STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495134	A. BUILDING _____ B. WING _____	05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST MANOR NURSING & REHABILITATION	157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244

(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 05/15/18 through 05/17/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 120 certified bed facility was 99 at the time of the survey. The final survey sample consisted of 21 current Resident reviews and 5 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/15/18 through 05/17/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 99 at the time of the survey. The survey sample consisted of 21 current Resident reviews and 5 closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607		6/29/18

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

Electronically Signed | 06/14/2018

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F 607	Continued From page 1 paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee file review, the facility staff failed to implement the written policies and procedures for 1 of 5 new employee files that were reviewed (Employee #5). The findings included: The surveyor reviewed 5 of the newly hired employee files on 5/16/18. The following was noted to be missing from Employee #5's file: Employee #5 is an agency hired RN (Registered Nurse with hire date of 4/27/18. There was no documentation of a sworn statement or the results of reference checks being completed before the hiring of this nurse. On 5/16/18 at 4:45 pm, the surveyor notified the administrator, DON (director of nursing) and the corporate nurse of the above documented findings. The administrator stated that he would call the hiring agency company about this. On 5/17/18 at 11:45 am, the administrator provided a copy of the facility's policy titled "Employee Background Screening" to the surveyor. It read in part " ... Obtain two references from prior employers ...All applicants and new employees must certify that they have not been convicted of any offense that would preclude employment in a nursing facility and that they are not excluded from participating in the Federal health care programs or state healthcare programs ..."	F 607	F607 1. Employee #5 now has a signed sworn statement that she has not committed any barrier crimes. Two Reference checks will be obtained for Employee #5. 2. Current employee files will be audited by the Human Resource Manager to ensure that they are compliant with having a signed sworn statement that they have not committed any barrier crimes and two reference checks have been completed. The HR/Payroll Coordinator has been re-educated by the Administrator concerning the requirement to have a sworn statement in the employee file that they have not committed any barrier crimes and two reference checks competed. This requirement applies to permanent facility staff and any staff employed by an agency. 3. The Administrator will review all newly hired employee files for the next weeks. Random review weeks of newly hired employee files will be done weekly for 8 weeks. 4 Monthly for a minimum of three (3) months, the Administrator will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance	

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F 607	Continued From page 2 At 12:45 pm, the administrator and human resource employee came to the surveyor and stated, "We have the statement that this nurse was not sanctioned from participating in the Federal health care programs or state healthcare programs." The surveyor asked if the statement also stated that the nurse had not been convicted of a crime or offense that would prevent employment in a nursing facility. The human resource employee stated, "No it does not." No further information was provided to the surveyor prior to the exit conference on 5/17/18.	F 607	Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegation of compliance date for this plan is 6/29/2018	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		6/29/18

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F 625	Continued From page 3 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the resident representative of the bed hold policy for 1 of 26 residents in the survey sample (Resident #29). The findings included: Resident #29 was readmitted to the facility on 4/16/18 with the following diagnoses of, but not limited to anemia, atrial fibrillation, End Stage Renal Disease, Arthritis, depression, Stage 2 pressure ulcer, diabetes and functional quadriplegia. On the last completed annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/12/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #29 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing. The surveyor performed a clinical record review on Resident #29 on 5/15 through 5/17/18. During this review, the surveyor noted that the resident had been discharged to the hospital on 4/11/18 with a GI (Gastrointestinal) Bleed. The surveyor could not find any documentation that the resident's responsible party (RP) was notified of the bed hold policy. On 5/17/18 at 12:42 pm, the surveyor spoke to	F 625	F625 1. Resident #29 returned from the hospital and was admitted into his prior room number/bed. 2. An audit will be completed by the facility Social Services Director on any facility resident currently in the hospital to ensure a bed hold has been offered. Licensed Nurses will be educated by the facility Director of Nursing or Unit Manager on policy & procedures related to bed holds. Educator will include ensuring a written notice of bed hold is sent with any resident discharged to the hospital. The facility Social Services Director will follow-up with the resident or responsible party to ensure a bed hold has been offered and documentation of offer will be entered into the resident medical record. 3. Weekly for a minimum of 12 weeks, the Social Services Director will audit discharges to the hospital to ensure a bed hold has been offered and offer is documented in the resident medical record.	

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F 625	Continued From page 4 the corporate nurse concerning Resident #29. The surveyor requested the following: did the facility notify the resident's RP (responsible party) of the bed hold policy and was the Ombudsman notified of the discharge. The corporate nurse stated that she would get back to me with this information. At 1:05 pm, the social worker came into the conference room and provided the surveyor with a copy of the information sent to the State Ombudsman concerning the discharge of Resident #29 to the hospital. The surveyor asked if the resident's RP was notified of the facility's bed hold policy when the resident was discharged to the hospital. The social worker replied, "No she wasn't. Sometimes we can get her and then sometimes her phone is cut off." The surveyor asked what was the procedure in notifying a resident's RP of the bed hold policy once a resident is discharged to the hospital. The social worker replied, "We are to call the resident's RP and notify them of the bed hold policy and see if they want to pay for this. The nurses' are to send a paper to the hospital with the resident that explains the bed hold policy too." The surveyor requested to speak to whomever was responsible for doing this for Resident #29 when he was discharged to the hospital. The social worker stated, "I will go and see who was working that day." At 5:30 pm, the admissions nurse returned to the surveyor and stated, "I cannot find any documentation on the A/R (accounts receivable) side and I can't find the date on my calendar of when I would had called them." At 5:45 pm, the surveyor notified the	F 625	4. Monthly for a minimum of three (3) months, the Social Services Director will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegation of compliance date for this plain is 6/29/2018	

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F 625	Continued From page 5 administrator, director of nursing and corporate nurse of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 5/3/18.	F 625		
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 and staff interview the facility staff failed to ensure and accurate MDS (minimum data set) assessment for 1 of 21 Residents, #102. The findings included: For Resident #102 the facility staff failed to ensure an accurate discharge MDS. Resident #102 was admitted to the facility on 05/26/17. Diagnoses included but not limited to heart failure, respiratory failure, dysphagia, and Down syndrome. The most recent MDS with an ARD (assessment reference date) of 04/27/18 coded the Resident as 6 out of 15 in section C, cognitive patterns. This is a discharge MDS. Section A of the MDS, subsection A2100, discharge status, coded the Resident as 03, which is the equivalent of acute hospital. Resident #102's clinical record was reviewed on	F 641	F641 1. Resident #102 MDS was corrected on 5/17/2018 to reflect discharge to home instead of hospital. 2. An audit will be completed by the facility MDS Coordinator(s) of all discharge assessments completed within the pas 30 days to ensure Sections "A" of the MDS coded accurately. Facility MDS Coordinator(s) were educated by the Regional MDS Nurse on ensuring accuracy of assessments with additional training regarding coding of Section "A" of the resident MDS. 3. All discharge assessments will be audited by the facility Director of Nursing weekly for 12 weeks to ensure Section 'A' of the MDS is coded accurately. 4. Monthly for a minimum of three (3) months, the Director of Nursing will report	6/29/18

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F 641	Continued From page 6 05/17/18. It contained nurse's progress notes dated 04/27/18, which read in part "(Resident) d/c (discharged) home today with her dad, sister, and brother. Discharge home instruction completed and reviewed with dad and sister ...." Surveyor spoke with the MDS coordinator on 05/17/18 at approximately 1015 regarding Resident #102's discharge status and MDS coordinator stated that Resident was discharged home. Also stated that the MDS was coded wrong. The concern of the incorrect MDS was discussed with the administrative team during a meeting on 07/15/18 at approximately 1115. The corporate compliance nurse provided the surveyor with a corrected copy of the discharge MDS on 05/17/18 at approximately 1215. No further information provided prior to exit.	F 641	completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegation of compliance date for this plan 6/29/2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		6/29/18

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F 657	Continued From page 7 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the residents comprehensive care plan in regards to fluid restrictions for one of 26 residents in the survey sample (Resident #27). The findings included: The facility staff failed to review and revise Resident #27's comprehensive care plan in regards to fluid restrictions. Resident #27 was readmitted to the facility on 4/12/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, end stage renal disease and diabetes. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/9/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #27 was also coded as requiring limited assistance of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene and bathing.	F 657	F657 1. Resident #27 fluid restriction orders were discontinued by the physician on 5/25/2018 2. An audit will be completed by the facility MDS Coordinator on current facility residents with fluid restriction orders to ensure fluid restriction is reflected in the resident care plan. MDS Coordinator(s) will be educated by the facility Director of Nursing on ensuring care plan is updated on any resident with fluid restriction orders. 3. Physician orders will be reviewed by the facility Director of Nursing during daily clinical meeting (Monday-Friday) to ensure any new orders for fluid restrictions are care planned.	

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F 657	Continued From page 8 The surveyor performed a clinical record review on Resident #27 on 5/16 and 5/17/18. During this clinical record review, the surveyor noted a physician order dated for 5/14/18, which read: "34-36 oz (ounces) fluid restriction daily". According to the nursing documentation timed and dated for 5/14/18 at 17:06 (5:06 pm) which read, "received order for 34-36 oz fluid restriction daily, resident made aware of new order, resident educated ...on following order, resident stated he understood." The surveyor also reviewed the resident's comprehensive care plan. The surveyor could not find documentation of the above documented fluid restriction as being included on the care plan. The surveyor notified the director of nursing on 5/17/18 at approximately 11 am of the above documented findings. The director of nursing stated, "Let me take a look at this and I will get back to you on this." At 1:45 pm, the director of nursing stated to the surveyor that she could not find documentation of the fluid restrictions, ordered on 5/14/18, on the resident's care plan. At 2:30 pm, the corporate nurse provided copies of the resident's care plan to the surveyor. The surveyor also notified the corporate nurse of the above documented findings that had been discussed with the director of nursing earlier at approximately 11 am and then again at 1:45 pm. No further information was provided to the surveyor prior to the exit conference on 5/17/18.	F 657	An audit will be completed by the facility MDS Coordinator(s) weekly for 12 weeks to ensure any resident fluid restriction orders care plan is updated. 4. Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegations of compliance date for this plan 6/29/2018	
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		6/29/18

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F 686 SS=D	Continued From page 9 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a treatment in regards to a pressure ulcer was in working order for one of 26 residents in the survey sample (Resident #29). The findings included: Resident #29 was readmitted to the facility on 4/16/18 with the following diagnoses of, but not limited to anemia, atrial fibrillation, End Stage Renal Disease, Arthritis, depression, Stage 2 pressure ulcer, diabetes and functional quadriplegia. On the last completed annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/12/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #29 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.	F 686	F686 1. Resident #29 mattress was evaluated by the Wound Nurse on 5/16/2018. Mattress began working after electrical plug was reinserted in wall. A physician order was written for Resident #29 for Licensed Nurses to monitor air mattress for functionality every shift. Documentation will be reflected on the resident treatment record. 2. An audit will be completed by the facility wound nurse to ensure any resident who utilizes an air mattress has a physician order to check air mattress for functionality every shift. Licensed Nurses will be educated by the Director of Nursing or Unit Manager(s) on ensuring functionality of air mattress and	

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F 686	Continued From page 10 On 5/16/18 at 9 am, the surveyor went into Resident #29's room. The surveyor noted that the air mattress did not have a green light on and the mattress did not cycle while the surveyor was in the resident's room. The surveyor returned to the resident's room at 10 am with the wound care nurse to observe wound care. During this observation the surveyor again noted that the air mattress was on the resident's bed but not working. At the end of the wound care observation at 10:20 am, the surveyor asked the wound care nurse if the air mattress was turned on. The wound care nurse stated, "It is but I don't think that it is working." She went around the bed and the plug from the air mattress was barely in the electrical outlet in the wall. The wound care nurse plugged the cord in tighter and the lights on the air mattress turned green and began working. At 10:40 am, the surveyor notified the director of nursing of the above documented findings. At 4 pm, the surveyor notified the administrative team of the above documented findings of the observations made while in Resident #29's room on 5/16/18. No further information was provided to the surveyor prior to the exit conference on 5/17/18.	F 686	documentation of mattress check on the resident treatment record. 3. Facility wound nurse will complete and audit of air mattress functionality on residents with air mattress. Audits will be completed (3) times weekly for 4 weeks, then weekly for 8 weeks. 4. Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegation of compliance date for this plan is 6/29/2018	
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	F 698		6/29/18

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F 698	Continued From page 11 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure collaboration of care in regards to fluid restrictions for one of 26 residents in the survey sample (Resident #27). The findings included: The facility staff failed to ensure collaboration of care in regards to fluid restrictions for Resident #27. Resident #27 was readmitted to the facility on 4/12/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, end stage renal disease and diabetes. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/9/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #27 was also coded as requiring limited assistance of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene and bathing. The surveyor performed a clinical record review on Resident #27 on 5/16/18. During this review, the surveyor noted the following documentation on the form titled "Dialysis/Nursing Facility Communication Form" under the portion that was filled out by the dialysis center: " 4/30/18 instructions from the dialysis center to the nursing facility stated "Limit PO (per mouth) fluids 32-34 fl. (fluid) oz (ounces)." " 5/2/18 instructions from the dialysis center to the nursing facility stated "32-34 fl.oz po per day." " 5/7/18 instructions from the dialysis center to	F 698	F698 1. Resident #27 was reviewed by the dietician on 5/14/2018. An order was written on 5/14/2018 for fluid restriction as specified by the dialysis center. 2. Licensed Nurses will be educated by the Director of Nursing or Unit Manager(s) on reviewing dialysis communication forms post dialysis to ensure any noted instructions or orders are communicated to the facility physician and orders are written timely. 3. Unit Manager(s) will review dialysis communication forms during the facility daily clinical meeting to ensure dialysis instructions or orders are implemented timely. This audit will be performed (3) times weekly for 12 weeks. 4. Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegation of compliance date for the plan is 6/29/2018	

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F 698	Continued From page 12	F 698		

the nursing facility stated "Pt. (patient) 19 lbs away ...please watch fluids. Pt's (patient's) BP (blood pressure) does not tolerate us pulling the fluids."

At 1:51 pm, the surveyor notified the director of nursing and the corporate nurse of the above documented findings. The surveyor asked the director of nursing how this fluid restriction had been documented, since the dialysis staff had written specific fluid restriction instructions on 4/30, 5/2 and 5/7/18. The director of nursing stated, "The fluid restriction was not placed on the MAR (Medication Administration Record) until the order was written on 5/14 by our staff. The only way that we would had kept track of it before this, was to see what dietary had placed on the resident's tray and count that. This resident has been on fluid restrictions before and was non-compliant with it because he had access to fluids in his room. He was then taken off of the fluid restrictions but this had been in the past."

A copy of the dialysis contract was provided to the survey team in the "Survey Readiness Notebook" at the beginning of the survey on 5/15/18. The surveyor reviewed the copy of the contract that was provided on 5/16/18 at 2:30 pm. The contract read in part under section 2 titled "Written Protocol", " ...The Nursing Facility will provide for the interchange of information useful or necessary for the care of the resident and will inform the ESRD Dialysis Unit of a contact person at the Nursing Facility whose responsibilities include oversight of provision of dialysis services by the Company and the ESRD Dialysis Unit to the residents of the Nursing Facility ..."

No further information was provided to the

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F 698	Continued From page 13 surveyor prior to the exit conference on 5/17/18.	F 698		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		6/29/18

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F 756	Continued From page 14 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure the pharmacist documented in the Residents clinical record that drug regimen reviews were completed and failed to file in the Residents clinical record the results of drug regimen recommendations for five of 26 Residents. Residents #11, #64, #87, #29, and #12. The findings included. 1. For Resident #11, the facility staff failed to ensure the Residents clinical record included the results of a pharmacy recommendation dated 01/25/18. The record review revealed that Resident #11 had been admitted to the facility 09/07/10. Diagnoses included, but were not limited to, dysphagia, chronic respiratory failure with hypoxia, anxiety disorder, muscle weakness, anoxic brain damage, cardiac arrest, apnea, and persistent vegetative state. Section B0100 (comatose) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/20/18 was coded with a (1) to indicate the Resident was in a persistent vegetative state. The clinical record included a progress note made by the pharmacist dated 01/25/18 "See report for any noted irregularities and/or	F 756	F756 1. Resident #11 pharmacy recommendation completed on 1/25/2018 was filed in the resident medical record on 5/17/2018. Resident #64, Resident #87, Resident # 29 and Resident @12 monthly medication regiment review was conducted by the pharmacy consultant in January 2018 and monthly thereafter. The review(s) are noted in the residents(s) medical record. 2. The facility Director of Nursing educated the pharmacy consultant on ensuring medication regimen reviews are completed monthly and documented in the resident medical record. 3. An audit will be completed monthly x3 months by the Director of Nursing to ensure medication regimen reviews are completed and documented in the resident(s) medical record. 4. Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to	

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F 756	Continued From page 15 recommendations." When reviewing the clinical record the surveyor was unable to find the results of this recommendation. On 05/16/18 at approximately 2:40 p.m., the unit manager was asked about the missing pharmacy recommendation. The facility staff notified the surveyor that the psych MD (medical doctor) had the pharmacy recommendation. The administrative team were notified of the missing pharmacy recommendation during a meeting with the survey team on 05/16/18 at approximately 4:00 p.m. Prior to the exit conference, the facility provided the surveyor with a copy of the pharmacy recommendation. The medical director and DON (director of nursing) had signed the recommendation on 01/25/18. The recommendation had been declined. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #64 the facility staff failed to ensure the monthly MMR (medication regimen review) was included in the clinical record. Resident #64 was admitted to the facility on 04/09/07 and readmitted on 11/09/16. Diagnoses included but not limited to anemia, hypertension, gastroesophageal reflux disorder, diabetes mellitus, cerebral palsy, paraplegia, seizure disorder, depression, and bipolar disorder.	F 756	ensure compliance is sustained ongoing; and determine the need for further audition beyond the three months. The allegation of compliance date for this plan is 6/29/2018	

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F 756	Continued From page 16	F 756		

The most recent MDS with an ARD of 04/13/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is an annual MDS.

Resident #64's clinical record was reviewed on 05/16/18. The surveyor could not locate the monthly MMR. The surveyor informed the DON of the missing MRR on 05/16/18 at approximately 1330.

The concern of the missing MRR was discussed with the administrative team during a meeting on 05/16/18 at approximately 1600.

On 05/17/18 at approximately 1420, the DON stated to the surveyor "For whatever reason the ones (MRR's) with recommendations did not make it into the chart".

No further information was provided prior to exit.

3. For Resident #87 the facility staff failed to ensure the monthly drug regimen review was included in the clinical record.

Resident #87 was admitted to the facility on 06/14/13 and readmitted on 04/14/15. Diagnoses included but not limited to anemia, atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disorder, dementia, Parkinson's disease, seizure disorder, anxiety disorder, schizophrenia, asthma, and dysphagia.

The most recent MDS with an ARD of 05/01/18 coded the Resident as 02 out of 15 in section C, cognitive patterns. This is an annual MDS.

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F 756	Continued From page 17	F 756		

Resident #87's clinical record was reviewed on 05/16/18. The surveyor could not locate the monthly MMR. The surveyor informed the DON of the missing MRR on 05/16/18 at approximately 1330.

The concern of the missing MRR was discussed with the administrative team during a meeting on 05/16/18 at approximately 1600.

On 05/17/18 at approximately 1420, the DON stated to the surveyor "For whatever reason the ones (MRR's) with recommendations did not make it into the chart".

No further information was provided prior to exit.
4. The facility staff failed to ensure that the pharmacist had a completed monthly drug regimen review for Resident #29.

Resident #29 was readmitted to the facility on 4/16/18 with the following diagnoses of, but not limited to anemia, atrial fibrillation, End Stage Renal Disease, Arthritis, depression, Stage 2 pressure ulcer, diabetes and functional quadriplegia. On the last completed annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/12/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #29 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.

The surveyor performed a clinical record review on Resident #29 on 5/15 through 5/17/18. During this review, the surveyor noted monthly drug regimen reviews in the electronic clinical record conducted by the pharmacist for the following

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F 756	Continued From page 18	F 756		

dates: 4/29/18, 3/14/18, 2/21/18, 1/24/18, 11/28/17, 10/16/17 and 9/14/17. There was no documentation noted by the surveyor in the electronic clinical record for the month of December 2017.

The surveyor notified the administrative team on 5/16/18 at 4 pm of the above documented findings.

On 5/17/18 at 9 am, the director of nursing stated to the surveyor, "I can't explain why this resident does not have a pharmacy review for December. I have asked medical records to look in the paper charts to see if the pharmacist had hand written something for December and it was placed in there instead of it being scanned in."

At 1:30 pm, the surveyor asked the director of nursing if she was able to locate anything else on the missing December pharmacy review for Resident #29. The director of nursing stated, "It wasn't in medical records either."

No further information was provided to the surveyor prior to the exit conference on 5/17/18.

5. The facility staff failed to ensure that the pharmacist had a completed monthly drug regimen review for Resident #12.

Resident #12 was admitted to the facility on 6/2/16 with the following diagnoses of, but not limited to atrial fibrillation, coronary artery disease, diabetes, high blood pressure, peripheral vascular disease, heart failure and arthritis. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/22/18, the resident was coded as having a

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F 756	Continued From page 19 BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. The surveyor performed a clinical record review of Resident #12's electronic medical record on 5/15 and 5/16/18. During this review, the surveyor noted monthly drug regimen reviews in the electronic clinical record conducted by the pharmacist for the following dates: 4/29/18, 3/14/18, 2/21/18, 1/24/18, 11/28/17, 10/16/17 and 9/14/17. There was no documentation noted by the surveyor in the electronic clinical record for the month of December 2017. The surveyor notified the administrative team on 5/16/18 at 4 pm of the above documented findings. On 5/17/18 at 9 am, the director of nursing stated to the surveyor, "I can't explain why this resident does not have a pharmacy review for December. I have asked medical records to look in the paper charts to see if the pharmacist had hand written something for December and it was placed in there instead of it being scanned in." At 1:30 pm, the surveyor asked the director of nursing if she was able to locate anything else on the missing December pharmacy review for Resident #12. The director of nursing stated, "It wasn't in medical records either." No further information was provided to the surveyor prior to the exit conference on 5/17/18.	F 756		
F 842	Resident Records - Identifiable Information	F 842		6/29/18

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F 842 SS=D	Continued From page 20 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 21 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for three of 26 Residents, Resident #44, 35, and #61 1. For Resident #44, facility staff failed to ensure medication administration orders addressed the correct route of administration. Resident #44 was admitted to the facility on	F 842	F 842 1. Resident #44 physician orders were reviewed and updated by the Unit Manager to ensure all medications reflect administration via gastrostomy tube. Resident #35 and Resident #61 were not affected by this deficient practice.	

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F 842	Continued From page 22 9/21/17 with diagnoses including dysphagia, diabetes mellitus, heart failure, dementia, and chronic kidney disease. On the significant change minimum data set assessment with assessment reference date 3/21/18, the resident was unable to complete the brief interview for mental status and scored 4/8 on measures of delirium. While observing the nurse administer a tube feeding bolus on 5/17/18 at 11:29 AM, the surveyor discussed medication administration for the resident. The nurse recounted the process for checking placement, administering the medication, and flushing the tube afterward. She stated that the resident's family had requested to be allowed to feed the resident, who is normally unable to swallow. Those feeding efforts amounted to placing a couple of spoons of Jello on the resident's tongue and waiting for it to dissolve. Clinical record review revealed that the resident's medications are ordered PO (by mouth). Nurses had signed daily administration of medications by mouth. The resident's medication nurse, when asked, confirmed that no medications were administered PO. The administrator and director of nursing were notified of the concern during a summary meeting on 5/17/18. 2. The facility staff failed to maintain a complete and accurate clinical record for Resident #35. Resident #35 was readmitted to the facility on 10/10/14 with the following diagnoses of, but not limited to heart failure, diabetes, high blood pressure, aphasia, dementia, anxiety disorder	F 842	2. Licensed Nurses will be educated by the Unit manager on ensuring physician orders reflect correct route of administration. Licensed Nurses will be educated by the Unit Manager on accurately completing behavior monitoring documentation. This education will instruct nurses to refer directly to legend to determine correct code of behavior documentation. The behavior documentation legend will be available for review on the medication cart. 3. During daily clinical meeting (Mon-Fri), the Unit Managers will review all new physician orders to ensure correct route of administration is ordered. An audit will be completed by the Unit Manager (3) times weekly for 4 weeks and then weekly for 8 weeks to ensure nurses are utilizing correct key code to document behavior monitoring. 4 Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegation of compliance date for	

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F 842	Continued From page 23	F 842		

and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #35 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.

The surveyor performed a clinical record review on Resident #35 on 5/15 through 5/17/18. During this review, the surveyor noted that on the MAR (Medication Administration Record) for the months of January, February, March and April 2018, the behavioral monitoring documentation did not follow the key that the staff was to use when documenting targeted behaviors.

The director of nursing and the corporate nurse were notified of the above documented findings on 5/17/18 at 10:30 am. The surveyor went through these months with the director of nursing and reviewed each entry that the staff did not document appropriately use the key to document on the behavioral monitoring sheets.

At 1:30 pm, the director of nursing stated to the surveyor, "I went back and reviewed the documentation on the behavioral monitoring sheets. I see where the staff did not use the key to document on the behavioral monitoring sheets. We will begin to work on this so that it can be corrected."

No further information was provided to the surveyor prior to the exit conference on 5/17/18.

3. The facility staff failed to maintain a complete and accurate clinical record for Resident #61.

this plan is 6/29/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495134	A. BUILDING _____ B. WING _____	05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGECREST MANOR NURSING & REHABILITATION	157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 24	F 842		

Resident #61 was admitted to the facility on 1/3/18 with the following diagnoses of, but not limited to anemia, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/11/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #61 was also coded as being totally dependent on 2 or more staff members on dressing, personal hygiene and bathing.

The surveyor performed a clinical record review on Resident #61 on 5/15/18 through 5/17/18. During this review, the surveyor noted that on the MAR (Medication Administration Record) for the months of January, February, March and April 2018, the behavioral monitoring documentation did not follow the key that the staff was to use when documenting targeted behaviors.

The director of nursing and the corporate nurse were notified of the above documented findings on 5/17/18 at 10:30 am. The surveyor went through these months with the director of nursing and reviewed each entry that the staff did not document appropriately use the key to document on the behavioral monitoring sheets.

At 1:30 pm, the director of nursing stated to the surveyor, "I went back and reviewed the documentation on the behavioral monitoring sheets. I see where the staff did not use the key to document on the behavioral monitoring sheets. We will begin to work on this so that it can be corrected."

No further information was provided to the

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F 842	Continued From page 25 surveyor prior to the exit conference on 5/17/18.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following 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	F 880		6/29/18

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F 880	Continued From page 26 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 staff interview and facility document review, the facility staff failed to ensure an effective infection control program. The findings included: The surveyor requested the infection control line list (tracking form for facility infections) from April	F 880	F880 1. On 5/17/2018, The Director of Nursing reviewed the infection control line listing log for the last 30 days. Any incomplete dates related to clearance of infection were updated on the log.	

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F 880	Continued From page 27 2017 through April 2018 from the director of nursing on 5/17/18. When the infection control line listing was provided to the surveyor at 2:30 pm, the form was found to be incomplete. The infection control line listing form did not have documentation on it to whether the infection had been resolved or continued to be ongoing. On 5/17/18 at 4 pm, the surveyor went over the line listing for tracking infections with the director of nursing for the months that were requested above. The surveyor found that there was no documentation on the line listing that stated whether the infection was resolved or continued to be ongoing for the following months: January and March 2018 and August, September and November 2017. The surveyor requested from the director of nursing any other information that could be provided to support that the facility traced and trended when the infections had been resolved or continued to be ongoing. The director of nursing stated that this was all the documentation that she had. No further information was provided to the surveyor prior to the exit conference on 5/17/18.	F 880	2. On 6/12/2018, The Regional Director of Nursing in-serviced the Unit Managers on completion of the infection control line listing log to include date infection cleared. 3. The Director of Nursing will audit the infection control line listing log monthly to validate entry of a date infection has cleared. 4. Monthly for a minimum of three (3) months, The Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The allegation of compliance date for this plan is 6/29/2018	