinary Tract	F 758	Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance: 11/06/18	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 35 Symptoms, Major Depressive Disorder, Hypertension, and Generalized Anxiety Disorder. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 9/14/18, coded Resident #131 as sometimes being able to understand and be understood by others. Resident #131's primary language was Spanish, and he spoke limited English. In addition, he was coded an not having any mood or behavioral issues. On 10/2/18 at 11:00 A.M., Resident #131 was observed sitting quietly in his room. He was well groomed and dressed appropriately. He smiled when greeted, and made appropriate eye-contact. On 10/2/18 a review was conducted of Resident #131's clinical record. His signed physician order read, "10/1/18. Seroquel Tablet 50 MG Give 1 tablet by mouth every 12 hours related to Generalized Anxiety Disorder." Resident #131's care plan read, "The resident has impaired cognitive function/dementia or impaired thought process related to dementia. Resident will become combative with staff and confused." Resident #131's physician's order contained the following Black Box Warning, "Dementia-Related Psychosis--not approved for dementia-related psychosis; increased mortality risk in elderly dementia patients on conventional or atypical antipsychotics; most deaths due to cardiovascular or infectious events." Resident #131's pharmacy reviews did not	F 758		

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F 758	Continued From page 36 address the use of Seroquel. The risks associated with the use of Seroquel was not was not addressed in the clinical record. On 10/3/18 the facility Director of Nursing (Administration B), and Administrator (Administration A) were informed of the findings. No further information was received. 2. For Resident #71 the facility administered antipsychotic medication without proper diagnosis and without attempting at Gradual Dose Reduction. Resident # 71 was admitted to the facility on 03/19/2018 with diagnoses of but not limited to Dementia without behavioral disturbance, anxiety disorder, major depressive disorder, cognitive communication deficit r/t dementia, abnormal gait and mobility. Resident #71's most recent (Minimum Data Set) MDS with an (assessment reference date) ARD date of 8/28/2018 coded resident as having a (Brief Interview of Mental Status) BIMS score of 99 meaning severe cognitive impairment or unable to test. On 10/4/2018 during clinical record review it was found resident was receiving Risperidone (an antipsychotic) for a diagnosis of Dementia. According to Resident # 71's admission MDS and the Quarterly dated 5/7/2018 and the Quarterly dated 8/28/2018 in Section N - 0450 was checked yes indicating that the resident received Anti-Psychotic medication routinely. In addition, a box was checked - No indicating a GDR was Not attempted. Also a box was checked that indicated - No GDR has not been documented as clinically contraindicated.	F 758		

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F 758	Continued From page 37 According to the Medication administration record Resident #71 was receiving Risperidone 3 Milligrams [an antipsychotic medication] twice daily for a diagnosis Dementia and Anxiety Disorder. The FDA and the Manufacturers boxed warning for Risperdal (Risperidone-an antipsychotic) state: WARNINGS: Cerebrovascular Adverse Events, Including Stroke, in Elderly Patients with Dementia Cerebrovascular adverse events (e.g., stroke, transient ischemic attack), including fatalities, were reported in patients (mean age 85 years; range 73-97) in trials of risperidone in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was a significantly higher incidence of cerebrovascular adverse events in patients treated with risperidone compared to patients treated with placebo. RISPERDAL has not been shown to be safe or effective in the treatment of patients with dementia-related psychosis. On 10/4/18 at 2:50 PM during a meeting with Administration D regarding QAPI the question was posed: "We have noticed that there are a number of residents currently receiving long term antipsychotic medications. Have you identified this as an issue, and if so what interventions are you looking at to reduce number of residents being given antipsychotic meds and the length of time they are on them?"	F 758		

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F 758	Continued From page 38 Administration D responded, "If the Physician does not agree with Pharmacy Recommendations/making changes to the order, there's nothing much that can be done." 3. For Resident #122 the facility failed to perform a GDR on psychotropic medications in spite of Pharmacy recommendations and hospital warning that it was dangerous to give Ambien and narcotic pain medicine. Resident #122 a 68 year old woman admitted to the facility on 10/02/2017 with diagnoses of but not limited to Anemia, Hypertension, history of knee replacement, unsteady gait, Osteoarthritis, Chronic Pain, Low back Pain, Her most recent (Minimum Data Set) MDS (a screening tool) has the Resident coded as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. Resident #122 was coded as needing physical assistance of 1 staff member for all transfers and toileting. On 10/3/2018 during a review of clinical records it was found that Resident #122 was receiving Ambien 10 mg for insomnia, Cymbalta 60 mg (Antidepressant), Celexa 10 mg (antidepressant), Oxycodone 15 mg every 4 hours routinely (narcotic pain medicine) and Neurontin 300 mg (a seizure medication also used for Neuropathic pain). Also during clinical record review there was a Pharmacy Consultation Report dated 2/6/18 asking the physician to consider a GDR for AMBIEN 10 mg to which the Physician refused stating it was unsuccessful in the past. No GDR has been attempted since that request.	F 758		

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F 758	Continued From page 39 Also during clinical record review there was a discharge summary from a recent hospitalization where the Resident fell off the toilet and fractured 3 ribs. The discharge summary stated "- Hold home Ambien use, Dangerous combination given Opioid use and age" According to the manufacturer of Ambien (Zolpidem) AMBIEN is a prescription medicine for the Short-Term treatment of adults who have trouble falling asleep. AMBIEN CR is a prescription medicine for treatment of adults with trouble falling asleep and/or waking up often during the night AMBIEN or AMBIEN CR may cause serious side effects, including: · Getting out of bed while not being fully awake and doing an activity that you do not know you are doing. · Abnormal thoughts and behavior. Symptoms include more outgoing or aggressive behavior than normal, confusion, agitation, Hallucinations, worsening of depression, and suicidal thoughts or actions · Memory loss · Anxiety · ·Falls, which may lead to severe injuries. According to Nursing 2015 Drug Guide pg. 1482 under the heading Indications and Dosage: Short Term management of Insomnia - Adults 5 or 10 Mg (Men) or 5 mg (Woman) by mouth immediately before bedtime	F 758		

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F 758	Continued From page 40 Adjust a Dose- for Elderly or debilitated patients use 5 mg immediately before bedtime Under the heading INTERACTIONS: Drug to Drug- (Central Nervous System) CNS depressants may cause excessive CNS Depression. According to the FDA: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning A U.S. Food and Drug Administration (FDA) review has found that the growing combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. Opioids are used to treat pain and cough; benzodiazepines are used to treat anxiety, insomnia, and seizures. In an effort to decrease the use of opioids and benzodiazepines, or opioids and other CNS depressants, together, we are adding Boxed Warnings, our strongest warnings, to the drug labeling of prescription opioid pain and prescription opioid cough medicines, and benzodiazepines. Health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and	F 758		

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F 758	Continued From page 41 symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants On 10/4/2018 the Administration was made aware during the end of day meeting and no further information was provided. 4. Resident #104 did not have an appropriate diagnosis for the use of Geodon (antipsychotic) as well as having no documented behaviors for over a year. The pharmacist issued two recommendations for a GDR (12-12-17 and 6-7-18) but the physician declined the recommendations. Resident #104 was admitted to the facility on 6-8-16. Diagnoses included anemia, Alzheimer's dementia and psychosis. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9-5-18. Resident #104 was coded as having short and long term memory impairments and was severely impaired in daily decision making. There were no behaviors coded for the last seven days of the ARD. On 10/2/18 at 1:01 PM, Resident #104 was observed eating in her room. She had a regular diet, eating well. On 10/03/18 at 10:38 AM, Review of the clinical record revealed the pharmacy requested on 6-1-18 a GDR (gradual dose reduction) for the use of Geodon (antipsychotic) 60 mg twice daily. The MD declined the recommendation with the statement, "Continued use is in accordance with	F 758		

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F 758	Continued From page 42	F 758		

the current standard of practice" However, Resident #104 had no diagnosis on record for the use of an antipsychotic and no documented behaviors (for over a year) that indicated the continued use of the antipsychotic medication. In addition, the physician had declined an earlier request for a GDR with the same rationale.

On 10/04/18 at 9:20 AM, the facility presented a physician note dated 9-25-18 which stated, "Recommend to continue with all current medications, including ferrous sulfate (iron), Vitamin D, oxybutynin (for bladder spasms), Donepezil (dementia) memantine (dementia) and Zyprexa (antipsychotic)." However, Resident #104 was not taking Zyprexa, she was taking Geodon.

On 10/04/18 at 9:24 AM, review of the PASARR-prescreening for mental illness, mental retardation, intellectual disability or related conditions, dated 6-21-16 revealed: "No serious mental illness Schizophrenia, mood disorders, paranoid, panic or other serious anxiety disorder." Review of the admission orders (dated 6-8-16) revealed the resident was admitted with a Geodon order of 60 MG twice daily for psychotic disorder with delusions due to known physiological condition. The review showed there has been no GDR since with admission.

Review of the care plan dated 9-20-18 revealed the following interventions for the use of antipsychotic medications:

* Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift.

* Consult with pharmacy, MD to consider dose reduction when clinically appropriate at least

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F 758	Continued From page 43 quarterly. * Monitor/document/report prn (as needed) any adverse reactions of psychotropic medications. * Monitor/record occurrence of for target behaviors symptoms. There were no targeted behaviors on the care plan nor any non pharmacological interventions on the plan of care. Review of Nursing Drug Handbook, 2019, pages 1604-1607 revealed the following information for Geodon: "Indications for use: symptomatic treatment for schizophrenia, acute bipolar mania." There is a black box warning for elderly patients with dementia related psychosis, "drug isn't indicated for use because of increased risk of death from CV (cardiovascular) events of infection." On 10/04/2018 at 2:50 PM: An interview was conducted regarding QAPI (quality assurance performance improvement) program. Administration A was asked about the residents who were receiving antipsychotic medications without GDR's stated, ..."If the Physician does not agree with Pharmacy Recommendations/making changes to the order, there's nothing much that can be done"... On 10/4/18 at 5:20 PM, the Administrator and DON (director of nursing) were notified of the above findings. 5. For Resident #81, the facility staff failed to ensure the resident was free from unnecessary	F 758		

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F 758	Continued From page 44 PRN (as needed) psychotropic medications. Resident #81 was admitted 8/7/2018 with diagnoses of: adult failure to thrive, schizophrenia, pressure ulcers, contractures, and dysphagia. On 9/15/2018, the physician ordered "Haldol 1mg tablet: give 1 mg by mouth every 1 hours as needed for nausea/delirium." Note: Haldol is an antipsychotic medication. The renewal for the specific prescription was due by 9/29/2018. The physician order for Haldol was still in place and active for staff on 10/3/2018. A staff interview was conducted with Admin B (the Director of Nursing) on 10/3/2018 at 2:15 PM. When asked what the status of the order was, Admin B replied "It is supposed to be reordered every 14 days. It has been more than that, so the order isn't valid anymore." When asked what the facility process is to ensure that orders were discontinued and renewed timely, Admin B didn't reply. Facility staff were asked to produce the policy or procedure for medication renewals, but did not. No further information was provided prior to exit. 6. For Resident #65 the facility staff failed to ensure the resident was free from unnecessary PRN (as needed) psychotropic medications. Resident #65, an 81 year old, was admitted to the facility on 3/3/17. Diagnoses included hyperlipidemia, depression, end stage renal disease, dementia, and anxiety. The most recent Minimum Data Set assessment	F 758		

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F 758	Continued From page 45 was a significant change assessment with an assessment reference date of 8/10/18. The resident was coded with a Brief Interview of Mental Status score of 5 indicating severe cognitive impairment and required extensive assistance with activities of daily living. Resident #65 had a physician order dated 8/7/18 for Haloperidol (antipsychotic medication) 1 milligram tab every hour as needed (PRN) for nausea. On 10/3/18 at 2:30 p.m. the Administrator and Director of Nursing were notified that Resident #65 had an order for a PRN antipsychotic medication for longer that 14 days. They were asked to provide documentation that the physician had assessed the resident to determine if the continuation of the medication was appropriate. No documentation was provided regarding the physician assessment.	F 758		
F 761 SS=E	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 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	F 761		

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F 761	Continued From page 46 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 and staff interview, the facility staff failed to ensure safe storage of medications. 1. Two medications were found to be expired, and open and available For Resident administration to Residents #52, and #133. 2. The facility staff failed to discard 2 bottles of expired medication (magnesium oxide) in 2 of 3 medication rooms (1st floor and 3rd floor medication rooms) 3. The facility staff failed to ensure the narcotic box was permanently affixed in 2 of 3 medication refrigerators (2nd and 1st floor medication rooms) In addition, the narcotic box in the 2nd floor medication refrigerator was not locked. The findings include: 1. Two medications were found to be expired, and open and available For Resident	F 761	Label/Store Drugs and Biologicals 1. Identified expired medications were removed from the medication carts and discarded during survey and replaced new medications. The narcotics boxes were permanently affixed in each medication room refrigerator during survey and are secured behind double locks. 2. DON/Designee has conducted a Quality Review of medication carts and medication rooms to ensure that no expired medications in use as well as ensure narcotics are properly secured and locked. Follow up based on findings. 3. DON/designee will educate nursing staff on proper medication storage of drugs and proper securement of scheduled II narcotic drugs. 4. DON/designee will perform Quality Improvement Monitoring of medication carts and medication rooms to ensure no expired medication and that narcotics are properly stored and locked weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance 11/06/18	

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F 761	Continued From page 47 administration to Residents #52, and #133. On 10-3-18, at 10:00 a.m., during the medication pour and pass observation, with LPN (B) (licensed practical nurse (B), two pill form, bulk dose medications were noted to be expired. LPN (B) was asked during the medication pour and pass observation how medications are dated for expiration, and she responded "we date them when we open them." She was asked how long would pills last that had been opened, and she responded "usually one year." During the medication pour and pass observation the bulk dose medications in the medication cart were found to be open and revealed an open date, hand written on each of the bottles, with what appeared to be permanent markers. At 10:10 a.m., LPN (B) was shown the open date on the Magnesium Oxide 400 milligram tablets, for Resident (#52), after she prepared it for administration, and it was 9-16-2017. At 10:20 a.m., LPN (B) was shown the open date on the Vitamin D-3 1000 internationalized units tablets, for Resident (#133), after she prepared it for administration, and it was 8-1-17. Both medications were expired. She stated "oh, I see, I will throw them away, and get a new bottle from central supply." The Central supply manager (Employee E) was asked to show the surveyor where bulk dose medications were stored. He opened the cabinet and revealed approximately one hundred bottles of different bulk dose tablet medications which were sealed and unopened. No open dates appeared on any of the bottles. Employee E was	F 761		

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F 761	Continued From page 48 interviewed and stated "I don't date the bulk dose medications when they arrive, the nurses date them when they are opened." The Director of Nursing and the administrator were made aware of the findings, and shown the bulk dose bottles of expired medications in the conference room at the end of day debriefing on 10-3-18. No further information was provided. 2. The facility staff failed to discard 2 bottles of expired medication (magnesium oxide) in 2 of 3 medication rooms (1st floor and 3rd floor medication rooms) On 10/02/2018 at 1:57 pm, an observation of the 3rd floor medication room was conducted with LPN L. The observation showed a bottle of magnesium oxide (500 milligram) that expired on 6/2018. LPN L verified the expiration date and stated that the magnesium oxide should have been discarded. On 10/02/18 at 02:25 pm, an observation of the 1st floor medication room was conducted the RN A. The observation showed a bottle of magnesium oxide 500 milligram (mg) that expired on 6/2018. RN A verified the expiration date and stated that the magnesium oxide should have been discarded. The facility was informed of the findings during a briefing on 10/03/2018. 3. The facility staff failed to ensure the narcotic	F 761		

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BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

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F 761	Continued From page 49 box was permanently affixed in 2 of 3 medication refrigerators (2nd and 1st floor medication rooms.) In addition, the narcotic box in the 2nd floor medication refrigerator was not locked. On 10/02/18 at 02:06 pm, an observation of the 2nd floor medication room was conducted the LPN A. The observation showed the narcotic box in the medication refrigerator was not permanently affixed. In addition, the narcotic box was not locked and it contained lorazepam 2 mg/1 ml (2 milligrams per 1 milliliter) On 10/02/18 at 02:25 pm, an observation of the 1st floor medication room was conducted the RN A. The observation showed the narcotic box in the medication refrigerator was not permanently affixed. The facility was informed of the findings during a briefing on 10/03/2018.	F 761		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A	F 801		

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F 801	Continued From page 50 qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:	F 801	Qualified Dietary Staff 1. The facility has a qualified dietary manager in place as of 10/24/2018. 2. No residents were affected by this deficient practice. 3.Executive Director has been re- educated on the requirements to employee a Certified Dietary Manager by the Regional Vice President of Operations (RVPO) 4. RVPO to conduct random Quality Improvement Monitoring. Monitoring of Dietary Management Team for required qualifications quarterly x 3 and as needed. Findings will be reported to Quality Assurance Performance Improvement (QAPI) Committee monthly and updated as indicated. Monitoring schedule modified based on findings. 5. Date of compliance: 11/06/18	

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F 801	Continued From page 51 (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility staff failed to ensure that the Acting Dietary Manager was certified. The facility staff failed to ensure that the Acting Dietary Manager was Certified in Dietary Management. The facility did not have a Dietary Manager. The Findings included: On 10/3/18 at 11:45 A.M., an observation was completed of the facility kitchen. The Acting Dietary Manager (Employee A), was working in the kitchen during lunch preparation and service. She stated that her position was Assistant Dietary Manager and Executive Chef. Her hire date according to her employee file was 8/1/18. She stated since the former Dietary Manager quit, that she supervised the meal preparation, ordered	F 801		

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F 801	Continued From page 52 food, and cooked food in the facility. She stated that she was not a Certified Dietary Manager, and that she planned to be trained for the certification the following week. On 10/3/18 a review was conducted of facility documentation, revealing a Employee A's Job Description that read, "Assistant Manager & Executive Chef. Qualifications: Certified Dietary Manager. Skilled in motivating and supervising dining services personnel." On 10/3/18 the Administrator was informed of the findings. No further information was received.	F 801		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

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F 880	Continued From page 53 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	Infection Control 1. CNA A was re- educated on proper infection control practices to include the use of individualized personal care items and no residents were found to be affected related to improper infection control practices. 2. DON/designee has conducted quality observation rounds to ensure that infection control practices related to personal care items carried out per standard of practice. Follow up based on findings. 3. The DON/designee provided re-education for nursing staff on infection control standards of practice to include the use of individualized personal care items. 4. DON/designee to conduct random Quality Improvement Monitoring to ensure staff members utilizing infection control practices per standard relative to resident personal care items weekly x 8 weeks, monthly x 3, then quarterly and as needed. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. Monitoring schedule modified based on findings. 5. Date of Compliance 11/06/18	

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F 880	Continued From page 54 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to provide Activities of Daily Living (ADL) care in a manner to prevent the spread of infection. A facility staff member carried a cloth bag from room to room, with no way to disinfect it. The Findings included: On 10-2-18 and 10-3-18 during multiple observations both days throughout the 7:00 a.m., to 3:00 p.m. shift, CNA (A) (certified nursing assistant A) was observed by 2 surveyors to be carrying a pink cotton cloth bag, (which resembled a ladies purse), in and out of Residents rooms. CNA (A) was observed laying it down on residents overbed tables when she entered each room. The bag contained shampoo, soap and other bathing supplies which were being used by CNA (A), and shared for all of the residents receiving ADL care from CNA (A). On 10-4-18 at 9:50 a.m., CNA (A) was interviewed, and stated the bag contained shampoo, soap and other bathing supplies which were being used by CNA (A) for all of the residents ADL care. She further stated "I buy it myself, but I won't carry the bag, or the bottles into each room anymore." The Director of Nursing, and the Administrator were made aware of the findings at the end of	F 880		

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F 880	Continued From page 55 day debrief on 10-4-18.	F 880		