STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495179	A. BUILDING _____ B. WING _____	C 10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTOMAC FALLS HEALTH & REHAB CENTER	46531 HARRY BYRD HIGHWAY STERLING, VA 20164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/9/18 through 10/11/18. 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		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 10/9/18 through 10/11/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 8 complaints were investigated during the survey. The census in this 150 certified bed facility was 147 at the time of the survey. The survey sample consisted of 32 current Resident reviews and 8 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, medical record review and facility documents the facility staff failed to provide for the accommodation of needs to maintain independence and to ensure the safety for 1 of 40 residents in the survey sample, Resident	F 558	1.Resident #154□s call bell was checked for placement upon notification by surveyor. 2.Any resident may be at risk if a call bell is not within reach. An audit of call bell	11/23/18

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

Electronically Signed | 11/01/2018

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F 558	Continued From page 1 #154. For Resident #154, he facility staff failed to ensure the call bell was placed within reach. The findings included: Resident # 154 was a 78 year old admitted to the facility on 09/28/2018 with diagnoses to include contusion of the lung, multiple fractures of ribs S/P fall, subsequent encounter for fracture with routine healing, Type 2 Diabetes Mellitus, Epilepsy, unsteadiness on feet, lack of coordination, muscle weakness, frontal lobe and executive deficit. The admission Minimum Data Set (MDS) had not been due/completed. Information was gathered from the Resident's baseline Care Plan. Focus: Name (Resident # 154) has an ADL (Activities of Daily Living) Demonstrates the need for ADL assistance r/t (related to) multiple rib fracture, s/p (status post) fall. Date Initiated: 09/28/18 Revision on: 10/05/18 Interventions: *Provide assistance for bed mobility as needed. *Provide assistance for locomotion as needed. *Provide assistance for toileting as needed. *Provide assistance with transfers as needed. *Provide assistance with bathing and dressing as needed. Focus: Risk for falls r/t epilepsy and h/o falls. Date Initiated: 09/28/18 Revision on: 10/02/18 Interventions: *Orient patient and family to room, call bell,	F 558	clips and cord length in relationship to seating in room will be conducted to ensure ability for call be to be within reach. 3. Education will be conducted for licensed and non-licensed staff members and the Facility□s call bell policy will be reviewed to ensure the importance and need for all residents to have call bell in reach. 4.Leadership Team members or designee will do random call bell placement checks on 20 residents call bells per week for four weeks and then monthly for 2 months. The results will be reviewed weekly in the standup meeting and results will be reported to our facility□s monthly QAPI meeting with any variances addressed	

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F 558	Continued From page 2	F 558		

lighting, and bathroom.
*Orient to call bell and encourage use to request assistance.
*Frequent patient checks during adjustments period to new surroundings and while assessing/ observing patient's routine.
*Pt. re-educated on the importance of making sure walker is locked when using to stand or transfer, before using it for mobility.
Focus: At risk for falls Unsteady gait. Date Initiated: 10/06/18 Created on: 10/06/18

Interventions:
*Anticipate and meet needs.
*Be sure call light is within reach and encourage to use it for assistance as needed.

During the survey the following observations were made:

On 10/09/18 at 2:38 PM the call bell was observed on the bed while Resident # 154 was sitting in the recliner chair, not within reach.

On 10/09/18 at approximately 3:40 PM, Resident # 154 said that she had fallen since being admitted to rehab. on 10/06/18, call bell was on Resident # 154's bed while she sat on the further side of the room, not within reach.

On 10/10/18 at approximately 10:39 AM a visit was made to Resident # 154 room. She stated that she was having "headache pain that feels like it's affecting my eyes"as well as pain from her fractured ribs. The resident said that she had spoken to the doctor earlier and requested to have xrays of her head. The Resident was sitting in her recliner, the call bell was laying on the bed out of reach.

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On 10/10/18 at approximately 10:58 AM Resident # 154 said that her blood sugar was 105 this morning and that she feels dizzy most of the time. She also said that the staff is aware. The Resident was sitting in her recliner, the call bell was laying on the bed, out of reach.

On 10/10/18 11:20 AM Call bell was observed not in reach while Resident # 154 was sitting in the recliner not within reach.

On 10/10/18 1:29 PM In to see resident in room, call bell on the bed while Resident # 154 was sitting in the recliner out of reach. Resident was watching tv.

On 10/10/18 2:28 PM Resident was observed on the phone talking. Her call bell remained on the far side of her bed out of reach.

On 10/10/18 2:30 PM an interview was conducted with LPN (Licensed Practical Nurse) # 1. LPN #1 was asked if she had been the nurse for the Resident #154 any this week. LPN #1 stated, "Yes!" LPN #1 was asked if she was aware that Resident # 154 call bell was on her bed while she sat in the recliner on the further side of the room yesterday and today. LPN # 1, shook her head, "No." She stated that CNA (Certified Nurses Aide) # 1 was Resident # 154 aide today. (10/10/18).

On 10/10/18 02:40 PM an interview was conducted with Certified Nursing Assistant (CNA) #1. She was asked if she noticed that Resident # 154 call bell was out of reach on her bed while she was sitting in her recliner on the further side of the room. CNA # 1, stated that she was not aware and that she had educated Resident # 154

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F 558	Continued From page 4	F 558		

to the call bell. CNA # 1 also said that the call bell should be near the resident.

On 10/10/18 2:38 PM Entered residents room call bell remained on the far side of Resident's bed while she sat in the recliner.

On 10/10/18 3:00 PM Entered residents room, Resident # 154 sitting in her recliner. Call bell was still on Resident #154's bed.

On 10/10/18 3:15 PM Resident # 154 was seen ambulating with her walker to the restroom. Call bell on the bed.

On 10/10/18 3:42 PM The administrator was notified that the call bell had been observed since yesterday out of reach on Resident #154's bed while she sat in her recliner.

On 10/10/18 at approximately 3:42 PM, the Administrator was asked for call bell policy.

The facility's policy titled CALL-BELL/LIGHT SYSTEM states that a well-functioning call-bell light shall be provided;so that each resident will have a way to communicate his/her needs to the Nursing staff. (1). Every call-bell/light should be acknowledged ASAP. The bathroom emergency lights must be answered immediately. (2.). The signal cord or button must be kept within the reach of the resident at all times. (3).If a resident is not within reach of his/her call-bell/light...unable to use the call bell-inactivate. The resident must have a way to call for help that is within reach;that meets their needs.

On 10/11/18 at 3:00 PM a pre-exit interview was conducted with the Administrator and the Director

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F 558	Continued From page 5 of Nursing where the above information was shared. The Director Of Nursing and Administrator were addressed with call bell concerns due to Resident # 154 having a history of falls, feeling dizzy, and being unsteady on her feet at times, as well as, having headaches, not having her call bell within reach. The Director Of Nursing was asked what she would have expected the staff to do with Resident # 154 call bell. The Director of Nursing stated, "The call bell should have been left in reach in order for the resident to maintain her safety and independence." No further information was provided by the facility staff.	F 558		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, clinical record review and facility documentation review, the facility staff failed to notify one of 40 residents (Resident #19) of a change in roommate.	F 559	1.Facility staff met with Resident #19 to discuss his concerns. 2.Any resident or patient located in a semi-private room within the facility has the potential to be affected if not properly	11/23/18

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F 559	Continued From page 6 The facility staff failed to inform Resident #19 in advance, of a roommate change of a resident that was transferred to his room from another unit in the facility. The findings included: Resident #19 was admitted to the nursing facility on 7/23/13 with diagnoses that included paraplegia. The most recent Minimum Data Set Assessment was an annual assessment dated 8/20/18 and coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment. During an interview with Resident #19 on 10/10/18 at 10:40 a.m., he stated he had several roommates move in and out of his room and was never approached by anyone to let him know of the change in roommates. He stated the roommates were transferred into his room from another unit within the facility. He stated, "I felt I was not important to them at all. It didn't mean I would not accept another roommate, just that it would have been respectful." On 10/10/18 at 2:00 p.m., the social worker verified Resident #19 had three roommates transferred into his room from within the facility on 6/21/18, 7/13/18, and 7/31/18. She stated she did not have any documentation that she approached the resident to inform him in advance of a change in roommate and indicated there was ample time to have let him know.	F 559	notified of an incoming resident or patient who will be moved into the room from another unit from within the facility. 3.IDT and licensed nurses will be educated on the process of roommate change or incoming patient notification and documentation. 4.The Social Services Director or designee will audit the EMR to ensure that notification is taking place as well as the notation in the resident□s or Patient□s EMR of room changes for the past 30 days and will conduct an audit of notification of roommate changes weekly for three months. Results of these audits will be analyzed and discussed for further recommendations during the facilities monthly Quality Assurance process, Results will be reported in QAPI committee and any variances addressed.	

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F 559	Continued From page 7 On 10/11/18 at 1:50 p.m., the aforementioned issue was brought to the attention of the Administrator, Regional Director of Operations and Director of Nursing (DON). No further information was brought forward prior to survey exit. The facility's policy and procedure titled Patient/Resident Room Changes dated 11/2017 indicated prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as possible.	F 559		
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 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	F 582		11/23/18

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F 582	Continued From page 8 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 a complaint investigation, record review, family interviews, staff interviews, and facility document review the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) prior to discharge for 1 of 40 residents in the survey sample, Resident #148. The facility staff failed to issue a Medicare Notice	F 582	1. Resident 148 no longer resides at the facility. It is duly noted facility failed to issue a notice of non-coverage letter prior to discharge resident #148. Notices of non-coverage were audited for patients discharged in the past 30 days. 2. Any resident who is under Medicare or Commercial Insurance coverage has the	

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F 582	Continued From page 9 of Non-Coverage prior to Resident #148's discharge that was facility planned on 8/8/17 however occurred on 8/9/17. The findings included: Resident #148 was admitted to the facility on 7/16/17 with diagnoses to include Left Femur Fracture, Atrial Fibrillation and Dementia. On the facility Admission Record Resident #148's son was listed as her Responsibility Party and Guardian. The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/23/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated that Resident #148 was not cognitively intact and incapable of daily decision making. The last Minimum Data Set (MDS) assessment was a Discharge with an Assessment Reference Date (ARD) of 8/8/17. Under Section A2000 Discharge Date Resident #148 was coded as 8/9/17. Under A2100 Discharge Status Resident #148 was coded as 1 (Community). ON 10/10/18 at 11:31 A.M. a phone interview was conducted with Resident #148's son (Responsible Party). Resident #148's son was made aware that surveyors were in the facility and his complaint investigation had begun. Resident #148's son stated, "The facility nurse called me on August 8, 2017 around 5 o'clock asking me if I was aware that my mother was being discharged today. I said "no" that no one had called me about a discharge because I needed to arrange for a private sitter to stay with	F 582	ability to be affected if not informed of services not covered under their payer source or for when any services will cease within proper time frame as deemed appropriate per Medicare guidelines 3. Social services personnel will be in serviced on providing proper notice of Medicare non-coverage within proper time frame as deemed appropriate per Medicare guidelines to Medicare patients prior to discharge. 4. The Social Services Director or designee will audit all Medicare/Commercial payer changes from the past 30 days and will conduct an audit of 5 payer changes weekly for two months. Results of these audits will be analyzed and discussed for further recommendations during the facilities monthly Quality Assurance process Results will be reported in QAPI committee and any variances addressed.	

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F 582	Continued From page 10	F 582		

her at nights at her assisted living for her safety. The nurse called me because her transport had not arrived yet so they canceled the discharge for that night but discharged her the next day. Resident #148's son was asked if he had received a Medicare Notice of Non-Coverage from the facility prior to discharge. Resident #148's son stated, "No, I wasn't given anything I did not even know she was being discharged."

Resident #148's Facility Progress Notes were reviewed and are documented in part, as follows:

8/4/17 at 8:51 A.M. Social Services Note=SSD (Social Services Director) spoke with (Name) at the Name (assisted living), is ready to accept resident back. Planned discharge Tuesday.

8/8/17 at 10:45 A.M. Social Services Note=resident set to discharge to ALF (Assisted Living Facility).

8/8/17 at 19:55 (7:55) P.M. Health Status Note=pt. (patient) was scheduled for discharge today. called and spoke with son and he stated that he was not aware of discharge today. discharge is canceled for today. In house supervisor made aware.

8/8/17 at 22:58 (10:58) P.M. Health Status Note=Spoke with SW (Social Worker) today, son still working on the D/C (discharge) date.

8/9/17 at 22:00 (10:00) P.M. Health Status Note= Patient discharged as planned. MD (Medical Doctor) aware.

A Skilled Nursing Facility Protection Notification Review was completed on 10/10/18. Resident

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#148's information was reviewed and documented in part, as follows:

Medicare Part A Skilled Services Episode Start Date: 7/16/17
Last covered day of Part A Service: 8/9/17

How was the Medicare Part A Service Termination/Discharge determined?
The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.

2. Was a Notice of Medicare Non-Coverage (NOMNC) provided to the resident?
No-If no, explain why the form was not provided:
2. Other: Not found in the Medical Record and no way to validate if completed or not.

On 10/10/18 at approximately 12:30 P.M. the Regional Director of Operations stated, "We cannot find a NOMNC for Name (Resident #148) that was issued, the Social Workers that were here then have all gone now."

The MDS Billing Calendar provided by the facility billing department for Resident #148 was reviewed.. The MDS Billing Calendar for Resident #148 indicated that the resident had 76 Part A Skilled Medicare days left.

On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations were the above information was shared. Prior to exit no further information was provided.

This is A COMPLAINT DEFICIENCY

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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 623	Continued From page 12	F 623		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623		11/23/18

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required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 623	Continued From page 14 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of a hospital discharge for 1 of 40 residents (Resident #63) in the survey sample. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #63's transfer to the emergency room (ER) from dialysis on 07/18/18. The finding included: Resident #63 was re-admitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *End Stage Renal Disease (ESRD).	F 623	1. Resident # 63 was transferred from Dialysis Center to the hospital. Resident 63 no longer resides at the facility. The facility sent a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for resident #63 2. Any resident being discharged has the ability to be affected. if the center does not inform the office of the State Long Term Care Ombudsman in writing of a resident or patient that is transferring or discharging from the facility in any capacity as soon as practicable. 3. Social Services personnel will be in serviced on providing the office of the State Long Term Care Ombudsman notice in writing of all residents or patient that transfer from facility at any capacity.	

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F 623	Continued From page 15 The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment. The Discharge MDS assessments was dated for 07/18/18, discharge return anticipated, re-admitted to the facility on 07/19/18. On 07/18/18, according to the facility's documentation, Resident #63 called the facility from the dialysis center to inform the nurse she was being sent to the local ER for evaluation due to complaints of dizziness. Resident returned to the facility on 07/19/18. On 10/10/18 at approximately at 12:35 p.m., an interview was conducted with the Assistant Social Worker who stated, "I was unable to locate in the medical record where the Ombudsman was notified of Resident #63's discharge to the hospital on 07/18/18. The surveyor asked, "Should you have notified the ombudsman of Resident #63's discharge to the hospital" she replied, "Yes." The facility administration was informed of the finding during a briefing on 10/11/18 at approximately 2:00 p.m. The facility did not present any further information about the findings. The facility's policy titled Notification of Discharge. -Policy: The facility must provide advance notice to the resident/resident representative, and a copy to the state ombudsman for planned discharges for all facility initiated discharges at or around the time of discharge. Advance notice is	F 623	4. The Social Services Director or designee will audit the EMR to ensure notification is in compliance for all residents or patients that have transferred or discharged from the facility with weekly x 4 weeks then monthly x 2 months. Results will be reported in QAPI committee and any variances addressed.	

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F 623	Continued From page 16 defined as 30 days or as soon as practicable depending on the reason for the discharge. -Discharges notice for emergent discharges will be provided to the patient/representative as soon as practicable. Copies of notices for emergency transfers must also be sent to the ombudsman, but they may be sent when practicable and may be provided in the form of a list of residents on a monthly basis. Definitions: *ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).	F 623		
F 641 SS=D	Accuracy of Assessments 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 clinical record review, staff interview, and facility documentation review, the facility staff failed to ensure one (Resident #146) of 40 residents in the survey sample had an accurate Minimum Data Set (MDS) assessment. Resident #146's discharge MDS, dated 8/28/18, was coded that she was discharged to the hospital rather than discharged home. The findings included:	F 641	. Resident #146□s, MDS dated 8/28/18 section A was modified to reflect discharge to home. 2. Any resident whose discharge status is not accurately coded in the MDS has the potential to be affected. A review of the current discharged residents will be conducted to ensure accurate coding of the MDS. 3. The interdisciplinary team responsible for coding the MDS will be educated	11/23/18

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F 641	Continued From page 17 Resident #146 was a 87 year old admitted to the facility on 8/15/18 with diagnoses to include Chronic Kidney Disease and Congestive Heart Failure. The most recent MDS assessment was a Discharge with an Assessment Reference date of 8/28/18. Under Section A Type of Assessment Resident #146 was coded as 10/1 (Discharge assessment-return not anticipated), planned. Under A 2100 Discharge Status Resident #146 was coded as 03 (discharge to acute hospital). Resident #146's progress note dated 8/28/18 at 11:26 A.M. was reviewed and is documented in part, as follows: pt. (patient) left the facility at 11:00 to home accompanied by her daughter. pt. received education regarding medication administration, diet, and emergency situation. pt. received all her belongings including medication and personal. pt. denied any pain or discomfort at the time of exit. Resident #146's Physician Order dated 8/28/18 at 6:02 A.M. was reviewed and is documented in part, as follows: Pt. to DC (discharge) home on 8/28/18. The facility Discharge Summary for Resident #146 was reviewed and is documented in part, as follows: A. 1. Date of admission: 8/15/18 2. Date of discharge/transition: 8/28/18 B. Discharge Disposition of Patient:	F 641	regarding accurate coding of the MDS. 4. MDS coordinators or designee(s) will conduct an audit of 6 completed discharge assessments weekly for four weeks then monthly for two months for coding of discharge status. Results of these audits will be analyzed and discussed for further recommendations during the facility□s monthly Quality Assurance process. Great except for date	

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F 641	Continued From page 18 1. Discharge/Transition destination: a. Home with caregiver/family. b. Home with Home Health services. On 10/10/18 03:15 PM an interview was conducted with the MDS Director regarding Resident #146's Discharge MDS dated 8/28/18. After reviewing the resident's medical record the MDS Director stated, "It looks like the resident went home. Yes it is an inaccurate MDS because the resident went home and did not go to the hospital." The facility policy titled "MDS COORDINATION AND COMPLETION" dated 10/11/18 was reviewed and documented in part, as follows: Procedure: 1. The MDS Coordinator shall be designated the responsibility of coordinating each resident's assessment (MDS) according to the RAI(Resident Assessment Instrument) manual guidelines. 3. Each individual who completed a portion of the assessment (MDS) must attest to the accuracy of that portion of the assessment. On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations were the above information was shared. Prior to exit no further information was provided.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		11/23/18

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F 656	Continued From page 19	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 656	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, record review, family interviews, staff interviews, and facility documentation review, the facility failed to develop a Comprehensive Care Plan to include discharge goals and interventions for 1 of 40 residents in the survey sample, Resident #148. The facility staff failed to develop a Comprehensive Care Plan to include discharge goals and interventions for Resident #148 The findings included: Resident #148 was admitted to the facility on 7/16/17 with diagnoses to include Left Femur Fracture, Atrial Fibrillation and Dementia. On the facility Admission Record Resident #148's son was listed as her Responsibility Party and Guardian. The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/23/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated that Resident #148 was not cognitively intact and incapable of daily decision making. The last Minimum Data Set (MDS) assessment was a Discharge with an Assessment Reference Date (ARD) of 8/8/17. Under Section A2000 Discharge Date Resident #148 was coded as 8/9/17. Under A2100 Discharge Status Resident #148 was coded as 1 (Community). ON 10/10/18 at 11:31 A.M. a phone interview was conducted with Resident #148's son	F 656	1. It is duly noted that Resident #148□s care plan failed to include discharge goals and interventions. Resident # 148 no longer resides in center. 2. Any resident who resides in the facility has the potential to be affected if care plan does not include discharge goals and interventions. A review of the current residents will be conducted to ensure that the Care Plan includes discharge goals and interventions. 3. The interdisciplinary team responsible for care planning will be educated regarding accurate care planning per the RAI manual. 4. MDS coordinators or designee(s) will conduct an audit of 10 care plans weekly for four weeks then monthly for two months. Results of these audits will be analyzed and discussed for further recommendations during the facility□s monthly Quality Assurance process.	

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(Responsible Party). Resident #148's son was made aware that surveyors were in the facility and his complaint investigation had begun. Resident #148's son stated, "The facility nurse called me on August 8, 2017 around 5 o'clock asking me if I was aware that my mother was being discharged today. I said "no" that no one had called me about a discharge because I needed to arrange for a private sitter to stay with her at nights at her assisted living for her safety. The nurse called me because her transport had not arrived yet so they canceled the discharge for that night but discharged her the next day. Resident #148's son was asked if he had received a Medicare Notice of Non-Coverage from the facility prior to discharge. Resident #148's son stated, "No, I wasn't given anything I did not even know she was being discharged."

Resident #148's Team Based Admission Assessment (TBAA) dated 7/18/17 was reviewed and is documented in part, as follows:

3. Family Member participated via: 1. Present for meeting (Son)

Summary of Discussion
Goals:
1. Summarize goals for safe transition identified during the meeting=go back to memory care home. Able to ambulate with walker by self.

Estimated Safe Transition:
3. Enter the estimated safe transition week based on today's status and discussions=30 days.

Plan of Care:
1. Plan was reviewed during meeting.

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F 656	Continued From page 22 2. Was developed and input from patient/RP (responsible party) Resident #148's Comprehensive Care Plan dated 7/16/17-8/9/17 was reviewed. There was no focus, goal, or interventions regarding Resident #148's plan for discharge back to her assisted living noted in her comprehensive care plan. On 10/11/18 at 9:45 A.M. an interview was conducted with MDS Coordinator #1. MDS Coordinator #1 was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. MDS Coordinator #1 stated, "Yes we do include discharge planning in the care plan, and it should have been done for her as well." On 10/11/18 at 9:55 A.M. am interview was conducted with the Regional Director of Operations. The Regional Director of Operations was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. The Regional Director of Operations stated, "Yes, absolutely the discharge should be included in the comprehensive care plan. It was missed for this resident." Resident #148's Facility Progress Notes were reviewed and are documented in part, as follows: 8/4/17 at 8:51 A.M. Social Services Note=SSD (Social Services Director) spoke with (Name) at the Name (assisted living), is ready to accept resident back. Planned discharge Tuesday. 8/8/17 at 10:45 A.M. Social Services	F 656		

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F 656	Continued From page 23 Note=resident set to discharge to ALF(Assisted Living Facility). 8/8/17 at 19:55 (7:55) P.M. Health Status Note=pt. (patient) was scheduled for discharge today. called and spoke with son and he stated that he was not aware of discharge today. discharge is canceled for today. In house supervisor made aware. 8/8/17 at 22:58 (10:58) P.M. Health Status Note=Spoke with SW (Social Worker) today, son still working on the D/C (discharge) date. 8/9/17 at 22:00 (10:00)P.M. Health Status Note= Patient discharged as planned. MD (Medical Doctor) aware. The facility policy titled "Comprehensive Care Planning Process" dated 4/19/18 was reviewed and documented in part, as follows: Policy: The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. An interdisciplinary assessment team shall develop a comprehensive assessment and care plan for each resident based on outcomes of assessments and input from the resident, family and interdisciplinary team members. On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations were the above information was shared. Prior to exit no further information was provided.	F 656		

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F 656	Continued From page 24 This is a COMPLAINT DEFICIENCY.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked	F 660		11/23/18

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about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

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F 660	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, record review, family interviews, staff interviews, and facility document review the facility failed to involve the resident and resident representative in the final discharge plan for 1 of 40 residents in the survey sample, Resident #148. The facility staff failed to ensure that Resident #148's son was involved in the final discharge plan scheduled on 8/8/17. The findings included: Resident #148 was admitted to the facility on 7/16/17 with diagnoses to include Left Femur Fracture, Atrial Fibrillation and Dementia. On the facility Admission Record Resident #148's son was listed as her Responsibility Party and Guardian. The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/23/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated that Resident #148 was no cognitively intact and incapable of daily decision making. The last Minimum Data Set (MDS) assessment was a Discharge with an Assessment Reference Date (ARD) of 8/8/17. Under Section A2000 Discharge Date Resident #148 was coded as 8/9/17. Under A2100 Discharge Status Resident #148 was coded as 1 (Community). ON 10/10/18 at 11:31 A.M. a phone interview was conducted with Resident #148's son	F 660	1. Resident #148 no longer resides in center. 2. Any resident who discharges from the facility has the potential to be impacted if they are discharging, the facility must develop and implement a discharge planning process that includes the resident, patient as well as their representative. 3. IDT team will be in-serviced on developing and implementing a discharge planning process that includes the resident or patient as well as their wanted representative. The IDT or designee will communicate all discharge plans with resident or patient as well as representative as wanted during the discharge planning process and notate these communications in resident or patient□s EMR. 4. The Social Services Director or designee will audit the EMR five times a week for 2 months to ensure communication documentation is complete and includes all intended parties Results will be reported in QAPI committee and any variances addressed.	

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(Responsible Party). Resident #148's son was made aware that surveyors were in the facility and his complaint investigation had begun. Resident #148's son stated, "The facility nurse called me on August 8, 2017 around 5 o'clock asking me if I was aware that my mother was being discharged today. I said "no" that no one had called me about a discharge because I needed to arrange for a private sitter to stay with her at nights at her assisted living for her safety. The nurse called me because her transport had not arrived yet so they canceled the discharge for that night but discharged her the next day. Resident #148's son was asked if he had received a Medicare Notice of Non-Coverage from the facility prior to discharge. Resident #148's son stated, "No, I wasn't given anything I did not even know she was being discharged."

Resident #148's Comprehensive Care Plan dated 7/16/17-8/9/17 was reviewed. There was no focus, goal, or interventions regarding Resident #148's plan for discharge back to her assisted living noted in her comprehensive care plan.

On 10/11/18 at 9:45 A.M. an interview was conducted with MDS Coordinator #1. MDS Coordinator
#1 was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. MDS Coordinator #1 stated, "Yes we do include discharge planning in the care plan, and it should have been done for her as well."

On 10/11/18 at 9:55 A.M. am interview was conducted with the Regional Director of Operations. The Regional Director of Operations

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was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. The Regional Director of Operations stated, "Yes, absolutely the discharge should be included in the comprehensive care plan. It was missed for this resident."

Resident #148's Facility Progress Notes were reviewed and are documented in part, as follows:

8/4/17 at 8:51 A.M. Social Services Note=SSD (Social Services Director) spoke with (Name) at the Name (assisted living), is ready to accept resident back. Planned discharge Tuesday.

8/8/17 at 10:45 A.M. Social Services Note=resident set to discharge to ALF(Assisted Living Facility).

8/8/17 at 19:55 (7:55) P.M. Health Status Note=pt. (patient) was scheduled for discharge today. called and spoke with son and he stated that he was not aware of discharge today. discharge is canceled for today. In house supervisor made aware.

8/8/17 at 22:58 (10:58) P.M. Health Status Note=Spoke with SW (Social Worker) today, son still working on the D/C (discharge) date.

8/9/17 at 22:00 (10:00) P.M. Health Status Note= Patient discharged as planned. MD (Medical Doctor) aware.

The facility policy titled "Safe Transition Planning (Anticipated Discharge)" dated 6/1/18 was reviewed and is documented in part, as follows:

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F 660	Continued From page 29 Specific Procedures/Requirements: 1. The interdisciplinary team, with input and collaboration from the resident/resident representative will develop a safe transition plan for all residents. 3. The transition plan will: a. Involve the resident and resident representative in the development of the plan and inform the resident and resident representative of the final plan. 6. If a resident is transferred to another skilled nursing facility, or home health agency, or intensive rehabilitation facility or long term hospital, the nursing facility: f. The resident/representative will be notified and oriented to the orientation to the upcoming transition to ensure that the transition is as safe and orderly as possible. On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations where the above information was shared. Prior to exit no further information was provided. This is a COMPLAINT DEFICIENCY	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews	F 677	1. Resident #61 and 63 received a	11/23/18

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F 677	Continued From page 30 and clinical record review the facility staff failed to provide personal care to include showers for two resident in the survey sample of 40 (Resident #61 and 63) who were unable to independently carry out activities of daily living (ADL's). 1. The facility staff failed to ensure Resident #61 received showers according to resident plan and preference. 2. The facility staff failed to ensure Resident #63 received showers according to resident plan and preference. The findings include: 1. Resident #61 was originally re-admitted to the facility on 05/25/17. Diagnosis for Resident #61 included but not limited to *Anxiety disorder and *Cardiomyopathy. Resident #61's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 08/24/18 coded Resident #61's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #61 total dependence of one with bathing, extensive assistance of two with bed mobility and transfer, extensive assistance of one with dressing and toilet use for Activities of Daily Living care. Resident #61 was also coded for frequently incontinent of bowel and bladder. The care plan dated 05/08/17 with a revision date of 04/30/18 identified Resident #61 comprehensive care plan with the need for ADL assistance. The goal set for the resident by the	F 677	shower on 10/1//2018 and the shower schedule was amended to reflect preference. 2. Any resident who does not receive showers per their plan and preference has the potential to be impacted if not implemented. A review of current residents plan for showers will be conducted, and the plan will be updated. 3. Education will be conducted for Nurses and CNAs to review the facility□s policy, and ensure that the staff understands that showers must be documented when provided, and provided as resident plan and preference. IT scheduling requirements for documentation will be reviewed with newly hired licensed and certified staff as well as Medical Records staff. 4. Unit Manager or Designee(s) will conduct an audit on five patients per unit weekly for four weeks and monthly for 2 Months to ensure showers are provided and documented on. Results of these audits will be discussed and reviewed in weekly clinical meeting to ensure compliance and it will also be discussed for further recommendations during the facility□s monthly Quality Assurance process	

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staff was that the resident will receive necessary level of ADL assistance through the next review. One of the interventions/approaches the staff would use to accomplish this goal included to provide assistance with bathing, dressing, grooming, toileting and eating as needed.

On 10/09/18 at approximately 3:05 p.m., an interview was conducted with Resident #61 who stated, "I have not been receiving my showers lately; at least for the last 2 months." The resident proceeded to say, "I should have gotten a shower today but the Certified Nursing Assistant (CNA) did not give it to me."

On 10/10/18, the surveyor reviewed the units shower schedule. Resident #61 was scheduled to have showers every Tuesday and Friday (7 a.m.-3 p.m. shift).

Review of Resident #61's documentation report for bathing revealed the following: Showers were not given on the following shower days: June 2018 (06/29/18), July 2018 (7/3, 7/13 and 7/31/18), August 2018 (8/7, 8/21, and 8/24/18), September 2018 (9/4, 9/7, 9/11, 9/14, 9/18, 9/25 and 9/28/18) and October 2018 (10/2, 10/5 and 10/9/18).

A phone call was placed to Certified Nursing Assistant (CNA) #2 on 10/11/18 at approximately 9:13 a.m. The CNA was assigned to Resident #61 on her shower days; a message was left, the CNA never called back.

An interview was conducted with Director of Nursing (DON) on 10/11/18 at approximately 9:50 a.m. She said when unit (Name) went from 40 residents to 47 residents, we decided to try a

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shower/restorative aide. The DON said the shower/restorative aide only lasted about 3 days (this was done as a trial basis only). The DON said, each CNA is now responsible for giving their own showers and performing the residents restorative program. The surveyor asked, "What are your expectation for your CNA's for giving Resident's their scheduled showers" she replied, "I expect for the CNA's to given resident's their showers twice a week and if they refused; they are to notify the nurse so the refusal could be documented."

2. Resident #63 was readmitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *Leukemia.

Resident #63's Minimum Data Set (MDS-an assessment protocol) was a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded Resident #63's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #63 total dependence of one with bathing, and supervision with limited assistance of one with bed mobility, transfer, dressing toilet use and personal hygiene for Activities of Daily Living care.

The care plan dated 05/22/18 with a revision date of 07/19/18 identified Resident #63 person-centered comprehensive care plan with the need for ADL assistance with a diagnosis of Leukemia, and is currently on hemodialysis. The goal set for the resident by the staff was that the resident will receive necessary level of ADL assistance through the next review. One of the interventions/approaches the staff would use to

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accomplish this goal included to provide assistance with bathing and hygiene as needed.

An interview was conducted with Resident #63 on 10/09/18 at approximately 3:37 p.m., who stated, "No one here is giving showers; I'm not getting my showers like I should." The resident said they use to be a shower aide but that position went away about 4 months ago and then the showers just stopped."

On 10/10/18, the surveyor reviewed the units shower scheduled. Resident #63 was scheduled to have showers given every Tuesday and Friday (7 a.m.-3 p.m. shift).

Review of Resident #63's documentation report for bathing revealed the following: Showers were not given on the following shower days: July 2018 (7/3, 7/6, 7/10, 7/13, 7/17, 7/20, 7/24, 7/27 and 7/31/18), August 2018 (8/3, 8/7, 8/10, 8/14, 8/17, 8/21, 8/24, 8/28 and 8/31/18), September 2018 (9/4, 9/7, 9/11, 9/14, 9/18, 9/25 and 9/28/18) and October 2018 (10/2, 10/5 and 10/9/18).

A phone call was placed to CNA #2 on 10/11/18 at approximately 9:13 a.m. The CNA was assigned to Resident
#63 on her shower days; a message was left, the CNA never called back.

An interview was conducted with the Director of Nursing (DON) on 10/11/18 at approximately 9:50 a.m. She said when unit (Name) went from 40 residents to 47 residents, we decided to try a shower/restorative aide. The DON said the shower/restorative aide only lasted about 3 days (this was done as a trial basis only). The DON

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said, each CNA is now responsible for giving their own showers and performing the residents restorative program. The surveyor asked, "What are your expectation for your CNA's for giving Resident's their scheduled showers" she replied, "I expect for the CNA's to give the resident's their showers twice a week and if they refuse; they are to notify the nurse so the refusal can be documented."

The facility administration was informed of the finding during a briefing on 10/11/18 at approximately 2:00 p.m. The facility did not present any further information about the findings.

The facility's policy titled Bathing, Whirlpool Tub (Revised 3/12).

-Policy: Residents are to receive whirlpool tub bath or shower at least twice weekly, unless otherwise ordered by the physician.

Definitions:

*Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm).

*Cardiomyopathy, or heart muscle disease is a type of progressive heart disease in which the heart is abnormally enlarged, thickened, and/or stiffened. As a result, the heart muscle's ability to pump blood is less efficient, often causing heart failure and the backup of blood in the lungs or rest of the body (webmd.com).

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F 677	Continued From page 35 *Leukemia is a cancer of blood-forming tissues, hindering the body's ability to fight infection (Mayoclinic.com).	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		11/23/18

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F 690	Continued From page 36 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to receives the appropriate care and services to prevent potential indwelling catheter complications for 1 of 40 residents (Resident #48), in the survey sample. The facility staff failed to anchor Resident #48's indwelling urinary catheter to prevent tension on the catheter and avoid potential kinking of the tubing. The findings included: Resident #48 was originally admitted to the facility 8/9/18 and readmitted 9/27/18 after an acute care hospital stay. The current diagnoses included; urinary retention with bilateral hydronephrosis (kidney swelling due to urine failing to drain properly). The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #48's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring supervision of 1 person with eating and extensive assistance of 1 person with locomotion, dressing, and personal hygiene and bathing, extensive assistance of 2 people	F 690	Resident #48 indwelling Urinary Catheter was anchored as soon as notified to prevent tension on the catheter and avoid potential kinking of the tubing. 2. Any Resident with a Foley Catheter has the potential to be impacted if their catheter is not being anchored properly with the potential for kinking the tubing. 3. Education to be provided for licensed and certified staff as it relates to catheter care and placement by 10/31/2018. The center□s Foley Catheter Policy will also be reviewed during the training. Newly hired licensed and certified staff will receive Indwelling Catheter Care policy information included in orientation. 4. Unit Manager or Designee(s) will conduct an audit on all patients with Foley Catheters in the facility daily for a week, weekly for three weeks and monthly for 2 Months, to ensure that indwelling catheters are anchored properly. Results of these audits will be discussed and reviewed in clinical meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility□s monthly Quality Assurance process with any variances addressed.	

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with bed mobility, transfers, and toileting, and total care of 2 people with bathing In section "H" Bladder and Bowel, the resident was coded as frequently incontinent of her bladder and bowels.

A Physician's order dated 10/1/18, read; Indwelling catheter 16 french, 10 milliliter balloon for hydronephrosis. Catheter care every shift.

The current care plan dated 10/9/18 had a problem which read (name of resident) has a history of urinary tract infection (UTI) and is at risk for future infections related to urinary retention and presence of urinary catheter with a diagnosis of bilateral hydronephrosis. The care plan goal read (name of resident) will remain free of UTI's through 1/1/2019. The interventions included; Foley catheter as ordered with catheter care per facility protocol. Give antibiotic therapy as ordered. Observe/document for side effects and effectiveness. Obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow-up as indicated

Clinical record notes had a nurse's note dated 10/1/18 at 9:59 a.m., which read; "Resident is alert and oriented times 3. At 8:00 a.m., this morning, resident was noted with a distended bladder. Resident was encouraged to void but unable to urinate by herself. Physician in house and assessed the resident. A new order was given to insert a Foley catheter for urinary retention. A 16 french catheter was inserted times 1 attempt. Clear yellow urine 2,000, milliliters drained and connected to urinary bag. Resident stated I feel so relieved. Resident denied pain and distress. Resident is her self responsible party and agreed daughters (name of daughter) and (name of daughter) were called and made

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aware. Will continue to monitor."

On 10/10/18 at approximately 1:05 p.m., Resident #48 complained of discomfort in her private area and desired to remove her pant. The resident called for staff assistance and CNA #5 came in and assisted her to remove there pants. Resident #48 was observed with the indwelling catheter tubing under her legs and without an anchor or a clip to prevent dislodgement or a urethral tear.

On 10/10/18 at approximately 1:30 p.m., an interview was conducted with Resident #48's physician. The physician stated the resident will continue to require the indwelling catheter until she is cleared by the urologist. The physician also stated a renal ultrasound must be performed first, then the urologist will determine if the hydronephrosis has resolved. The physician further stated she provide the primary care for the urinary retention and hydronephrosis but all to maintain the indwelling catheter (catheter care, positioning, anchoring, etc) are roles of the nursing staff.

An interview was conducted with on 10/10/18 at approximately 1:40 p.m., Licensed Practical Nurse (LPN) #50, stated she was going to obtain the necessary equipment and anchor the resident's catheter. At approximately 4:05 p.m., Resident #48 stated LPN #50 had taped the tubing to her thigh.

The facility's undated policy titled "Catheter Care" read; Purpose, to maintain a Foley catheter and help prevent UTI which can cause serious

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F 690	Continued From page 39 compromise to the resident's health. Procedure "G" read; Use soap and water to the catheter tubing from point of entry out for at least 4 inches using rotating outward movement. Do not pull on the catheter. Procedure "H" read; position catheter tubing and collection container so that tubing is no kinked or clamped off, tubing is not pulling, tubing is not touching the floor, and collection container is below the bladder level but not touching the floor. On 10/11/18, at approximately 2:30 p.m., the above findings were shared with the Administrator, Director of Nursing and corporate consultant. The Director of Nursing stated the facility's expectation is for the resident's indwelling catheter to be anchored, not making contact with the floor, for the drainage bag to remain below the bladder and to keep the tubing from becoming kinked.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure 2 of 40 residents (Resident #53 and #63) received the care and services consistent with the standards of practice and comprehensive person-centered care plan.	F 698	1. Resident # 53 and 63 had bruit and thrill assessed as normal as soon as notification was received and Dialysis Company was contacted to receive communication	11/23/18

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F 698	Continued From page 40 1. The facility staff failed to ensure hemodialysis care was provided for Resident #53 to include consistent and accurate assessments of *bruit and *thrill by the licensed nurses. 2. The facility staff failed to ensure hemodialysis care was provided to Resident #63 to include consistent assessments of bruit and thrill, as well as communication between the facility and dialysis center. The findings included: 1. Resident #53 was re-admitted to the nursing facility on 11/7/17 with a diagnosis that included end stage renal disease (ESRD) on hemodialysis. The most recent Minimum Data Set (MDS) assessment dated 8/21/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The resident was coded to receive hemodialysis. The care plan dated as revised 9/10/18 identified Resident #53 was on dialysis related to ESRD Tuesday, Thursday and Saturday. The goal the staff set for the resident was that she would receive treatments as scheduled with monitoring of disease process through next review. One of the approaches to accomplish this goal included monitor thrill and bruit every shift per order and protocol. A physician's order dated 2/26/18 included the following: "Please listen to bruit and palpate for	F 698	2.Any resident receiving dialysis has the potential to be impacted if staff does not include consistent assessments of bruit and thrill as well as communication between the facility and the dialysis center. An education audit was conducted on licensed nurses skills with on the spot retraining on bruit and thrill assessment conducted by the ADON on 10/11/2018 An audit of hemodialysis patients admitted for past 30 days was conducted to determine presence of communication to and from dialysis with scanned into EMR as appropriate. . 3.The Facility will conduct training for licensed Nurses including those newly hired on assessing and documentation of bruit and thrill, and ensuring that each dialysis patient takes along with them their dialysis Communication binder to dialysis on each dialysis day and returns with communication from dialysis. 4.Unit Manager or Designee(s) will conduct an audit on hemodialysis patients to ensure presence of dialysis communication 3 times a week x 1 week, weekly for three weeks and monthly for 2 Months. Results of these audits will be discussed and reviewed in Risk meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility s monthly Quality Assurance process	

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thrill to dialysis site on left arm on dialysis days, Tuesday, Thursday and Saturdays and every shift."

On 10/10/18 at 9:30 a.m., Resident #53 was observed in her wheelchair. On 10/10/18 at 11:15 a.m., Licensed Practical Nurse (LPN) #3 was asked to demonstrate an assessment of the resident's Arterio-Venous shunt (AV) bruit and thrill as signed off per shift on the Medication Administration Record (MAR). The LPN retrieved a stethoscope and placed it over the AV shunt site on the residents left forearm and stated the bruit and thrill was the same; "You listen for the blood flow". Afterwards she stated she needed to look up the procedure to make sure, but indicated she had been signing off on the MAR she performed an assessment of the AV shunt. Another LPN #4 was asked to demonstrate an assessment of Resident #53 AV shunt bruit and thrill. The LPN retrieved a stethoscope and placed the diaphragm over the shunt site. LPN #4 said, "That's all you have to do; that is the procedure for bruit and thrill, you listen closely. Did I do it right?" She stated when she has the resident, she signs off on the MAR per her shift that she made assessment of the bruit and thrill.

On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated the LPN's did not perform the accurate assessment of bruit and thrill and was surprised because they each had recent inservicing by the infusionist from the dialysis center on 6/25/18, as well as a video on 6/17/18. Both LPNs had attended the aforementioned training as verified through review of the original education sign in sheets.

On 10/11/18 at 1:50 p.m., the aforementioned

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issue was brought to the attention of the Administrator, Regional Director of Operations and Director of Nursing (DON). No further information was brought forward prior to survey exit.

The facility policy and procedures titled "Dialysis Services" undated indicated the licensed nurse, on a regular basis, will palpate the AV (Arterio-Venous) hemodialysis shunt site that is usually in the arm, to feel the "thrill" and use the stethoscope to hear the "whoosh" or "bruit" of blood flow through the access to detect possible clots and obstruction of the shunt. Emergency guidelines are to be followed if it is determined blood flow is disrupted and the physician is to be called immediately. Observe for "steal" syndrome, caused by too little blood in the extremity distal to the fistula.

3. Resident #63 was re-admitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week every Monday, Wednesday and Friday.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS was coded under section O for receiving dialysis treatments.

The comprehensive care plan dated 05/22/18 with a revision date of 09/17/18 identified

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Resident #63 requires hemodialysis related to ESRD. The goal set for the resident by the staff was that the resident would receive dialysis services as ordered with no avoidable negative effects. One of the intervention/approaches to manage goal include to assess dialysis access site as ordered and to check *bruit and *thrill as per order or protocol.

Resident #63's physician orders contained the following order: Please listen for bruit and thrill to left arm dialysis shunt on dialysis days and report any dialysis shunt malfunctions to MD.

An interview was conducted with License Practical Nurse (LPN) #5 on 10/10/18 at approximately 9:55 a.m. The surveyor asked the LPN, "How do you check for bruit and thrill." The LPN demonstrated the following on Resident #63; she placed her stethoscope on to the left arm (proximal of shunt site) then said, "You listen for bruit." The surveyor then asked, "How do you check for thrill," she replied, "The same way as the bruit; you use the stethoscope and listen for the thrill."

An interview was conducted with Registered Nurse (RN) #1 on 10/11/18 at approximately 9:25 a.m. who stated, "I expect for all nurses to know how to check for bruit and thrill." The surveyor asked the UM, "How do you check bruit and thrill, she replied, "You use a *stethoscope to hear the bruit and you feel with your fingers for the thrill."

The above information was shared with Administration staff during a pre-exit meeting on 10/11/18 at 2:00 p.m. No additional information was provided.

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The facility's policy titled Dialysis services included:

Procedure:
1. Prior to admission of any resident requiring dialysis services, the Director of Nursing will ensure that nursing personnel will receive training in the special care and needs of dialysis residents.

2. Training will include the response of medial and non-medical emergencies and complications that typically are associated with dialysis residents, the development and implementation of special considerations in the dialysis resident's comprehensive care plan, and the exchange of information regarding the dialysis resident's care with the dialysis services provider and the resident's physician.

3. Training will also address the appropriate care of shunts and fistulas.

Definitions:

*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).

*Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.

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F 698	Continued From page 45 *For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301). *Bruit is listening for adequate bruit with a *stethoscope. A continuous low-pitched bruit should be present (www.laminatemedical.com/assessment-and-monitoring-of-av-fistulas-for-new-dialysis). *Thrill - Check the pulse in your access arm. You should feel blood rushing through that feels like a vibration. This vibration is called a "thrill."(Source: https://medlineplus.gov/ency/patientinstructions/000705.htm). *Stethoscope is an instrument used to detect and study sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a usually cup-shaped piece placed upon the area to be examined. (Source: http://c.merriam-webster.com/medlineplus/stethoscope).	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		11/23/18

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F 726	Continued From page 46 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure the licensed nursing staff were competent with the appropriate skills to provide assessments of Arterio-Venous (AV) dialysis shunts for 2 of 40 residents (#53 and	F 726	1.The identified nurses received training on accurately assessing bruit and thrill. An education audit was conducted on licensed nurses skills with on the spot retraining on bruit and thrill assessment conducted by the ADON on 10/11/2018.	

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F 726	Continued From page 47 #63) in the survey sample. 1. The facility staff failed to ensure the licensed nursing staff were competent in the provision of hemodialysis care for Resident #53 to include accurate assessments of *bruit and *thrill. 2. The facility staff failed to ensure the licensed nursing staff were competent in the provision of hemodialysis care for Resident #63 to include accurate assessments of bruit and thrill. The findings included: 1. Resident #53 was re-admitted to the nursing facility on 11/7/17 with a diagnosis that included end stage renal disease (ESRD) on hemodialysis. The most recent Minimum Data Set (MDS) assessment dated 8/21/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The resident was coded to receive hemodialysis. The care plan dated as revised 9/10/18 identified Resident #53 was on dialysis related to ESRD Tuesday, Thursday and Saturday. The goal the staff set for the resident was that she would receive treatments as scheduled with monitoring of disease process through next review. One of the approaches to accomplish this goal included monitor thrill and bruit every shift per order and protocol. A physician's recent order dated 2/26/18 indicated the following: "Please listen to bruit and palpate	F 726	2. Any hemodialysis patient has the potential to be impacted if nurses do not accurately assess bruit and thrill. 3. The Facility will conduct a training for all Nurses on assessing and documentation of bruit and thrill, to ensure competence. Newly hired nurses will receive training during orientation. 4. ADON/Staff Educator will do checks on dialysis patients with their assigned nurses to demonstrate competent skills in assessing for bruit and thrill weekly for 4 weeks and monthly for 2 months. Results of these audits will be discussed and reviewed in Risk meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility□s monthly Quality Assurance process	

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for thrill to dialysis site on left arm on dialysis days, Tuesday, Thursday and Saturdays and every shift."

On 10/10/18 at 9:30 a.m., Resident #53 was observed in her wheelchair. On 10/10/18 at 11:15 a.m., Licensed Practical Nurse (LPN) #3 was asked to demonstrate an assessment of the resident's Arterio-Venous shunt (AV) bruit and thrill as signed off per shift on the Medication Administration Record (MAR). The LPN retrieved a stethoscope and placed it over the AV shunt site on the residents left forearm and stated the bruit and thrill was the same; "You listen for the blood flow". Afterwards she stated she needed to look up the procedure to make sure, but indicated she had been signing off on the MAR she performed an assessment of the AV shunt. Another LPN (#4) was asked to demonstrate an assessment of Resident #53 AV shunt bruit and thrill. The LPN retrieved a stethoscope and placed the diaphragm over the shunt site. LPN #4 said, "That's all you have to do; that is the procedure for bruit and thrill, you listen closely. Did I do it right?" She stated when she has the resident, she signs off on the MAR per her shift that she made assessment of the bruit and thrill.

On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated the LPNs did not perform the accurate assessment of bruit and thrill and was surprised because they each had recent inservicing by the infusionist from the dialysis center on 6/25/18, as well as a video on 6/17/18. Both LPNs had attended the aforementioned training as verified through review of the original education sign in sheets.

On 10/11/18 at 1:50 p.m., the aforementioned

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issue was brought to the attention of the Administrator, Regional Director of Operations and Director of Nursing (DON). No further information was brought forward prior to survey exit.

The facility policy and procedures titled "Dialysis Services" undated indicated the licensed nurse, on a regular basis, will palpate the AV (Arterio-Venous) hemodialysis shunt site that is usually in the arm, to feel the "thrill" and use the stethoscope to hear the "whoosh" or "bruit" of blood flow through the access to detect possible clots and obstruction of the shunt. Emergency guidelines are to be followed if it is determined blood flow is disrupted and the physician is to be called immediately. Observe for "steal" syndrome, caused by too little blood in the extremity distal to the fistula.

3. Resident #63 was re-admitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week every Monday, Wednesday and Friday.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS was coded under section O for receiving dialysis treatments.

The comprehensive care plan dated 05/22/18 with a revision date of 09/17/18 identified

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Resident #63 requires hemodialysis related to ESRD. The goal set for the resident by the staff was that the resident would receive dialysis services as ordered with no avoidable negative effects. One of the intervention/approaches to manage goal include to assess dialysis access site as ordered and to check *bruit and *thrill as per order or protocol.

Resident #63's physician orders contained the following: Please listen for bruit and thrill to left arm dialysis shunt on dialysis days and report any dialysis shunt malfunctions to MD every shift every Monday, Wednesday and Saturday.

An interview was conducted with License Practical Nurse (LPN) #5 on 10/10/18 at approximately 9:55 a.m. The surveyor asked the LPN, "How do you check for bruit and thrill." The LPN demonstrated the following on Resident #63; she placed her stethoscope on to the left arm (proximal of shunt site) then said, "You listen for bruit." The surveyor then asked, "How do you check for thrill," she replied, "The same way as the bruit; you use the stethoscope and listen for the thrill."

An interview was conducted with Registered Nurse (RN) #1 on 10/11/18 at approximately 9:25 a.m. who stated, "I expect for all nurses to know how to check for bruit and thrill." The surveyor asked the UM, "How do you check bruit and thrill, she replied, "You use a stethoscope to hear the bruit and you feel with your fingers for the thrill."

On 10/11/18, at approximately 1:05 p.m., the surveyor was given an In-service attendance form dated 6/17/18. The facilities objective of session read in part; Topic - Manual Peritoneal

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Dialysis/Hemodialysis. The summary remarks, method of instructions read: Watch the video from You - Tube (see policy attached). The review of the attendance record revealed that LPN #5 did not watch the video.

The review of LPN #5's licensed nurse/charge nurse performance checklist signed and dated 7/12/18 did not include the assessment of A-V fistula or A-V shunt for dialysis residents.

An interview was conducted with the Chief Clinical Officer on 10/11/18 at approximately 1:15 p.m. Two surveyors were present doing the interview. The surveyor informed the Chief Clinical Officer that LPN #5 was unable to demonstrate how to check for bruit and thrill on a dialysis resident. The surveyor asked, "How do you ensure sure your nurses are competent when caring for a dialysis resident" she replied, "The Virginia Board of Nursing say they are competent." She then stated, "She (LPN #5) will know now."

The facility's policy titled Dialysis services.

Procedure:
1. Prior to admission of any resident requiring dialysis services, the Director of Nursing will ensure that nursing personnel will receive training in the special care and needs of dialysis residents.

2. Training will include the response of medial and non-medical emergencies and complications that typically are associated with dialysis residents, the development and implementation of special considerations in the dialysis resident's

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comprehensive care plan, and the exchange of information regarding the dialysis resident's care with the dialysis services provider and the resident's physician.

3. Training will also address the appropriate care of shunts and fistulas.

The facility's policy titled Dialysis Services - Care of Shunt/Fistula/Device/Site
-Policy: The access point (A-V fistula or A-V shunt) will be monitored per physician order by the RN/LPN.

Procedure read in part:
-Report signs of thrombosis formation - in a healthy fistula a bruit can be heard over the venous side and a thrill can be palpated as arterialized blood flows through the vein. Absence of these signs may indicate clot development.

Definitions:

*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).

*Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.

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F 726	Continued From page 53 *For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301). *Bruit is listening for adequate bruit with a *stethoscope. A continuous low-pitched bruit should be present (www.laminatemedical.com/assessment-and-monitoring-of-av-fistulas-for-new-dialysis). *Thrill - Check the pulse in your access arm. You should feel blood rushing through that feels like a vibration. This vibration is called a "thrill."(Source: https://medlineplus.gov/ency/patientinstructions/000705.htm) *Stethoscope is an instrument used to detect and study sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a usually cup-shaped piece placed upon the area to be examined. (Source: http://c.merriam-webster.com/medlineplus/stethoscope).	F 726		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		11/23/18

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F 880	Continued From page 54 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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:	F 880		

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F 880	Continued From page 55 (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. §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 observations, staff interviews, clinical record review and review of facility documentation, the facility staff failed to ensure hand washing after removal of gloves during accuchecks (a fingerstick for blood glucose testing) for 2 of 40 residents (Resident #53 and #13) in the survey sample. 1. The facility staff failed to ensure hand washing after the removal of gloves during the accucheck procedure for Resident #53.	F 880	1. Handwashing after removal of gloves following accucheck procedure was reviewed with the nurses identified. 2. Any resident has the potential to be impacted if staff fail to ensure hand washing after the removal of gloves during the accucheck procedure, the importance of handwashing was reviewed with the nurses identified.	

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F 880	Continued From page 56 2. The facility staff failed to ensure hand washing after the removal of gloves during the accucheck procedure for Resident #13. The finding include: 1. Resident #53 was re-admitted to the nursing facility on 11/7/17 with a diagnosis that included diabetes. The most recent Minimum Data Set (MDS) assessment dated 8/21/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The resident was coded to be an insulin dependent diabetic. The care plan dated as revised 9/10/18 identified Resident #53 was a diabetic that required finger stick accuchecks before meals and at bedtime. On 10/10/18 at 11:50 a.m., Licensed Practical Nurse (LPN) #3 performed a finger stick accucheck. The LPN failed to wash her hands after removal of her gloves and prior to exiting the resident's room. On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated LPN #3 should have washed her hands after removal of her gloves per standard precautions protocol because it was a procedure that involved blood. She stated, "Hands are to be washed after removal of gloves period." On 10/11/18 at 1:50 p.m., the aforementioned	F 880	3. A return demonstration training session will be conducted for licensed and non-licensed staff at which time the importance of hand washing will be emphasized, as it relates to infection control, and prevention of the spread of bacteria and germs. The education will also include reminders to wash hands after glove removal. Licensed and non-licensed staff will perform a hand washing return demonstration to ensure that their hands are washed properly 4. ADON/Unit Managers/Supervisors or Designee will do random checks and observation on nurses during Medication administration pass and associated with accuchecks and glove use, to ensure handwashing protocols are observed. Each designee will observe 2 nurses weekly for 2 months. Results of these audits/observations will be discussed and reviewed in clinical meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility's monthly Quality Assurance process	

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issue was brought to the attention of the Administrator, Regional Director of Operations and reviewed with Director of Nursing (DON). No further information was brought forward prior to survey exit.

The facility's policy and procedure titled Hand Hygiene undated indicated hands need to be washed using proper accepted standards of practice after the removal of gloves.

The facility's policy and procedure titled Blood Glucose Monitoring, Finger Stick undated indicated after finger stick glucose testing and removal of gloves, wash hands.

2. Resident #13 was admitted to the nursing facility on 7/16/17 with a diagnosis that included diabetes.

The most recent Minimum Data Set (MDS) assessment dated 7/9/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 13 out of a possible score of 15 which indicated the resident was intact in the skills needed for daily decision making. The resident was coded to be an insulin dependent diabetic.

The care plan dated as revised 7/26/18 identified Resident #13 was a diabetic that required finger stick accuchecks before meals and at bedtime.

On 10/10/18 at 11:40 a.m., Licensed Practical Nurse (LPN) #4 performed a finger stick accucheck. The LPN failed to wash her hands after removal of her gloves and proceeded to administer insulin subcutaneous for coverage of an elevated blood sugar. Following

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administration of the insulin, again after removal of gloves, she failed to wash her hands. LPN #4 proceeded to the nursing station to perform other duties.

On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated LPN #4 should have washed her hands after removal of her gloves per standard precautions protocol because both the accucheck and insulin administration were procedures that involved blood. She stated, "Hands are to be washed after removal of gloves period."

On 10/11/18 at 1:50 p.m., the aforementioned issue was brought to the attention of the Administrator, Regional Director of Operations and reviewed with Director of Nursing (DON). No further information was brought forward prior to survey exit.