STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495086	A. BUILDING ______ B. WING ______	C 10/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE AND REHAB-BAY POINTE	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

(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 10/23/2018 through 10/26/2018. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) 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 survey was conducted 10-23-18 through 10-26-18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey. The census in this 112 certified bed facility was 92 at the time of the survey. The survey sample consisted of 33 residents, 30 active and 3 closed records.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		12/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/18/2018

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

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a dignified living experience for two residents (Resident #59 and Resident #41) in a survey sample of 33 residents. 1. Resident #59 was not offered a clothing protector during her meals and her clothing became stained with food.	F 550	Cross Referenced to 12 VAC 5-371-220(E) 1.Resident #59s clothing was changed following lunch. A clothing protector was provided for her use on Oct. 24, 2018. Resident #41s neck and chest area were assessed for skin impairment on November 2, 2018. Resident #41 was provided a clothing protector on Oct. 24, 2018. Staff present at the time of incorrect	

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F 550	Continued From page 2 2. Resident #41 had excessive drooling. There was no towel or clothing protector in place and his neck/shoulder was wet with mucus. 3. Residents in the dining room were called Grandma and Grandpa. The findings included: 1. Resident #59 was not offered a clothing protector during her meals and her clothing became stained with food. Resident #59 was admitted to the facility on 8-4-16 with diagnoses which included, but not limited to, Alzheimer's dementia, high blood pressure and depression. Resident #59's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 9/4/18. Resident #59 was coded with a Brief Interview of Mental Status score of "7" out of a possible 15 indicating severe cognitive impairment. Resident #59 required supervision to extensive assistance of one staff member for bed mobility and bathing and toileting. The resident was coded as being frequently incontinent of urine. On 10/26/18 at 9:37 AM, an interview with CNA (certified nursing assistant) A was conducted. CNA (A) stated, "We didn't have them (clothing protectors) on Tuesday. She went on to state that clothing protectors were a dignity issue, and "They are to keep the resident's clothes clean."	F 550	communication in the dining room were educated about dignity when addressing residents. Education/training for staff on the topics of resident rights, respect, and dignity was initiated on Oct. 24, 2018. 2.Residents at Bay Point have the potential to be affected. 3.The Administrator and/or Designee will educate staff on the use of clothing protectors and the proper way to address residents. Residents will be offered a clothing protector for all meals. Residents with drooling will be offered a clothing protector. Residents will be addressed by their proper name and treated with respect. The Administrator and/or designee will conduct dignity observation rounds daily for seven days, followed by weekly week for seven weeks, and then monthly for one month. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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F 550	Continued From page 3	F 550		

2. Resident #41 had excessive drooling. There was no towel or clothing protector in place and his neck/shoulder was wet with mucus.

Resident #41 was admitted to the facility on 10-27-14 with diagnoses which included, but not limited to, congestive heart failure, traumatic brain injury and seizure disorder.

Resident #41's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 8-22-18. Resident #41 was coded with a Brief Interview of Mental Status score of "9" out of a possible 15 indicating moderate cognitive impairment. Resident #41 required extensive to total assistance of one to two staff members for bed mobility and bathing and toileting.

On 10/24/18 at 8:44 AM, Resident #41 was observed in bed in the room. The head of the bed was elevated. Oxygen was at 3 liters per minute via a nasal cannula and Tube feeding was off. Resident #41 was drooling clear mucus, moaning, and holding saliva in the mouth. No towel or clothing protector were in use.

On 10/24/18 at 10:50 AM, Resident #41 was observed in bed, holding saliva in mouth. Resident #41's neck/chest was red with light rash and drool pooling on chest.

On 10/24/18 at 4:22 PM, the facility Administrator and DON (director of nursing) were notified of above findings. The DON stated, "We have them (clothing protectors) to provide."

3. Residents in the dining room were called

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F 550	Continued From page 4 Grandma and Grandpa. On 10/23/18 at 3:13 PM, Staff were observed calling residents in the dining room "Grandma" and "Grandpa." During the lunch meal, no clothing protectors were in use. Resident #59 was observed to have spaghetti sauce on her skirt from lunch. On 10/26/18 at 9:37 AM, an interview with CNA (certified nursing assistant) A was conducted. CNA (A) stated, stated to call residents names like "honey" and "Grandma" was "a dignity issue."	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review the facility staff failed to ensure 1 resident (Resident #28) of 33 residents in the survey sample were assessed to self administer medications. For Resident #28, Systane eye drops were observed on the bedside table. The findings included: Resident #28, an 87 year old, was admitted to the facility on 8/27/18. Diagnoses included anxiety, anemia, gout, diabetes, history of breast cancer, peripheral vascular disease, and heart disease.	F 554	Cross Referenced to 12 VAC 5-371-300(B) 1.The Systane eye drops were removed from the resident #28□s room. The Resident was asked on Oct. 24, 2018 if she wished to be assessed for self administration of eye drops and the resident informed the DON that she did not wish to be assessed. The nurse assigned to resident #28 was educated on Oct. 24, 2018 regarding medications at bedside. Licensed Nurse education was initiated on November 15, 2018 for not leaving medications at bedside.	12/10/18

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F 554	Continued From page 5 The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 9/2/18. Resident #28 was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 10/23/18 at 12:00 p.m., an interview was conducted with Resident #28. At this time, the Systane eye drops were observed on the bedside table. Resident #28 was asked if she used the eye drops. She stated yes, the nurse had put drops in both of her eyes and left the medication on the bedside table. The Systane eye drops were observed on the bedside table again on 10/23/18 at 2:00 p.m. Resident #28 had a physician order dated 8/27/18 for Systane Ultra Solution 0.4-0.3% Instill 1 drop in both eyes one time a day. At the end of day meeting on 10/24/18, the Director of Nursing (DON) and Administrator were notified that the eye drops were observed on the resident's bed side table on two occasions. The DON was asked if Resident #28 had been assessed to self administer medications which would include keeping medications at the bedside. On 10/25/18 at the end of day meeting, the DON stated that Resident #28 had not been assessed to self administer medications.	F 554	2.Residents determined to not meet criteria for self administration have the potential to be affected. 3.The Director of Nursing and/or designee will educate licensed nursing staff on self administration protocol. Residents that request to self administer mediations will be assessed and orders obtained if appropriate. The Director of Nursing and/or Designee will educate licensed nursing staff on not leaving medications at bedside. The Director of Nursing and/or designee will conduct medication pass observation rounds daily for seven days, followed by weekly for seven weeks, and then once a week for four weeks. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		12/10/18

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F 582	Continued From page 6	F 582		

Continued From page 6

§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 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

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F 582	Continued From page 7 per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure Advanced Beneficiary notices were provided prior to loss of benefits, for 3 residents (Resident #18, #146, and #147), in a survey sample of 33 residents. The facility staff failed to provide Residents #18, #146, and #147 with written notification prior to their loss of benefits. The Findings included: For Residents #18, 146, and 147, clinical records, admissions records, hospital records, and discharge records were reviewed. The review revealed "Notice of Medicare Non-Coverage" (NOMNC) documents. Two of the NOMNC documents were signed with the names of Resident #18, and #147's Power of attorneys (POA's). The signatures appeared on the documents as the following example; "John Smith via 757-000-0000" and were dated. The third NOMNC of Resident #146 only had the POA	F 582	Cross Referenced to 12 VAC 5-371-150(B) 1.Residents #146 and #147 are no longer in the facility. Resident #18 received a NOMNC, not an ABN, on August 10, 2018. 2.Medicare/Medicaid eligible residents have the potential to be affected. 3.The Business Office Manager, Social Worker, and MDS Coordinator will be educated on the use of the ABN and Notice of Medicare Non Coverage (NOMNC) forms by the Vice President of Case Management and/or designee. The Administrator and/or designee will review loss of coverage forms before and following issuance to residents to ensure compliance. This review will occur as forms are issued for three months. 4.Any noted discrepancies will be immediately corrected and forwarded	

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F 582	Continued From page 8 signature and a phone number. The word, "via" was not included. The handwriting and signatures, appeared identical in all three documents. Copies of the NOMNC documents, and copies of original documents with the POA's signatures were reviewed. They did not match. On 10-25-18 at 10:00 a.m., a telephone interview was conducted with the POA of Resident #18. The POA stated she had not been notified of nor received a document for medicare refusal to pay for skilled nursing treatment services (NOMNC), and was not in the building on 8-10-18. She further told surveyors that the Resident needed, and was still getting skilled nursing services. Resident #18's POA was surprised to learn that was not the case. On 10-25-18 at 11:00 a.m., The Social worker (Employee A) was interviewed with other surveyors present in the conference room. She stated that she filled out the forms. When asked if she signed the form with the POA's signature, she stated "yes, I spoke with them on the telephone." When she was told that the POA was required to receive the information in writing per the federal regulation, she stated; "Well that is not the way I was trained. I was told that I could call on the phone, and just fill out the form myself." Employee A was told that the POA for Resident #18 did not receive any information about loosing skilled nursing benefits, and told surveyors that the Resident was still getting skilled nursing services, and she was surprised to learn that was not the case. Employee A stated "I call them, and then I fill out the form. I can't prove that I call them."	F 582	monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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F 582	Continued From page 9 Social work notes were reviewed, and none stated any information about these three Residents loosing medicare coverage. The Administrator and Director of Nursing were notified of the failure of staff to provide in writing, NOMNC federal documents, to Residents and their responsible parties. No further information was provided.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		12/10/18

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F 584	Continued From page 10 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and clinical documentation, the facility failed to maintain a clean and homelike environment. Resident #59's room had a sustained strong urine odor. The findings included: On 10/23/18 at 2:54 PM, Resident #59 was resting in bed with the window open. The room still had a strong urine odor. On 10/24/18 at 8:37 AM, Resident #59 was in bed asleep, however there was a strong smell urine odor from the hallway. On 10/24/18 at 9:51 AM, An interview was conducted with the account manager-housekeeping (Other-F). He stated, We are trying to solve the problem." He stated that the room had been mopped and cleaned. The room continued to have a strong urine odor.	F 584	Cross Referenced to 12 VAC 5-371-370(A) 1.Resident #59s room was deep cleaned during the survey and the odor was eliminated on October 25, 2018. The residents room will be checked following toileting and care plan updated to reflect intervention. The nursing assistants will be educated 2.Residents with dementia who self-toilet have the potential to be affected. 3.The Administrator and/or designee will educate staff on the residents right to have, and the facilitys obligation to provide, a safe, clean, comfortable, and homelike environment. Resident rooms will be deep cleaned by housekeeping on an ongoing basis. Angel Rounds will be completed daily by management to include checking for odors and reviewed	

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F 584	Continued From page 11 On 10/24/18 at 4:22 PM, the facility Administrator and DON (director of nursing) were notified of above findings. On 10/25/18 at 8:56 AM, the resident's room has no odor. The housekeeping account manager was asked if the source of the odor had been found. He stated that they moved items in the room and found some "diapers and linens", which were removed.	F 584	at the morning meeting for three months. 4.Any noted discrepancies will be corrected, recorded and forwarded for three months, or until sustained, to the Quality Assurance Committee for review and further recommendation.	
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by:	F 606		12/10/18

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F 606	Continued From page 12 Based on staff interview and employee record review the facility staff failed to verify licensure with the State licensing board prior to hire for 5 nurses and failed to verify certification of nursing assistants with the State nurse aide registry prior to hire for 3 nursing assistants. It was identified during an employee record review that the credentials of a total of 8 licensed and certified nursing staff were not verified prior to hire or verified at all. The findings included: Employee records were reviewed during the survey. The following issues were identified when reviewing employee records: 1. Employee #4 was hired as a Licensed Practical Nurse (LPN) on 3/6/18. The license was verified after hire on 3/9/18. 2. Employee #8 was hired as a Registered Nurse (RN) on 3/6/18. Her license was never verified. 3. Employee #9 was hired as a RN on 5/8/18. Her license was never verified. This employee was working during the survey. 4. Employee #10 was hired as a Certified Nursing Assistant (CNA) on 7/31/18. Her certification was verified after hire on 8/28/18. 5. Employee #13 was hired as a LPN on 3/27/18. Her license was never verified. 6. Employee #15 was hired as a RN on 3/27/18. Her license was never verified. 7. Employee #18 was hired as a CNA on 2/6/18. Her license was never verified. 8. Employee #19 was hired as a CNA on 8/14/18. Her certification was verified after hire on 8/15/18. At the end of day meeting on 10/25/18, the	F 606	1.Licenses of all licensed staff, in house and contracted, have been verified with their designated licensing board on October 30, 2018 and again on November 13, 2018. 2.Residents residing at Bay Pointe have the potential to be affected. 3.The Administrator and/or designee will educate the Payroll Benefits Coordinator and/or back up/designee on the onboarding licensure verification process for licensed staff. The Administrator and/or Designee will review all licenses prior to licensed staff start date weekly for 8 weeks, then twice a month for one month. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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F 606	Continued From page 13 Administrator was asked if the facility had a Human Resources staff. The Administrator stated that she and the payroll employee shared the role. When asked who was responsible for checking the licenses and certifications of potential new hires, the Administrator stated that the hiring manager would be responsible. At the end of day meeting on 10/26/18 held with the Administrator, Director of Nursing and Corporate Staff, the names of the eight staff that had a late license/ certification check or no check at all were shared with the facility administration.	F 606		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by	F 640		12/10/18

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F 640	Continued From page 14 CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a discharge MDS (Minimum data set) for one resident (Resident # 2) in a survey sample of 33 residents. For Resident # 2, the facility staff failed complete a Discharge MDS after discharge on 7/10/2018. Findings included: Resident # 2 was a 94 year old female admitted	F 640	1.A discharge MDS was completed for resident #2. 2.Residents discharging from the facility have the potential to be affected. 3.The Vice President of Case Management and/or designee will educate the MDS Coordinator and/or designee on discharge MDS compliance timeframes. The Director of Nursing and/or Designee will review discharges weekly for 12	

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F 640	Continued From page 15 to the facility on 5/2/2018 with the diagnoses of but not limited to: Hypertension, Respiratory Failure with Hypoxia, Congestive Heart Failure, Emphysema, Anxiety, Gastroesophageal Reflux Disease, Tachycardia, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease. Review of the clinical record was conducted on 10/24/2018 at 4:00 PM. Review of the Nurses Notes dated 7/1/2018 at 3:51 PM revealed Resident # 2 was discharged with family to another state. The only MDS assessments in the clinical record were an Admission Assessment dated 5/9/2018 and a 14 Assessment dated 5/16/2018. Further review of the clinical record revealed no documentation of a MDS (Minimum Data Set) was transmitted at the time of discharge on 7/10/2018. On 10/25/2018 at 4:10 PM, an interview was conducted with the Director of Nursing who stated there was no Discharge MDS in the clinical record. The Director of Nursing stated there should have been a discharge MDS done upon discharge. Page 2-37 from the October 2017 RAI Manual reads: OBRA Discharge Assessments (A0310F) OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated. 09. Discharge Assessment-Return Not Anticipated (A0310F=10) - Must be completed when the resident is	F 640	weeks to ensure mandated timeframes for obtaining, encoding, and transmitting data are followed. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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F 640	Continued From page 16 discharged from the facility and the resident is not expected to return to the facility within 30 days. - Must be completed (Item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). - Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). - Consists of demographic, administrative, and clinical items. - If the resident returns, the Entry tracking record will be coded A1700=1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident's stay will be covered by Medicare Part A, the PPS schedule starts with a Medicare-required 5-day scheduled assessment or combination of the Admission and 5- day PPS assessment. On 10/26/2018 at 11:00 AM, the Director of Nursing stated the facility staff completed an audit of all the discharges in the past 6 months to make sure no other discharge assessments had been omitted. The Director of Nursing and Administrator stated the facility had recently promoted one of the nurses to be the new MDS Coordinator. The Administrator reported that the full time MDS position had been vacant for about 3 weeks between 7/26/2018 and 8/17/2018. No further information was provided.	F 640		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		12/10/18

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F 644	Continued From page 17 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to Incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident ' s assessment, care planning, and transitions of care for one resident (Resident #12) in a sample of 33 residents. 1. For Resident #12, the facility staff failed to implement the PASARR II recomendations to meet the Resident's intellectual disability (ID) needs. The findings included: Resident #12, a 26 year old female, was admitted to the facility on 04/18/2018 following a hospital	F 644	1.Resident #12 received a psychiatry consult on July 2, 1018. The Social Services Director has reached out to and will continue to follow up with appropriate agencies for services, guardianship, and an ID waiver. Calls were placed to Adult Protective Services, the Community Services Board, local day support programs, and her eligibility worker between November 14 and November 16, 2018. An appointment with Eden Counseling and Consultation for Resident #12 to receive psychotherapy services for functional assessment and grief counseling is scheduled for December 3, 2018. Resident #12s care plan has been updated to reflect new interventions to include the ID waiver process,	

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F 644	Continued From page 18 admission for influenza with wheezing, cough, fever, and systemic inflammatory response syndrome. Note: The Resident's primary caregiver died of influenza/pneumonia the day before the Resident's hospital admission. Diagnoses for Resident #12 include athetoid cerebral palsy, moderate intellectual disability (ID), depression, anxiety, asthma, and anemia. Resident # 12's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 07/25/2018. Resident # 12 did not have a Brief Interview of Mental Status (BIMS) conducted but cognitive skills for daily decision-making were coded as moderately impaired. Functional status for personal hygiene, dressing, mobility, and transfers were coded as extensive assistance for performance and support. Resident #12 was in a wheelchair and locomotion on and off unit was coded as requiring supervision and oversight. Preferences for customary routine and activities were not coded. On 10/24/18 at 8:30 AM, the Resident was observed rolling herself in wheelchair in the hallway. The Resident was crying and asking to go to school and wanting to get on the school bus. The DON was in the hallway and was asked if the resident went to school. The DON stated, "No, she has finished school." The DON was then asked if the resident went to a day program. The DON stated that she did not think so that, "She lives here." On 10/25/18, the clinical record was reviewed. The PASARR Level II dated 04/12/18 documented "Specialized services recommended at this time as determined by the Level II include community living skills, day support and	F 644	psychotherapy services with grief counseling, and day school program search. 2.Residents with a Level 2 PASARR have the potential to be affected. 3.Concordia Bay Pointe will screen all referrals to ensure residents requiring Level 2 PASARRs are completed prior to admitting. The Clinical Admission Grid will be updated to reflect this change. The Admission Team to include the Clinical Liaisons, Business Office Manager, and Admission Coordinator will be educated on the change to the Clinical Admission Grid. The Administrator and/or Designee will review PASARRs prior to admission daily for two weeks, then weekly for 6 weeks, followed by twice monthly for one month. The Administrator and/or Designee will review Residents with Level 2 PASARR recommendations, monitor weekly until recommendations have been completed for that resident. This will be on an ongoing basis. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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F 644	Continued From page 19 habilitation (sic), self-help/personal care, social skills development, transportation to specialized services, and mobility aids." The Level II assessor also documented, "As with any admission, discharge planning begins at the time of admission. I encourage the nursing facility to start discharge planning for (Resident) to be able to transition to a lesser restrictive setting if appropriate. It is recommended that the nursing facility work with (Resident) to maintain independent skills to the maximal extent possible while she is rehabilitating there in preparation for a transition back to a community setting when she is able. I encourage the nursing facility to work with the local Community Services Board to assist in identifying supports and services that she could benefit from." A Physician's order dated 04/18/18 documented, "May participate in activities (including out of building activities) per plan of care." An order dated 04/18/18 documented a psychiatry consult. An order dated 05/07/18 documented, "Discharge potential [within 31-90 days]." There were four social services notes since the Resident's admission. The first entry dated 04/28/18 documented, "Summary: Resident was admitted from the hospital. Resident is alert. She is here to regain her strength and endurance. Her sister is involved with care. APS is also involved. Code status is Full Code. Discharge plan is either LTC (long-term care) here or a group home." An entry dated 05/23/18 documented, "SW (social worker) spoke with APS regarding this resident. APS was involved with this resident prior to admitting to this facility. APS is assisting with trying to get the resident's MCD (Medicaid)	F 644		

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F 644	Continued From page 20	F 644		

re-instated and also trying to assist with the resident getting the ID waiver for a group home which would be a more appropriate setting for the resident. SW will continue to work with APS to put a safe plan in place."

An entry dated 07/30/18 documented, "SW and APS are working together to find a more appropriate setting for the resident. A group home would be more appropriate setting for her. Resident is currently on the waiting list for the ID waiver. SW will continue to work with APS regarding this resident."

It should be noted that social worker had been on maternity leave from 5/25/18 to 7/23/18 and that nursing staff were filling in for social service needs.

The last entry on 10/24/18 at 10:11 AM documented, "Late entry: (name) (APS) and SW spoke regarding placement for the resident. She stated that the resident's sister is working on a place for her in (out-of-state) with her. SW asked APS about the ID waiver and group home for the resident. She stated that the resident's sister does not want to move the resident twice and wants her to stay in the facility until placement is established out of state. SW will continue to work with APS for discharge placement."

On 10/25/2018 at 11:10 AM, the social worker was asked about the Resident's legal guardianship and she stated there was no legal guardian documentation. The social worker stated the Resident does not have a legal guardian but the sister is the next of kin. The social worker stated the sister knows the Resident has been crying about being here and

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F 644	Continued From page 21 the sister is working with adult protective services (APS) to get the Resident moved to a facility near her (out of state). When asked about enrolling the Resident in a day program, the social worker stated that an ID waiver is needed in order for her to participate in a day program or live in a group home. When asked if she could apply for the waiver, stated she could apply through the city "but the APS worker is spear-heading this." On 10/25/18 at 2:55 PM, the APS worker familiar with the resident was interviewed. She stated that the Resident was initially admitted to LTC (long-term care) as her UAI showed she required full Activities of Daily Living (ADL) care. Her supervisor was also on the phone call and she stated that initially the Resident was referred to APS for a community issue that she could not go into. She went on to state "We don't participate in the discharge planning, it should be the LTC facility." The APS worker also stated that the Resident had previously been in a day program in Portsmouth, which was not renewed since her mother died. She stated that the Resident had "not applied for an ID waiver" (necessary for placement in a group home). On 10/25/18 at 3:55 PM an interview with Activities Director was conducted. When asked what the Resident's activity preferences were, she stated the Resident liked puzzles, a squeeze ball, and a tablet that plays songs. She stated that the Resident joins us for activities but doesn't like to stay and we let her go. When asked if Resident participated in a day program when living in Portsmouth, stated she didn't think so. On 10/26/18 at approximately 10:00 AM, the certified nursing assistant (CNA) C stated she	F 644		

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F 644	Continued From page 22 had heard the Resident say she wants to go home. CNA C went on to say she thought the Resident needs to "be in one of those ID homes." On 10/26/18 at approximately 11:30 AM, the social worker was asked about the Resident participating in a day program and she stated "I haven't investigated how she can get into a day program." On 10/26/18 at approximately 2:00 PM, the Administrator and the DON were notified of findings. The Administrator stated that the social worker was on maternity leave from 05/25/18 through 07/23/18. The Administrator also stated that the MDS (minimum data set) coordinator (an LPN) served as social worker in (social worker) absence. No further information or documentation was presented.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645		12/10/18

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F 645	Continued From page 23 (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.	F 645		

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F 645	Continued From page 24 §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure the PASARR was completed prior to admission for three residents (Resident #74, #29, #85) in a sample of 33 residents. 1. For Resident #74, the facility staff failed to ensure a PASARR was completed prior to admission. 2. For Resident #29, the facility staff failed to ensure a PASARR was completed prior to admission. 3. For Resident #85, the facility staff failed to ensure a PASARR was completed prior to admission. The findings included: 1. For Resident #74, the facility staff failed to ensure a PASARR was completed prior to admission. Resident #74 was admitted to the facility on 06/18/18 and current diagnoses include major	F 645	1.PASARRs for Resident□s #74,29 and 85 were obtained on October 25, 2018. 2.Residents admitting to Bay Pointe have the potential to be affected. 3.The Admission Team to include the Clinical Liaisons, Business Office Manager, and Admission Coordinator will be educated on regulatory expectation to obtain PASARRs prior to admission for any resident admitting to a Medicaid Certified facility. The Administrator and/or Designee will review PASARRs prior to admission daily for two weeks, then weekly for 6 weeks, followed by twice monthly for one month. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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depressive disorder, post-traumatic stress disorder, and anxiety disorder.

Resident #74's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/24/2018 was coded as a quarterly review. Resident #74 was coded with a Brief Interview of Mental Status score of "14" out of possible "15" indicative of little to no cognitive impairment. The MDS quarterly review also indicated Resident # 74 had received antipsychotic and antidepressant medications and there was no recent psychological therapy by a licensed mental health professional.

Review of the clinical record revealed there was no PASARR I documentation on the chart.

On 10/25/2018, a copy of the PASARR was requested. The facility staff presented a document that stated Resident "does not meet the requirement" to have a PASARR.

On 10/26/18, the Administrator was asked to describe the PASARR process and she stated, "They should have them upon admission."

On 10/26/2018, the Administrator and DON were notified that all applicants to Medicaid-certified facilities are required to be screened prior to admission. They offered no further documentation.

2. For Resident #29, the facility staff failed to ensure a PASARR was completed prior to admission.

Resident #29 was admitted to the facility on

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F 645	Continued From page 26 07/18/14 and current diagnoses include dementia, Parkinson's disease, anxiety, major depression, and psychotic disorder (other than schizophrenia). Resident #29's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/15/2018 was coded as a quarterly review. Resident #29 was coded with a Brief Interview of Mental Status score of "12" out of possible "15" indicative of moderate cognitive impairment. The MDS quarterly review also indicated Resident #29 had received antipsychotic, antidepressant, and antianxiety medications and there was no recent psychological therapy by a licensed mental health professional. Review of the clinical record revealed there was no PASARR I documentation on the chart. On 10/25/2018, a copy of the PASARR was requested. The facility staff presented a document that stated Resident "does not meet the requirement" to have a PASARR. On 10/26/18, the Administrator was asked to describe the PASARR process and she stated, "They should have them upon admission." On 10/26/2018, the Administrator and DON were notified that all applicants to Medicaid-certified facilities are required to be screened prior to admission. They offered no further documentation. 3. For Resident #85, the facility staff failed to ensure a PASARR was completed prior to	F 645		

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admission.

Resident # 85 was admitted to the facility on 5/31/2018 with diagnoses of Cardiomyopathy, Dysphagia, Bipolar Schizoaffective Disorder, Tracheostomy, Absence of Left Leg Below the Knee Amputation, History of Cardiac Arrest, Chronic Respiratory Failure, Gastrostomy Tube and Congestive Heart Failure.

On 10/23/2018 at 2:30 PM, review of the clinical record was conducted.

Review of the clinical record revealed there was no PASARR Level 1 Screening in the electronic or paper clinical record.

On 10/24/2018 at 11:00 AM, an interview was conducted with the Social Worker stated the Business Office did not have a PASARR for Resident # 85 "because she is still on Medicare." The Social Worker stated the hospital did not send a PASARR on Resident # 85.

On 10/24/2018 at 4:30 PM during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings of no PASARR.

On 10/25/2018 at 1:30 PM, the Director of Nursing presented a copy of a form that quoted "Required PASRR Components." On the top of the form was written Resident # 85's name and "patient did not meet requirements." In the body of the form "mental illness was underlined. The bottom line was underlined "Persons with sole dementia with no suspicion of an underlying mental illness and with no suspicion of an IDD condition do not need to be referred for PASRR."

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F 645	Continued From page 28 A copy of the Virginia Uniform Assessment Instrument dated 6/26/2017 was also submitted. On 10/25/2018 at 2:45 PM, an interview was conducted with the Social Worker who stated Resident # 85 did not meet the requirements for a PASARR. The Social Worker and Director of Nursing were advised that residents admitted to nursing facilities must have a Level 1 screening. No further information was provided.	F 645		
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 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	F 656		12/10/18

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F 656	Continued From page 29 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to develop and implement a comprehensive person centered care plan for three Residents (Residents #93, #53, #28) of 33 residents in the survey sample. 1. Resident #93's care plan did not include person centered interventions for weight loss. 2. Resident #53's care plan did not include person centered interventions for pressure sores. 3. For Resident #28, a discharge care plan was not included in the comprehensive care plan. The findings included; 1. Resident #93's care plan did not include person centered interventions for weight loss.	F 656	Cross Referenced to 12 VAC 5-371-250(G) 1.Resident #93 was referred to and evaluated by Speech Therapy on November 13, 2018. The Registered Dietician reviewed resident #93□s nutritional status and caloric intake on November 13, 2018. Resident #93□s physician was notified of resident□s weight loss during survey. A reweight was obtained on Oct. 26, 2018. Resident #53□s wounds are healed, and skin is intact. Resident was on a Span (brand) low air loss pressure reduction mattress at the time of the survey. A longer bed was ordered for the resident. The resident□s stated preference is to remain in bed. A positioning wedge will be offered to promote turning and	

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Resident #93 was admitted to the facility on 7-12-18. Diagnoses included; diabetes, heart disease, hypertension, stroke, gout, contractures, hypothyroidism, , depression, dementia, recurrent urinary tract infections (UTI's), hematuria, and anemia.

Resident #93's most recent Minimum Data Set assessment was a 14 day re-entry assessment after hospitalization on 9-21-18 for hematuria and UTI, with readmission on 9-25-18. The assessment reference date was 10-9-18. The Resident was coded with a Brief Interview of Mental Status score of unable to complete due to severe cognitive impairment. The Resident required extensive assistance to total dependence on staff for completion of activities of daily living. Section K, Swallowing/Nutritional Status, question K0300 asked "Loss of 5% or more in the last month or loss of 10% or more in the last 6 months." Resident #93 was coded as "2. Yes, not on a physician-prescribed weight-loss regimen." The Resident was coded as weighing 125 pounds in the assessment.

The previous MDS assessments were also reviewed and revealed that the Resident was coded on all of them as at risk for weight loss, had a history of pressure ulcers, contractures, dementia, needed assistance with eating, was diabetic, and receiving insulin.

The following MDS documents at section K, hospital records, and facility readmission and weight records review revealed the following;

7-12-18 - Admission assessment weight - 150 pounds (lbs).

F 656

positioning.

Resident #28s initial discharge potential and plan was to remain in long term care at Concordia Bay Pointe; the Residents new current desire is to discharge home. Contact was made with Resident #28s Power of Attorney on Nov. 13, 2018 to update and initiate residents discharge plan.

2.Residents residing at Bay Pointe have the potential to be affected.

3.The Director of Nursing and/or Designee will review resident care plans to verify recommendations (i.e. Dietary, PASARR, wounds) for treatment have been reported to the MD and ordered interventions incorporated in the care plan. Recommendations will be reviewed in morning meetings to follow up on MD notification, if new orders obtained and/or physician response documented when recommendations are declined, and ensure care is based on residents needs. The Director of Nursing and/or Designee will follow up in Stand Down meeting to validate follow through on recommendations and their inclusion in the care plan. The Director of Nursing and/or Designee will conduct audits weekly on consults/recommendations to verify follow up and implementation of recommendation inclusion in care plans.

4.Any noted discrepancies will be immediately addressed, recorded and forwarded, until compliance is sustained,

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F 656	Continued From page 31 7-19-18 - 149.1 lbs weights summary. 7-24-18 - 147.6 lbs weights summary. 7-30-18 - 146.9 lbs weights summary. 8-7-18 - 147 lbs, MDS no weight loss, and not on a weight loss program 9-6-18 - 147 lbs, MDS no weight loss, and not on a weight loss program. No weight taken from 9-6-18 to 9-25-18. 9-21-18 - out to the hospital for 4 days. 9-25-18 - returned from hospital weight 131 lbs. according to the hospital records, and readmission assessment. and 7 days later on 10-2-18, a 6 lb weight loss was again noted. 10-2-18 - MDS 125 lbs, yes weight loss, and not on a weight loss program. 10-9-18 - MDS 125 lbs, yes weight loss, and not on a weight loss program. The Resident had lost 25 pounds (16.66%) from 7-12-18 to 10-2-18 (less than 3 months), and no further weights were recorded at the time of survey on 10-25-18, (2 weeks more). Registered Dietician (RD) assessments were reviewed and revealed only one assessment had been completed, and it was dated 7-12-18. The previous RD completed the assessment upon the Resident's admission, and no longer was employed by the facility. A new RD had begun, but when interviewed stated she had not yet assessed this Resident. The initial & only RD assessment revealed the following recommendations for the Resident: "at risk for weight loss", and recommended "assistance with feeding", had "increased nutrient needs", "Nutrition monitoring & evaluation", "Medical food supplement", "House supplement 120 cc (cubic centimeters) QID (4 times per day)	F 656	to the Quality Assurance Committee for review and further recommendation.	

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@ medication pass for wounds", and "Multivitamin". Only the multivitamin had been ordered. None of the other recommendations were followed.

The Resident was on a "controlled carbohydrate no salt added diet" to be "mechanically soft" in texture from admission and never changed.

All Physician orders since admission were reviewed, and revealed the only 2 dietary orders and their dates of implementation included:

1. Resident needs assistance with eating ordered 7-12-18, and discontinued the same day.

2. Multivital tablet (multivitamin) ordered on admission 7-12-18, discontinued 7-13-18, and restarted on 9-28-18.

Resident #93's lunch meal tray was observed on 10-23-18, in her room. The Resident was expected to eat independently, and she had consumed 25% when the tray was removed. Breakfast on 10-24-18 could not be observed because the Resident was "nothing by mouth" status after midnight, the night before, for a procedure she was having that morning at her physician's office. This indicated 2 more meals essentially missed from the Resident's diet.

The meal card on Resident #28's tray read that she was to receive the prescribed diet.

Nursing progress notes were reviewed and revealed that occasionally the staff would feed the Resident, and she would then most often consume 75 to 100% of the meal.

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All Physician's progress notes were reviewed and revealed that on 10-4-18, 8-14-18, and 7-12-18 were the only visits for the Resident. The 10-4-18 note documented "Weight stable, appetite good". Which indicated the doctor was unaware of the Resident's significant (16.66 %) weight loss in 3 months.

On 10-25-18 the Residents care plan was reviewed and revealed that there was no weight loss care planned for this Resident. The care plan does not have any interventions for weight loss, even though the Resident was at risk from her admission, having had dementia, wounds, diabetes, and the care plan does not denote her significant weight loss. A weight loss care plan was never developed.

The failure of staff to recognize and intervene timely in a significant weight loss, and to develop a weight loss care plan was reviewed with the Administrator and Director of Nursing at the end of day meeting on 10-25-18, and 10-26-18. No further information was provided.

2. Resident #53's care plan did not include person centered interventions for pressure sores.

Resident #53 was admitted to the facility on 9-8-18. Diagnoses for Resident #72 included but were not limited to; anemia, chronic kidney disease, pulmonary hypertension, and insulin dependant diabetes.

Resident #53's most recent Minimum Data Set (an assessment protocol) was an admission assessment, with an Assessment Reference Date of 9-15-18. The MDS coded Resident #53 as

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F 656	Continued From page 34 alert, oriented to person, place, time and situation, with no cognitive impairment. The Minimum Data Set further coded Resident #53 as needing extensive assistance to being totally dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was incontinent of bowel, and had a foley catheter for urination. The Resident was also coded as at risk for skin breakdown, and having currently, 4 admitted wounds, being (1) venous stasis ulcer, and (3) stage 2 pressure ulcers. However, only 2 pressure ulcers were ever documented in nursing notes, and skin assessments. The Resident received Hemodialysis on Tuesday, Thursday, and Saturday, every week, at a dialysis center less than a mile from the facility. The Resident's "chair time" started at 10:30 a.m. at the dialysis center and lasted approximately 6 hours per day, which meant he should return to the facility between 4:30 and 5:00 p.m. every day. On 10-24-18 at approximately 11:30 a.m. Resident #53 was interviewed and observed. The Resident was sitting up in bed at a reclined angle of approximately 45%, with his eyes closed. The room door was set up with isolation supplies, the surveyor gowned and entered the room. The mattress was not remarkable in any way, and looked like every other mattress in the facility. The Resident was asked if he was comfortable with his feet pushed against the foot board, and he responded that he slid down in the bed often, and had to wait for nurses to pull him up. He stated that the nurses did not come very often, and when asked how often he replied "a couple times a day". He was asked how often they changed the dressing on his bottom, and he replied, "when it gets dirty, not every day." The	F 656		

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F 656	Continued From page 35 Resident was asked how long he had the sores, and he replied "I got them a couple weeks after I got here, about a month ago." A review of Resident #53's clinical record was conducted during the survey. The review included the entire computerized and paper charts, which revealed documents entitled "Weekly Skin check", "Clinical Evaluations", "nursing progress (NPN) notes, physician's (MD) orders, and Medication, and Treatment Administration Records (MAR/TAR)". The Director of Nursing (DON) provided the skin assessment records and stated "these are all we have for skin assessment records". "The Resident has only been here for 6 weeks." All of the documents that were reviewed, revealed the following chronological order of events; 9-8-18 - nursing note & weekly skin check - Identification of 2 wounds right (R) buttock, and left (L) buttock both deep tissue injury (DTI), both dime size. No further description. No preventative, or protective care ordered. 9-9-18 - nursing note - Stage 2 - (R) buttock measures length (L) 1.0 cm (centimeters) x width (W) 1.5 cm x Depth (D) 0.1 cm. Stage 2 - (L) buttock (L) 1.0 x (W) 2.0 x (D) 0.1. No further description, per RN (A) Assistant Director of Nursing (ADON) documentation. No preventative, or protective care ordered from identification for 2 days, and the wound was now open. 9-10-18 - nursing note & MAR/TAR - "Sodium Hypochlorite (Dakins solution) every day topical"	F 656		

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	495086	A. BUILDING ______ B. WING ______	C 10/26/2018

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F 656	Continued From page 36 per RN (A) documentation. The order was documented as not completed on 9-10-18, 9-11-18, 9-12-18, 9-13-18, 9-15-18, 9-18-18, 9-20-18, 9-22-18, 9-29-18, 10-2-18, 10-4-18, 10-6-18, and was discontinued on 10-7-18. No wound dressing cover accompanied this order, and none was documented on the treatment record. Only the liquid Dakins solution was wiped on the wound for 4 days until a dressing was ordered 9-12-18, which was not administered until 9-14-18. 9-12-18 treatment added "clean left and right buttocks with normal saline, skin prep (peri wound skin) and cover with alginate and composite dressing every other day, on day shift." This order did not begin until 9-14-18 (2 days after ordered.) Again the orders were for "Day shift". The treatments were not planned for dialysis days. This order was discontinued 9-26-18. 9-14-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.0 cm x (W) 1.4 cm x (D) 0.1 cm. Stage 2 (L) buttock (L) 1.0 x (W) 1.0 x (D) 0.1. No further description, per RN (A) documentation. Treatment unchanged. 9-15-18 - Skin check sheet & nursing notes - (R) buttock. (L) buttock. No further description in documents. Treatment unchanged. 9-21-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.0 cm x (W) 1.0 cm x (D) 0.1 cm. Stage 2 (L) buttock (L) 1.0 x (W) 1.4 x (D) 0.1. No further description, per RN (A) documentation. 9-24-18 - Skin check sheet & nursing notes- (R) buttock. (L) buttock. No further description in	F 656		

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documents. Treatment unchanged..

9-26-18 A new treatment order was received, and the only change was to apply "Santyl ointment" every day which is a debriding agent that liquefies dead necrotic tissue in a wound, and to cover the wound bed with "Drawtex", a synthetic man made absorbent material. The alginate used previously was a natural seaweed derivative that became a gel in the wound which was also absorbent. The only difference is that one becomes a gel to absorb and the other does not. These products are used interchangeably. This order was discontinued on 10-3-18 and was used for only 6 days as the treatment was not completed on 10-3-18.

9-28-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.5 cm x (W) 2.5 cm x (D) 0.2 cm. Stage 2 (L) buttock resolved. "Conjoined together now noted as sacrum wound with the MD (doctor) assessment." No further description, per RN (A) documentation.

10-1-18 - Skin check sheet - (R) buttock. (L) buttock. No further description, per RN (A) documentation.

10-3-18 - The Santyl and Drawtex daily treatment was discontinued, and no treatment was completed this day.

10-4-18 - A new treatment order was begun with Santyl ointment and the Alginate was reinstated. This treatment was administered for 4 days, then discontinued on 10-7-18.

10-5-18 - nursing note - nursing note - Stage 2 - (R) buttock measures (L) 1.7 cm x (W) 1.0 cm x

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(D) 0.2 cm. No further description, per RN (A) documentation.

10-7-18 - No treatments were received for 3 days and a new treatment was begun on 10-11-18.

10-8-18 - Skin check sheet - No site noted, and no description noted. No further documentation.

10-11-18 - A new treatment was begun, and missed on 10-13-18. The only change was to apply the dressing every other day, instead of every day. This order was discontinued on 10-17-18.

10-12-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.5 cm x (W) 1.0 cm x (D) 0.1 cm. No further description, per RN (A) documentation.

10-15-18 - Skin check sheet - No site noted, and no description noted. On back of the sheet it states "current treatment in place for sacral area." No further documentation.

10-17-18 - nursing note - nursing note - Stage 3 - (L) buttock "initial observation (Obs) 9-17-18" - measures (L) 4.5 cm x (W) 2.0 cm x (D) 0.2 cm. No further description was given, per RN (A) documentation, and there is no note documented on 9-17-18 about this wound being identified at that time. On 9-28-18 the nursing documents stated that the left buttock wound was resolved as the wounds had joined and were going to be documented as "Sacrum" for both by RN (A).

10-18-18 - No treatment was administered, and 2 orders were written on 10-18-18 which contradicted each other, re-instituting the same treatment, however, one for "every day"

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treatment, and one for "every other day treatment." This treatment was also omitted on 10-22-18.

10-19-18 - nursing note - (R) buttock resolved. No further description, per RN (A) documentation.

10-22-18 - Skin check sheet - No site noted, and no description noted. On back of the sheet it states "current treatment in place for sacrum & right leg area." No further description per RN (A) documentation.

10-22-18 - Treatment omitted, and both contradicting orders written 10-18-18 were discontinued, and the original order for the every other day treatment was begun on 10-23-18.

10-24-18 - nursing note - "Dressing to sacrum changed due to being soiled".

10-25-18 - Last nursing note in record describes the Alginate order and states "Dressing change yesterday". No further description per RN (A) documentation.

The 22 times that treatments were omitted by staff were as follows;

9-10-18 - "Sodium Hypochlorite (Dakins solution) every day topical" per RN (A) documentation. The Dakins order was documented as not completed on 9-10-18, 9-11-18, 9-12-18, 9-13-18, 9-15-18, 9-18-18, 9-20-18, 9-22-18, 9-29-18, 10-2-18, 10-4-18, 10-6-18, and was discontinued on 10-7-18. No wound dressing cover accompanied the Dakins order, and none was documented on the treatment record.

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Only the liquid Dakins solution was wiped on the wound for 4 days until a dressing was ordered on 9-12-18, which was not administered 9-12-18, nor 9-13-18. The treatments were not planned for dialysis days. The dressing order was discontinued 9-26-18.

9-26-18 A new treatment order was received. This order was discontinued on 10-3-18 and was used for only 6 days as this treatment was not completed on 10-3-18. 10-4-18 through 10-7-18 - treatments were completed. No treatments were received for 3 days (10-8-18, 10-9-18, and 10-10-18) and a new treatment was begun on 10-11-18, and omitted on 10-13-18. The only change was to apply the dressing every other day, instead of every day. This order was discontinued on 10-17-18, omitted on 10-18-18. 2 orders were written on 10-18-18, which contradicted each other, re-instituting the same treatment, however, one for "every day" treatment, and one for "every other day treatment." This treatment was also omitted on 10-22-18, and both were discontinued on 10-22-18. On 10-22-18 the order for re-instituting the "every other day" treatment order was begun on 10-23-18.

Physician progress notes were reviewed and revealed that the Dakins solution was first mentioned by the doctor as the ordered treatment on 10-17-18, and was affirmed again on the 10-24-18 note as the treatment. The Dakins Solution was discontinued by nursing on 10-7-18, and was never restarted. The doctor was unaware of this according to his progress notes.

On 10-24-18 RN (A) ADON, was interviewed and asked why the omissions happened in Resident

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#53's treatments, and why the documentation of the wounds was incomplete with missing descriptions, and orders were duplicated. She stated "I don't know, I'll have to check on that". She was asked again on 10-25-18, and stated "I still have no answer." RN (A) was the individual changing orders, assessing, and documenting most frequently on this Resident.

The full care plan "initiated 9-9-18" was reviewed and revealed an intervention which read "(Resident name) has an actual impairment to skin integrity related to wound on right buttock" "Goal date 3-16-19." The goal date was 6 months from the initiation date, and all care plans must be intervention and goal revised at least quarterly per federal regulation.

There were only 4 care plan interventions on 9-9-18, for the right buttock. The left buttock was not mentioned. Those were; "1) Daily skin inspection during care. Notify licensed nurse of skin integrity impairments. 2) Encourage good nutrition and hydration in order to promote healthier skin. 3) Follow facility protocols for treatment of injury. 4) Identify/document potential causative factors and eliminate/resolve where possible."

A second care plan was added 2.5 weeks later on 9-26-18 for the left buttock, "(Resident name) has an actual impairment to skin integrity related to wound on left buttock". "Goal date 3-16-19." The goal date was 6 months from the initiation date, and all care plans must be intervention and goal revised at least quarterly. There were only 2 added interventions, from the right buttock care plan, and those were; "1)Keep skin clean and dry, and 2) Observe location, size, and treatment of

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skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc to MD."

These care plans were not measurable, not Resident specific, not timely, as the wounds were both found on admission, and no instruction was given in the care plan as to treatment, prevention, repositioning, or documentation of the wound progression. The MDS indicated devices were to be used for this Resident, however, none of those appear in the care plan which directs nurses in the specific care for the resident.

On 10-24-18, the Resident was asked if wound care could be observed. He stated "not today, I am too tired, and they did it yesterday." The Resident was at dialysis all day 10-25-18, and was asked again 10-26-18, and he stated "they did it last night, and it hurts, I don't want it messed with."

No wound doctor notes were found in the clinical record, and they were requested on 10-25-18 from the DON. She stated "I can't find any."

The facility pressure ulcer policy was requested from the facility on 10-25-18. None was ever received.

The facility administration was informed of the findings during an end of day briefing on 10-25-18, and 10-26-18, The facility stated they had nothing further to present about the findings at the time of exit.

3. For Resident #28, a discharge care plan was

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not included in the comprehensive care plan.

Resident #28, an 87 year old, was admitted to the facility on 8/27/18. Diagnoses included anxiety, anemia, gout, diabetes, history of breast cancer, peripheral vascular disease, and heart disease.

The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 9/2/18. Resident #28 was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment and required extensive assistance with activities of daily living.

On 10/23/18 at 12:00 p.m., an interview was conducted with Resident #28. At this time, Resident #28 stated that she had just finished therapy and she wanted to go home and live on her own. She stated that she did not know what was happening now that she was finished therapy.

Resident #28's clinical record was reviewed. It included one social services note dated 9/4/18. The note read, "resident will remain here for LTC (long term care) placement."

The comprehensive care plan did not include any information about discharge planning.

On 10/24/18 at 8:30 a.m., the social worker was asked to provide all of her documentation regarding Resident #28's discharge planning. She provided the 9/4/18 note and two additional notes she documented on 10/24/18 at 10:14 a.m. and 10/24/18 at 10:18 a.m. The two additional notes were written after the survey team had requested the documentation.

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F 656	Continued From page 44 On 10/25/18 at the end of day meeting, the Administrator, Director of Nursing and Corporate Nurse were notified that Resident #28's comprehensive care plan did not included discharge planning.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow professional practice standards for two residents (Residents #53) of the 33 residents in the survey sample. 1a) For Resident #53, the facility staff failed to administer physician ordered treatments. 1b) For Resident #53, the facility staff falsified medication and treatment administration records. 2. For Resident #96, an activities staff without a nursing background completed the baseline care plan The findings included: 1a) For Resident #53, the facility staff failed to administer physician ordered treatments.	F 658	Cross Referenced to 12 VAC 5-371-200(B)(1)(ii) 1.Resident #53s wounds are healed, and skin is intact. Review of resident #53s accuchecks indicate blood sugars have been stable. Resident #96 discharged on July 28, 2018. 2.Residents have the potential to be affected. 3.The Director of Nursing and/or Designee will in-service nurses to carry out physicians order. Goals and interventions for residents will be timely, resident specific, and include the following is applicable: devices, repositioning, prevention, and treatments. Residents care planned goals and interventions will be reviewed quarterly. The Director of	12/10/18

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Resident #53 was admitted to the facility on 9-8-18. Diagnoses for Resident #72 included but were not limited to; anemia, chronic kidney disease, pulmonary hypertension, and insulin dependant diabetes.

Resident #53's most recent Minimum Data Set (an assessment protocol) was an admission assessment, with an Assessment Reference Date of 9-15-18. The MDS coded Resident #53 as alert, oriented to person, place, time and situation, with no cognitive impairment. The Minimum Data Set further coded Resident #53 as needing extensive assistance to being totally dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was incontinent of bowel, and had a foley catheter for urination. The Resident was also coded as at risk for skin breakdown, and having currently, 4 admitted wounds, being (1) venous stasis ulcer, and (3) stage 2 pressure ulcers. Only 2 pressure ulcers were ever documented in nursing notes, and skin assessments.

The Resident received Hemodialysis on Tuesday, Thursday, and Saturday, every week, at a dialysis center less than a mile from the facility. The Resident's "chair time" started at 10:30 a.m. at the dialysis center and lasted approximately 6 hours per day, which meant he should return to the facility between 4:30 and 5:00 p.m. every day.

On 10-24-18 at approximately 11:30 a.m. Resident #53 was interviewed and observed. The Resident was sitting up in bed at a reclined angle of approximately 45 degrees with his eyes closed. The room door was set up with isolation supplies, the surveyor gowned and entered the

F 658

Nursing and/or Designee will in-service nurses on conducting self-audits of MARs/TARs at the end of each shift to verify documentation is complete. The Director of Nursing and/or Designee will audit MARs/TARs for nurses to verify medications/treatments are administered and documented daily for one week, weekly for four weeks, and monthly for two months. The Director of Nursing and/or Designee will in-service nurses on accurate documentation and late entry documentation.

Baseline care plans will be specific to specific needs. The Director of Nursing and/or Designee will educate the Interdisciplinary team and nursing staff that once a baseline care plan is completed by all disciplines it will be reviewed, locked and signed by a licensed nurse. Baseline care plans will be reviewed at the morning clinical meeting daily.

4.Any noted discrepancies will be immediately addressed, recorded and forwarded, until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.

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room.. The mattress was not remarkable in any way, and looked like every other mattress in the facility. The Resident was asked if he was comfortable with his feet pushed against the foot board, and he responded that he slid down in the bed often, and had to wait for nurses to pull him up. He stated that the nurses did not come very often, and when asked how often he replied "a couple times a day". He was asked how often they changed the dressing on his bottom, and he replied, "when it gets dirty, not every day." The Resident was asked how long he had the sores, and he replied "I got them a couple weeks after I got here, about a month ago."

A review of Resident #53's clinical record was conducted during the survey. The review included the entire computerized and paper charts, which revealed documents entitled "Weekly Skin check", "Clinical Evaluations", "nursing progress (NPN) notes, physician's (MD) orders, and Medication, and Treatment Administration Records (MAR/TAR)". The Director of Nursing (DON) provided the skin assessment records and stated "these are all we have for skin assessment records". "The Resident has only been here for 6 weeks."

All of the documents that were reviewed, revealed the following chronological order of events;

9-8-18 - nursing note & weekly skin check - Identification of 2 wounds right (R) buttock, and left (L) buttock both deep tissue injury (DTI), both dime size. No further description.. No preventative, or protective care ordered.

9-9-18 - nursing note - Stage 2 - (R) buttock

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measures length (L) 1.0 cm (centimeters) x width (W) 1.5 cm x Depth (D) 0.1 cm. Stage 2 - (L) buttock (L) 1.0 x (W) 2.0 x (D) 0.1. No further description, per RN (A) Assistant Director of Nursing (ADON) documentation. No preventative, or protective care ordered from identification for 2 days, and the wound was now open.

9-10-18 - nursing note & MAR/TAR - "Sodium Hypochlorite (Dakins solution) every day topical" per RN (A) documentation. The order was documented as not completed on 9-10-18, 9-11-18, 9-12-18, 9-13-18, 9-15-18, 9-18-18, 9-20-18, 9-22-18, 9-29-18, 10-2-18, 10-4-18, 10-6-18, and was discontinued on 10-7-18. No wound dressing cover accompanied this order, and none was documented on the treatment record. Only the liquid Dakins solution was wiped on the wound for 4 days until a dressing was ordered 9-12-18, which was not administered until 9-14-18.

9-12-18 treatment added "clean left and right buttocks with normal saline, skin prep peri wound skin and cover with alginate and composite dressing every other day, on day shift." This order did not begin until 9-14-18 (2 days after ordered.) Again the orders were for "Day shift". The treatments were not planned for dialysis days. This order was discontinued 9-26-18.

9-14-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.0 cm x (W) 1.4 cm x (D) 0.1 cm. Stage 2 (L) buttock (L) 1.0 x (W) 1.0 x (D) 0.1. No further description, per RN (A) documentation. Treatment unchanged.

9-15-18 - Skin check sheet & nursing notes - (R)

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buttock. (L) buttock. No further description in documents. Treatment unchanged.

9-21-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.0 cm x (W) 1.0 cm x (D) 0.1 cm. Stage 2 (L) buttock (L) 1.0 x (W) 1.4 x (D) 0.1. No further description, per RN (A) documentation.

9-24-18 - Skin check sheet & nursing notes- (R) buttock. (L) buttock. No further description in documents. Treatment unchanged..

9-26-18 A new treatment order was received, and the only change was to apply "Santyl ointment" every day which is a debriding agent that liquefies dead necrotic tissue in a wound, and to cover the wound bed with "Drawtex", a synthetic absorbent material. The alginate used previously was a natural seaweed derivative that became a gel in the wound which was also absorbent. The only difference is that one becomes a gel to absorb and the other does not. These products are used interchangeably. This order was discontinued on 10-3-18 and was used for only 6 days as the treatment was not completed on 10-3-18.

9-28-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.5 cm x (W) 2.5 cm x (D) 0.2 cm. Stage 2 (L) buttock resolved. "Conjoined together now noted as sacrum wound with the MD (doctor) assessment." No further description, per RN (A) documentation.

10-1-18 - Skin check sheet - (R) buttock. (L) buttock. No further description, per RN (A) documentation.

10-3-18 - The Santyl and Drawtex daily treatment was discontinued, and no treatment was

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F 658	Continued From page 49 completed this day. 10-4-18 - A new treatment order was begun with Santyl ointment and the Alginate was reinstated. This treatment was administered for 4 days, then discontinued on 10-7-18. 10-5-18 - nursing note - nursing note - Stage 2 - (R) buttock measures (L) 1.7 cm x (W) 1.0 cm x (D) 0.2 cm. No further description, per RN (A) documentation. 10-7-18 - No treatments were received for 3 days and a new treatment was begun on 10-11-18. 10-8-18 - Skin check sheet - No site noted, and no description noted. No further documentation. 10-11-18 - A new treatment was begun, and missed on 10-13-18. The only change was to apply the dressing every other day, instead of every day. This order was discontinued on 10-17-18. 10-12-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.5 cm x (W) 1.0 cm x (D) 0.1 cm. No further description, per RN (A) documentation. 10-15-18 - Skin check sheet - No site noted, and no description noted. On back of the sheet it states "current treatment in place for sacral area." No further documentation. 10-17-18 - nursing note - nursing note - Stage 3 - (L) buttock "initial observation (Obs) 9-17-18" - measures (L) 4.5 cm x (W) 2.0 cm x (D) 0.2 cm. No further description was given, per RN (A) documentation, and there is no note documented on 9-17-18 about this wound being identified at	F 658		

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that time. On 9-28-18 the nursing documents stated that the left buttock wound was resolved as the wounds had joined and were going to be documented as "Sacrum" for both.

10-18-18 - No treatment was administered, and 2 orders were written on 10-18-18 which contradicted each other, re-instituting the same treatment, however, one for "every day" treatment, and one for "every other day treatment." This treatment was also omitted on 10-22-18.

10-19-18 - nursing note - (R) buttock resolved. No further description, per RN (A) documentation.

10-22-18 - Skin check sheet - No site noted, and no description noted. On back of the sheet it states "current treatment in place for sacrum & right leg area." No further description per RN (A) documentation.

10-22-18 - Treatment omitted, and both contradicting orders written 10-18-18 were discontinued, and the original order for the every other day treatment was begun on 10-23-18.

10-24-18 - nursing note - "Dressing to sacrum changed due to being soiled".

10-25-18 - Last nursing note in record describes the Alginate order and states "Dressing change yesterday". No further description per RN (A) documentation.

The 22 times that treatments were omitted by staff were as follows;

9-10-18 - "Sodium Hypochlorite (Dakins solution)

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every day topical" per RN (A) documentation. The Dakins order was documented as not completed on 9-10-18, 9-11-18, 9-12-18, 9-13-18, 9-15-18, 9-18-18, 9-20-18, 9-22-18, 9-29-18, 10-2-18, 10-4-18, 10-6-18, and was discontinued on 10-7-18. No wound dressing cover accompanied the Dakins order, and none was documented on the treatment record.

Only the liquid Dakins solution was wiped on the wound for 4 days until a dressing was ordered on 9-12-18, which was not administered 9-12-18, nor 9-13-18. The treatments were not planned for dialysis days. The dressing order was discontinued 9-26-18.

9-26-18 A new treatment order was received. This order was discontinued on 10-3-18 and was used for only 6 days as this treatment was not completed on 10-3-18. 10-4-18 through 10-7-18 - treatments were completed. No treatments were received for 3 days (10-8-18, 10-9-18, and 10-10-18) and a new treatment was begun on 10-11-18, and omitted on 10-13-18. The only change was to apply the dressing every other day, instead of every day. This order was discontinued on 10-17-18, omitted on 10-18-18. 2 orders were written on 10-18-18, which contradicted each other, re-instituting the same treatment, however, one for "every day" treatment, and one for "every other day treatment." This treatment was also omitted on 10-22-18, and both were discontinued on 10-22-18. On 10-22-18 the order for re-instituting the "every other day" treatment order was begun on 10-23-18. No other changes were made.

Physician progress notes were reviewed and revealed that the Dakins solution was first

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mentioned by the doctor as the ordered treatment on 10-17-18, and was affirmed again on the 10-24-18 note as the treatment. The Dakins Solution was discontinued by nursing on 10-7-18, and never restarted.

On 10-24-18 RN (A) ADON, was interviewed and asked why the omissions happened in Resident #53's treatments, and why the documentation of the wounds was incomplete with missing descriptions, and orders were duplicated. She stated "I don't know, I'll have to check on that". She was asked again on 10-25-18, and stated "I still have no answer for that."

The full care plan "initiated 9-9-18" was reviewed and revealed an intervention which read "(Resident name) has an actual impairment to skin integrity related to wound on right buttock" "Goal date 3-16-19." The goal date was 6 months from the initiation date, and all care plans must be intervention and goal revised at least quarterly.

There were only 4 care plan interventions, for the right buttock, and the left buttock was not mentioned. Those were; 1) Daily skin inspection during care. Notify licensed nurse of skin integrity impairments. 2) Encourage good nutrition and hydration in order to promote healthier skin. 3) Follow facility protocols for treatment of injury. 4) Identify/document potential causative factors and eliminate/resolve where possible.

A second care plan was added 2.5 weeks later on 9-26-18 for the left buttock, "(Resident name) has an actual impairment to skin integrity related to wound on left buttock". "Goal date 3-16-19." The goal date was 6 months from the initiation date,

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and all care plans must be intervention and goal revised at least quarterly. There were only 2 added interventions, from the right buttock care plan, and those were; 1)Keep skin clean and dry, and 2) Observe location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc to MD.

These care plans were not measurable, not Resident specific, not timely, as the wounds were documented as both found on admission, and no instruction was given in the care plan as to treatment, prevention, repositioning, or documentation. The MDS indicated devices were to be used for this Resident, however, none of those appear in the care plan which directs nurses in the specific care for the resident.

On 10-24-18, the Resident was asked if wound care could be observed. He stated "not today, I am too tired, and they did it yesterday." The Resident was at dialysis all day 10-25-18, and was asked again 10-26-18, and he stated "they did it last night, and it hurts, I don't want it messed with."

No wound doctor notes were found in the clinical record, and they were requested on 10-25-18 from the Director of Nursing (DON). She stated "I can't find any."

The facility pressure ulcer policy was requested from the facility on 10-25-18. None was ever received.

The facility administration was informed of the findings during an end of day briefing on 10-25-18, and 10-26-18, The facility stated they

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F 658	Continued From page 54 had nothing further to present about the findings at the time of exit. 1b) For Resident #53, the facility staff falsified medication and treatment administration records. On 10-24-18 Resident #53's medication administration records were reviewed in the computer, and 5 blank box areas (where nurse initials are documented to denote medications have been administered) appeared on the Resident's MAR for the following physician's order; "Accucheck before meals and at bedtime for diabetes" a finger stick blood sugar (FSBS) check, and the Resident was receiving sliding scale insulin according to the result. Those dates and times were written by the surveyor on a CMS (Centers for Medicare and Medicaid Services) form #805 for this Resident, with other pertinent information gathered during the inspection. Those dates were 10-7-18 (11:30 a.m.), 10-12-18 (6:00 a.m., and 11:30 a.m.), and 10-15-18 (11:30 a.m.). The DON was asked to provide surveyors with copies of the documents. On 10-25-18 the DON delivered the documents, and they were reviewed. The blank areas on the Medication Administration Record were now signed in with nursing initials, and had been changed from the previous day. The DON was asked who changed the documents, and if she was aware if any of those staff members had come into the facility to sign the documents, and when. She stated "I know nothing about that." She was asked to provide the nursing staff	F 658		

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names for the initials which had been newly placed on the MAR document, and to provide surveyors with a contact number to reach the individuals for interview, and was asked to provide time clock records for staff for the days in question. The time clock records were provided, and a list of 4 staff members names and numbers were provided, however, no initials to match with signatures, and of the 4 names provided only 3 of them had signed the days in question for 5 different sets of signatures requested.

On 10-25-18, Current and previous nursing staff were interviewed in person, and by cellular phone, and they requested anonymity, for fear of retaliation. Staff that were interviewed denied documenting the falsified initials, and were asked to identify initials, and were able to match the correct staff member with the initials for surveyors. MAR and other documents from Residents residing directly next to this Resident were reviewed for initials of those staff providing care to that group of Residents on the days in question, and nursing staff stated they were assigned each shift to gave care, administer medications, and document on a specific location in the facility, and a staff member who documented the items for a particular Resident would also be caring for the residents in the rooms around that resident.

For the dates in question, 10-7-18 (11:30 a.m.), 10-12-18 (6:00 a.m., and 11:30 a.m.), and 10-15-18 (11:30 a.m.), the staff members initials which were placed in those boxes, were not in the building, and did not work, or get paid for those shifts.

One of the individuals whose initials appeared on

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Resident #53's MAR, on 10-23-18, was never in the building, and had been terminated.

In review of the staff statements, Resident #53's MAR, other resident MAR's who were neighbors of Resident #53, and the time clock records, it was determined that the records were falsified after first viewed on 10-24-18, and prior to receipt of copies on 10-25-18 at 11:00 a.m.

On 10-26-18 the DON was again asked to provide the information, and she did not reply, nor did she provide the information. The Administrator and DON were made aware of the findings at the end of day debrief on 10-25-18, and 10-26-18. No further information was provided by the facility.

Complaint deficiency

2. For Resident #96, an activities staff without a nursing background completed the baseline care plan.

Resident #96, a 73 year old, was admitted to the facility on 6/22/18. Diagnoses included anxiety, heart disease, hypothyroidism, and diabetes. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 7/6/18. Resident #96 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living.

On 10/26/18 at 1:10 p.m., a meeting was held

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F 658	Continued From page 57 with the Administrator, Director of Nursing (DON) and Corporate Nurse. It was reviewed with the DON that there was no signature of completion on Resident's #96's Baseline Care Plan. The DON pulled up the document in the computer and showed that Employee E had electronically signed the document on 6/25/18. When asked what was Employee E's role at the facility, the DON stated that Employee G was the activities staff. Employee G was not a nurse. When asked if it was ok that a staff member without a nursing background completed a care plan that required nursing assessment, the DON stated that the admission nurse was supposed to complete the baseline care plan. The facility used Lippincott for their nursing standard reference. Additionally, Page 318 of Potter and Perry's 6th edition of Fundamentals of Nursing provided guidance about care planning. The textbook read, "Once a nurse assesses a client's condition and identifies appropriate nursing diagnoses, a plan is developed for the client's nursing care. Planning is a category of nursing behaviors in which client-centered goals and expected outcomes are established and nursing interventions are selected."	F 658		
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	F 660		12/10/18

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F 660	Continued From page 58 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 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	F 660		

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F 660	Continued From page 59 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. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to develop and implement an effective discharge planning process for two residents (Resident #12, #96) in a sample of 33 residents. 1. For Resident #12, the facility staff failed to implement a timely discharge plan to a facility equipped to meet the Resident's intellectual disability (ID) needs. 2. For Resident #96 the facility staff failed to	F 660	1.Resident #12 received a psychiatry consult on July 2, 1018. A therapy screen for PT, OT and ST for support self help/personal care, social skills development, and assess for mobility aids was requested on November 13, 2018 by the Director of Nursing to prepare Resident #12 for school and/or discharge. The Social Services Director has reached out to and will continue to follow up with appropriate agencies for services, guardianship, and an ID waiver. Calls	

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develop a discharge plan.

The findings included:

Resident #12, a 26 year old female, was admitted to the facility on 04/18/2018 following a hospital admission for influenza with wheezing, cough, fever, and systemic inflammatory response syndrome. Note: The Resident's primary caregiver died of influenza/pneumonia the day before the Resident's hospital admission.

Diagnoses for Resident #12 include athetoid cerebral palsy, moderate intellectual disability (ID), depression, anxiety, asthma, and anemia. Resident # 12's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 07/25/2018. Resident # 12 did not have a Brief Interview of Mental Status (BIMS) conducted but cognitive skills for daily decision-making were coded as moderately impaired. Functional status for personal hygiene, dressing, mobility, and transfers were coded as extensive assistance for performance and support. Resident #12 was in a wheelchair and locomotion on and off unit was coded as requiring supervision and oversight. Preferences for customary routine and activities were not coded.

On 10/24/18 at 8:30 AM, the Resident was observed rolling herself in wheelchair in the hallway. The Resident was crying and asking to go to school and wanting to get on the school bus. The DON was in the hallway and was asked if the resident went to school. The DON stated, "No, she has finished school." The DON was then asked if the resident went to a day program. The DON stated that she did not think so that,

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were placed to Adult Protective Services, the Community Services Board, local day support programs, and her eligibility worker between November 14 and November 16, 2018. An appointment with Eden Counseling and Consultation for Resident #12 to receive psychotherapy services for functional assessment and grief counseling is scheduled for December 3, 2018. Resident #12□s care plan has been updated to reflect new interventions to include therapy screen, the ID waiver process, psychotherapy services with grief counseling, and day school program search.

Resident #96 is no longer a resident in this facility.

A 100% resident review was completed on November 13, 2018 to ensure all residents needing discharge plans have them.

2.Residents wishing to return to the community and/or need placement in a more appropriate setting have the potential to be affected.

3.At admission, the Social Worker will complete a psychosocial assessment and include resident discharge goals and barriers to discharge in the baseline care plan. Discharge plans will be reviewed and updated with changes as appropriate during baseline, comprehensive, and quarterly care plan timeframes to ensure their discharge plan is current. Residents voicing a change in plan prior to their next

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"She lives here."

On 10/25/18, the clinical record was reviewed. The PASARR Level II dated 04/12/18 documented "Specialized services recommended at this time as determined by the Level II include community living skills, day support and habilitation (sic), self-help/personal care, social skills development, transportation to specialized services, and mobility aids."

The Level II assessor also documented, "As with any admission, discharge planning begins at the time of admission. I encourage the nursing facility to start discharge planning for (Resident) to be able to transition to a lesser restrictive setting if appropriate. It is recommended that the nursing facility work with (Resident) to maintain independent skills to the maximal extent possible while she is rehabilitating there in preparation for a transition back to a community setting when she is able. I encourage the nursing facility to work with the local Community Services Board to assist in identifying supports and services that she could benefit from."

A Physician's order dated 04/18/18 documented, "May participate in activities (including out of building activities) per plan of care." An order dated 04/18/18 documented a psychiatry consult. An order dated 05/07/18 documented, "Discharge potential [within 31-90 days]."

The initial psychiatric evaluation dated 07/02/18 documented, "She (resident) is aware of her mother's death and cries when she says, "Mommy died." Staff reports frequent crying episodes and attention seeking behavior. She seems restless, obsessively asking for help and

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scheduled date will receive an updated or new discharge plan of care and necessary referrals will be made at that time. The Executive Director will verify discharge plan, with goals for discharge, is in place during weekly case management meeting until compliance is sustained.

4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.

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can be disruptive with repetative (sic) verbalizations. These behaviors reflect underlying anxiety and depression associated with the loss of her mother and the security that she is not alone. She scored 10 on the cornell scale for depression in dementia which indicates probable major depression. Will start Citalopram to target her anxiety and depression. Psychotherapy would be beneficial if available."

A psychiatric follow-up evaluation dated 07/24/18 documented, "She was started on Citalopram to target her underlying anxiety and depression. According to staff, the crying episodes are significantly reduced." The note further documented, "She is attention seeking and tries to engage the nurses to help her with things that she is able to do for herself."

A progress note dated 08/22/18 documented, "Staff reports labile mood and behavior with crying one minute and laughing the next." It also documented, "According to staff, she actually had an increase in her tearfulness with the start of Citalopram. She is grieving the loss of her mother who recently passed. She was her primary caregiver and I am sure that she has a lot of emotions that she does not quite know how to deal with. Will increase citalopram to improve efficacy for any underlying anxiety and depression. My recommendation is to just give her some time as this is likely a juge (sic) adjustment for her and she lacks the maturity to be able to regulate her emotions." The entry also documented, "Consider psychotherapy."

A progress noted dated 09/11/18 documented, "there may be a bit of attention seeking associated with her crying spells. No agitation or

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F 660	Continued From page 63 behavioral dysregulation has been reported. She is easily redirected. She repetitively verbalizes anything that she is thinking and is quite needy for attention. She needs to be placed in a living situation that provides structure and guidance to assist her to become as independent as possible." The nurse's notes were reviewed for the month of October 2018. An entry dated 10/09/2018 documented, "Resident calling out to staff and stating she's going home on Saturday." An entry dated 10/12/2018 documented Resident "calling out to staff with occasional crying stating that she was upset." An entry dated 10/17/2018 documented Resident "calling out to staff stating she was going home by bus on Saturday and that she wanted to call (sister)." An entry dated 10/18/2018 documented Resident "calling out to staff stating she was going home on Saturday." There were four social services notes since the Resident's admission. The first entry dated 04/28/18 documented, "Summary: Resident was admitted from the hospital. Resident is alert. She is here to regain her strength and endurance. Her sister is involved with care. APS is also involved. Code status is Full Code. Discharge plan is either LTC (long-term care) here or a group home." An entry dated 05/23/18 documented, "SW (social worker) spoke with APS regarding this resident. APS was involved with this resident prior to admitting to this facility. APS is assisting with	F 660		

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trying to get the resident's MCD (Medicaid) re-instated and also trying to assist with the resident getting the ID waiver for a group home which would be a more appropriate setting for the resident. SW will continue to work with APS to put a safe plan in place."

An entry dated 07/30/18 documented, "SW and APS are working together to find a more appropriate setting for the resident. A group home would be more appropriate setting for her. Resident is currently on the waiting list for the ID waiver. SW will continue to work with APS regarding this resident."

It should be noted that social worker had been on maternity leave from 5/25/18 to 7/23/18 and that nursing staff were filling in for social service needs.

The last entry on 10/24/18 at 10:11 AM documented, "Late entry: (name) (APS) and SW spoke regarding placement for the resident. She stated that the resident's sister is working on a place for her in (out-of-state) with her. SW asked APS about the ID waiver and group home for the resident. She stated that the resident's sister does not want to move the resident twice and wants her to stay in the facility until placement is established out of state. SW will continue to work with APS for discharge placement."

On 10/25/2018 at 11:10 AM, the social worker was asked about the Resident's legal guardianship and she stated there was no legal guardian documentation. The social worker stated the Resident does not have a legal guardian but the sister is the next of kin. The social worker stated the sister knows the

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F 660	Continued From page 65 Resident has been crying about being here and the sister is working with adult protective services (APS) to get the Resident moved to a facility near her (out of state). When asked about enrolling the Resident in a day program, the social worker stated that an ID waiver is needed in order for her to participate in a day program or live in a group home. When asked if she could apply for the waiver, stated she could apply through the city "but the APS worker is spear-heading this." On 10/25/18 at 1:55 PM, the Resident was asked did she like going to school. She stated, "Yes, no, I don't like school here." On 10/25/18 at 2:00 PM, the Resident was observed in the therapy hallway, giving gloves to the therapist (likes to pull gloves from box). The therapist stated that the Resident was social and would follow her when she would ambulate with other residents. On 10/25/18 at 2:55 PM, the APS worker familiar with the resident was interviewed. She stated that the Resident was initially admitted to LTC (long-term care) as her UAI showed she required full Activities of Daily Living (ADL) care. Her supervisor was also on the phone call and she stated that initially the Resident was referred to APS for a community issue that she could not go into. She went on to state "We don't participate in the discharge planning, it should be the LTC facility." The APS worker also stated that the Resident had previously been in a day program in Portsmouth, which was not renewed since her mother died. She stated that the Resident had "not applied for an ID waiver" (necessary for placement in a group home).	F 660		

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On 10/25/18 at 3:55 PM an interview with Activities Director was conducted. When asked what the Resident's activity preferences were, she stated the Resident liked puzzles, a squeeze ball, and a tablet that plays songs. She stated that the Resident joins us for activities but doesn't like to stay and we let her go. When asked if Resident participated in a day program when living in Portsmouth, stated she didn't think so.

On 10/26/18 at approximately 10:00 AM, the certified nursing assistant (CNA) C stated she had heard the Resident say she wants to go home. CNA C went on to say she thought the Resident needs to "be in one of those ID homes."

On 10/26/18 at approximately 11:30 AM, the social worker was asked about the Resident participating in a day program and she stated "I haven't investigated how she can get into a day program."

On 10/26/18 at 12:50 PM, a call was placed to the Resident's sister but there was no answer.

In summary, the facility delayed discharge for this 26 year old with intellectual disabilities. The psychiatric nurse practitioner and the social worker both documented the Resident needs to be in a more appropriate setting. The Resident has been at the facility for over 6 months and there was no provision for community living skills, day support and rehabilitation, a social skills development program, or transportation to specialized services.

On 10/26/18 at approximately 2:00 PM, the Administrator and the DON were notified of findings. The Administrator stated that the social

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worker was on maternity leave from 05/25/18 through 07/23/18. The Administrator also stated that the MDS (minimum data set) coordinator (an LPN) served as social worker in (social worker) absence. No further information or documentation was presented.

2. For Resident #96 the facility staff failed to develop a discharge plan.

Resident #96, a 73 year old, was admitted to the facility on 6/22/18. Diagnoses included anxiety, heart disease, hypothyroidism, and diabetes. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 7/6/18. Resident #96 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living.

On 7/28/18, it was documented in a nursing note that Resident #96 left the facility against medical advice.

Resident #96's care plan dated 6/24/18 was reviewed. The comprehensive care plan did not include any details of a discharge plan or discharge goals. There was no evidence that the interdisciplinary team was working on a discharge plan.

No Social Work notes for Resident #96's stay between 6/22/18- 7/28/18 were located in the clinical record. During the survey, the Administrator shared that the social worker had been on maternity leave from 5/25/18 to 7/23/18

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and that nursing staff were filling in for social service needs.

At the end of day meeting on 10/25/18, the Administrator and Director of Nursing (DON) were asked to provide all documentation regarding Resident #96's discharge plan.

On 10/26/18, the document titled "Psychosocial Evaluation" was provided. This document dated 6/29/18 read "Summary: Resident was admitted to this facility from the hospital. Resident is alert and able to make some needs known. He is here to regain his strength and endurance. Friends involved with care. Code status is Full Code. Discharge plan is to return to the community when deemed medically feasible." It should be noted that there was no signature on the document and it is unclear who completed this evaluation.

The Baseline Care Plan was also provided. Section G "Initial Admission/ Discharge Goals" was reviewed. The question "Initial discharge goals" was answered "remain in the facility." The question "Discharge plans initiated" was answered "No." The "Signature of Resident and Representative" section was blank. The "Signatures of Staff Completing the Baseline Care Plan" was blank.

On 10/26/18 at 1:10 p.m., it was reviewed with the DON that there was no signature of completion on the Baseline Care Plan. The DON pulled up the document in the computer and showed that Employee G had electronically signed the document on 6/25/18. When asked what was Employee G's role at the facility, the DON stated that Employee G was the activities

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F 660	Continued From page 69 staff. When asked if it was ok that a staff without a nursing background completed a care plan that required nursing assessment, the DON stated that the admission nurse was supposed to complete the baseline care plan. In summary, the discharge plan in the Psychosocial Evaluation documented that Resident #96 was going to return to the community and the Baseline Care Plan documented that Resident #96 was going to remain in the facility. There was no documentation regarding a discharge plan in the comprehensive care plan. There was no documentation that an interdisciplinary team discussed a discharge plan for the resident.	F 660		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to provide activities appropriate for Resident's age and intellectual disability for one Resident (Resident #12) in a sample of 33 residents.	F 679	Cross Referenced to 12 VAC 5-371-280(A) 1.Resident #12□s care plan was updated to reflect resident□s current likes and interventions related to activity	12/10/18

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The findings include:

Resident #12, a 26 year old female, was admitted to the facility on 04/18/2018 following a hospital admission for influenza with wheezing, cough, fever, and systemic inflammatory response syndrome. Diagnoses include athetoid cerebral palsy, moderate intellectual disability (ID), depression, anxiety, asthma, and anemia.

Resident # 12's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 07/25/2018. Resident # 12 did not have a Brief Interview of Mental Status (BIMS) conducted but cognitive skills for daily decision-making were coded as moderately impaired. Functional status for personal hygiene, dressing, mobility, and transfers were coded as extensive assistance for performance and support. Resident #12 was in a wheelchair and locomotion on and off unit was coded as requiring supervision and oversight. Preferences for customary routine and activities were not coded.

On 10/24/18 at 8:30 AM, the Resident was observed rolling self in wheelchair in the hallway. The Resident was crying and asking to go to school and wanting to get on the school bus. The DON was in the hallway and was asked if the resident went to school. The DON stated, "No, she has finished school." The DON was then asked if the resident went to a day program and she stated she did not think so that, "She lives here."

On 10/25/18, the clinical record was reviewed.

The PASARR Level II dated 04/12/18

F 679

preferences, ID waiver process, therapy screenings for self help/personal care, social skills development and mobility aids, and day school search.

2.Residents have the potential to be affected by not having a patient centered activity care plan.

3.The Activity Director will complete a 100% activity care plan review for all current residents. Each activity care plan will be updated to reflect resident□s current preferences. The Activity Director will plan an appropriate schedule of activities for residents with Intellectual disabilities and update care plan. The Administrator and/or Designee will conduct a random activity care plan review to verify the plan meets residents□ interests and needs weekly for four weeks, then monthly for two months. The Administrator and/or Designee will activity schedule week for 8 weeks, then monthly for one month.

4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.

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documented "Specialized services recommended at this time as determined by the Level II include community living skills, day support and habilitation (sic), self-help/personal care, social skills development, transportation to specialized services, and mobility aids."
The Level II assessor also documented, "As with any admission, discharge planning begins at the time of admission. I encourage the nursing facility to start discharge planning for (Resident) to be able to transition to a lesser restrictive setting if appropriate. It is recommended that the nursing facility work with (Resident) to maintain independent skills to the maximal extent possible while she is rehabilitating there in preparation for a transition back to a community setting when she is able. I encourage the nursing facility to work with the local Community Services Board to assist in identifying supports and services that she could benefit from."

Physician's order dated 04/18/18 documented, "May participate in activities (including out of building activities) per plan of care." An order dated 04/18/18 documented a psychiatry consult. An order dated 05/07/18 documented, "Discharge potential [within 31-90 days]."

The provider progress notes dated 07/02/18, 07/24/18, 08/22/18, and 09/11/18 documented, "Encourage participation in planned activities and social gatherings."

The care plan was reviewed. One focus "Activity/requires assistance in structuring day RT (related to) cognitive deficits, physical limitations" had the following interventions listed:
Encourage family to attend activities; engage in simple, structured activities; invite (Resident) to

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F 679	Continued From page 72 scheduled activities; (Resident) needs assistance with ADLs as required during the activity; (Resident) needs assistance/escort activity functions; (Resident) preferred activities are: listening to music, looking at pictures in books/magazines, arts/crafts, pet visits with large animals, going outside, watching TV, parties, socials, nail group, dancing, exercise, special events/luncheons, music groups, group games, being read to, putting on make-up, electronic educational games, meeting new people and making friends." The nurse's notes were reviewed for the month of October 2018. There were no entries addressing structured activities. On 10/25/2018 at 11:10 AM, the social worker was asked about enrolling the Resident in a day program. The social worker stated that an ID waiver is needed in order for her to participate in a day program or live in a group home. When asked if she could apply for the waiver, stated she could apply through the city "but the APS worker is spear-heading this." On 10/25/18 at 1:55 PM, the Resident was asked did she like going to school. She stated, "Yes, no, I don't like school here." On 10/25/18 at 2:00 PM, the Resident was observed in the therapy hallway, giving gloves to the therapist (likes to pull gloves from box). The therapist stated that the Resident was social and would follow her when she would ambulate with other residents. On 10/25/18 at 2:55 PM, the APS worker familiar with the resident returned call. She stated that	F 679		

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F 679	Continued From page 73 the Resident had previously been in a day program in Portsmouth, which was not renewed since her mother died. She stated that the Resident had "not applied for an ID waiver." On 10/25 at 3:55 PM, the Activities Director was asked about the Resident's activity preferences. She stated the Resident likes puzzles, a squeeze ball, and a tablet that plays songs. She stated the Resident "joins us for activities but doesn't like to stay and we let her go." When asked if Resident participated in a day program when living in Portsmouth, stated she didn't think so. On 10/26/18 at approximately 10:00 AM, the certified nursing assistant (CNA) C stated she had heard the Resident say she wants to go home. CNA C went on to say she thought the Resident needs to "be in one of those ID homes." On 10/26/18 at approximately 11:30 AM, the social worker was asked about the Resident participating in a day program and she stated "I haven't investigated how she can get into a day program." In summary, the Resident was not observed participating in or encouraged to participate in meaningful activities she is interested in. On 10/26/18 at approximately 2:00 PM, the Administrator and the DON were notified of findings. The Administrator stated that the social worker was on maternity leave from 05/25/18 through 07/23/18. The Administrator also stated that the MDS (minimum data set) coordinator (an LPN) served as social worker in (social worker) absence. No further information or documentation was presented.	F 679		

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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, resident interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide treatments, failed to follow doctor's orders, and failed to complete a measurable comprehensive care plan for pressure ulcers for 1 Resident (Resident #53) in a survey sample of 33 residents. For Resident #53, the staff failed to treat 2 pressure ulcers on the Resident's left and right buttocks, failed to follow doctor's orders, and failed to appropriately care plan the Resident's needs. The findings included; Resident #53 was admitted to the facility on 9-8-18. Diagnoses for Resident #72 included but were not limited to; anemia, chronic kidney disease, pulmonary hypertension, and insulin	F 686	Cross Referenced to 12 VAC 5-371-220(C)(1) 1.Resident #53 received treatment as ordered post survey until healed as of November 6, 2018. 2.Residents with wounds have the potential to be affected. 3.The Director of Nursing and/or Designee will conduct a 100% audit of residents with wounds to verify treatment(s) being provided as ordered. The Director of Nursing and/or Designee will review treatment record(s) in clinical meeting to verify treatment was provided. Residents with newly identified wound will be reviewed in clinical meeting to verify treatment was obtained and implemented timely on an ongoing basis. Licensed	12/10/18

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F 686	Continued From page 75 dependant diabetes. Resident #53's most recent Minimum Data Set (an assessment protocol) was an admission assessment, with an Assessment Reference Date of 9-15-18. The MDS coded Resident #53 as alert, oriented to person, place, time and situation, with no cognitive impairment. The Minimum Data Set further coded Resident #53 as needing extensive assistance to being totally dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was incontinent of bowel, and had a foley catheter for urination. The Resident was also coded as at risk for skin breakdown, and having currently, 4 admitted wounds, being (1) venous stasis ulcer, and (3) stage 2 pressure ulcers. Only 2 pressure ulcers were ever documented in nursing notes, and skin assessments. The Resident received Hemodialysis on Tuesday, Thursday, and Saturday, every week, at a dialysis center less than a mile from the facility. The Resident's "chair time" started at 10:30 a.m. at the dialysis center and lasted approximately 6 hours per day, which meant he should return to the facility between 4:30 and 5:00 p.m. every day. On 10-24-18 at approximately 11:30 a.m. Resident #53 was interviewed and observed. The Resident was sitting up in bed at a reclined angle of approximately 45%, with his eyes closed. The room door was set up with isolation supplies, the surveyor gowned and entered the room.. The mattress was not remarkable in any way, and looked like every other mattress in the facility. The Resident was asked if he was comfortable with his feet pushed against the foot board, and he responded that he slid down in the bed often,	F 686	nursing staff will be educated on obtaining treatment orders for wounds when identified. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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and had to wait for nurses to pull him up. He stated that the nurses did not come very often, and when asked how often he replied "a couple times a day". He was asked how often they changed the dressing on his bottom, and he replied, "when it gets dirty, not every day." The Resident was asked how long he had the sores, and he replied "I got them a couple weeks after I got here, about a month ago."

A review of Resident #53's clinical record was conducted during the survey. The review included the entire computerized and paper charts, which revealed documents entitled "Weekly Skin check", "Clinical Evaluations", "nursing progress (NPN) notes, physician's (MD) orders, and Medication, and Treatment Administration Records (MAR/TAR)". The Director of Nursing (DON) provided the skin assessment records and stated "these are all we have for skin assessment records". "The Resident has only been here for 6 weeks."

All of the documents that were reviewed, revealed the following chronological order of events;

9-8-18 - nursing note & weekly skin check - Identification of 2 wounds right (R) buttock, and left (L) buttock both deep tissue injury (DTI), both dime size. No further description.. No preventative, or protective care ordered.

9-9-18 - nursing note - Stage 2 - (R) buttock measures length (L) 1.0 cm (centimeters) x width (W) 1.5 cm x Depth (D) 0.1 cm. Stage 2 - (L) buttock (L) 1.0 x (W) 2.0 x (D) 0.1. No further description, per RN (A) Assistant Director of Nursing (ADON) documentation. No

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F 686	Continued From page 77 preventative, or protective care ordered from identification for 2 days, and the wound was now open. 9-10-18 - nursing note & MAR/TAR - "Sodium Hypochlorite (Dakins solution) every day topical" per RN (A) documentation. The order was documented as not completed on 9-10-18, 9-11-18, 9-12-18, 9-13-18, 9-15-18, 9-18-18, 9-20-18, 9-22-18, 9-29-18, 10-2-18, 10-4-18, 10-6-18, and was discontinued on 10-7-18. No wound dressing cover accompanied this order, and none was documented on the treatment record. Only the liquid Dakins solution was wiped on the wound for 4 days until a dressing was ordered 9-12-18, which was not administered until 9-14-18. 9-12-18 treatment added "clean left and right buttocks with normal saline, skin prep peri wound skin and cover with alginate and composite dressing every other day, on day shift." This order did not begin until 9-14-18 (2 days after ordered.) Again the orders were for "Day shift". The treatments were not planned for dialysis days. This order was discontinued 9-26-18. 9-14-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.0 cm x (W) 1.4 cm x (D) 0.1 cm. Stage 2 (L) buttock (L) 1.0 x (W) 1.0 x (D) 0.1. No further description, per RN (A) documentation. Treatment unchanged. 9-15-18 - Skin check sheet & nursing notes - (R) buttock. (L) buttock. No further description in documents. Treatment unchanged. 9-21-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.0 cm x (W) 1.0 cm x (D) 0.1 cm.	F 686		

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Stage 2 (L) buttock (L) 1.0 x (W) 1.4 x (D) 0.1. No further description, per RN (A) documentation.

9-24-18 - Skin check sheet & nursing notes- (R) buttock. (L) buttock. No further description in documents. Treatment unchanged..

9-26-18 A new treatment order was received, and the only change was to apply "Santyl ointment" every day which is a debriding agent that liquefies dead necrotic tissue in a wound, and to cover the wound bed with "Drawtex", a synthetic absorbent material. The alginate used previously was a natural seaweed derivative that became a gel in the wound which was also absorbent. The only difference is that one becomes a gel to absorb and the other does not. These products are used interchangeably. This order was discontinued on 10-3-18 and was used for only 6 days as the treatment was not completed on 10-3-18.

9-28-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.5 cm x (W) 2.5 cm x (D) 0.2 cm. Stage 2 (L) buttock resolved. "Conjoined together now noted as sacrum wound with the MD (doctor) assessment." No further description, per RN (A) documentation.

10-1-18 - Skin check sheet - (R) buttock. (L) buttock. No further description, per RN (A) documentation.

10-3-18 - The Santyl and Drawtex daily treatment was discontinued, and no treatment was completed this day.

10-4-18 - A new treatment order was begun with Santyl ointment and the Alginate was reinstated. This treatment was administered for 4 days, then

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F 686	Continued From page 79 discontinued on 10-7-18. 10-5-18 - nursing note - nursing note - Stage 2 - (R) buttock measures (L) 1.7 cm x (W) 1.0 cm x (D) 0.2 cm. No further description, per RN (A) documentation. 10-7-18 - No treatments were received for 3 days and a new treatment was begun on 10-11-18. 10-8-18 - Skin check sheet - No site noted, and no description noted. No further documentation. 10-11-18 - A new treatment was begun, and missed on 10-13-18. The only change was to apply the dressing every other day, instead of every day. This order was discontinued on 10-17-18. 10-12-18 - nursing note - Stage 2 - (R) buttock measures (L) 1.5 cm x (W) 1.0 cm x (D) 0.1 cm. No further description, per RN (A) documentation. 10-15-18 - Skin check sheet - No site noted, and no description noted. On back of the sheet it states "current treatment in place for sacral area." No further documentation. 10-17-18 - nursing note - nursing note - Stage 3 - (L) buttock "initial observation (Obs) 9-17-18" - measures (L) 4.5 cm x (W) 2.0 cm x (D) 0.2 cm. No further description was given, per RN (A) documentation, and there is no note documented on 9-17-18 about this wound being identified at that time. On 9-28-18 the nursing documents stated that the left buttock wound was resolved as the wounds had joined and were going to be documented as "Sacrum" for both.	F 686		

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10-18-18 - No treatment was administered, and 2 orders were written on 10-18-18 which contradicted each other, re-instituting the same treatment, however, one for "every day" treatment, and one for "every other day treatment." This treatment was also omitted on 10-22-18.

10-19-18 - nursing note - (R) buttock resolved. No further description, per RN (A) documentation.

10-22-18 - Skin check sheet - No site noted, and no description noted. On back of the sheet it states "current treatment in place for sacrum & right leg area." No further description per RN (A) documentation.

10-22-18 - Treatment omitted, and both contradicting orders written 10-18-18 were discontinued, and the original order for the every other day treatment was begun on 10-23-18.

10-24-18 - nursing note - "Dressing to sacrum changed due to being soiled".

10-25-18 - Last nursing note in record describes the Alginate order and states "Dressing change yesterday". No further description per RN (A) documentation.

The 22 times that treatments were omitted by staff were as follows;

9-10-18 - "Sodium Hypochlorite (Dakins solution) every day topical" per RN (A) documentation. The Dakins order was documented as not completed on 9-10-18, 9-11-18, 9-12-18, 9-13-18, 9-15-18, 9-18-18, 9-20-18, 9-22-18, 9-29-18, 10-2-18, 10-4-18, 10-6-18, and was discontinued

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on 10-7-18. No wound dressing cover accompanied the Dakins order, and none was documented on the treatment record.

Only the liquid Dakins solution was wiped on the wound for 4 days until a dressing was ordered on 9-12-18, which was not administered 9-12-18, nor 9-13-18. The treatments were not planned for dialysis days. The dressing order was discontinued 9-26-18.

9-26-18 A new treatment order was received. This order was discontinued on 10-3-18 and was used for only 6 days as this treatment was not completed on 10-3-18. 10-4-18 through 10-7-18 - treatments were completed. No treatments were received for 3 days (10-8-18, 10-9-18, and 10-10-18) and a new treatment was begun on 10-11-18, and omitted on 10-13-18. The only change was to apply the dressing every other day, instead of every day. This order was discontinued on 10-17-18, omitted on 10-18-18. 2 orders were written on 10-18-18, which contradicted each other, re-instituting the same treatment, however, one for "every day" treatment, and one for "every other day treatment." This treatment was also omitted on 10-22-18, and both were discontinued on 10-22-18. On 10-22-18 the order for re-instituting the "every other day" treatment order was begun on 10-23-18. No other changes were made.

Physician progress notes were reviewed and revealed that the Dakins solution was first mentioned by the doctor as the ordered treatment on 10-17-18, and was affirmed again on the 10-24-18 note as the treatment. The Dakins Solution was discontinued by nursing on 10-7-18, and never restarted.

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F 686	Continued From page 82 On 10-24-18 RN (A) ADON, was interviewed and asked why the omissions happened in Resident #53's treatments, and why the documentation of the wounds was incomplete with missing descriptions, and orders were duplicated. She stated "I don't know, I'll have to check on that". She was asked again on 10-25-18, and stated "I still have no answer." The full care plan "initiated 9-9-18" was reviewed and revealed an intervention which read "(Resident name) has an actual impairment to skin integrity related to wound on right buttock" "Goal date 3-16-19." The goal date was 6 months from the initiation date, and all care plans must be intervention and goal revised at least quarterly. There were only 4 care plan interventions, for the right buttock, and the left buttock was not mentioned. Those were; 1) Daily skin inspection during care. Notify licensed nurse of skin integrity impairments. 2) Encourage good nutrition and hydration in order to promote healthier skin. 3) Follow facility protocols for treatment of injury. 4) Identify/document potential causative factors and eliminate/resolve where possible. A second care plan was added 2.5 weeks later on 9-26-18 for the left buttock, "(Resident name) has an actual impairment to skin integrity related to wound on left buttock". "Goal date 3-16-19." The goal date was 6 months from the initiation date, and all care plans must be intervention and goal revised at least quarterly. There were only 2 added interventions, from the right buttock care plan, and those were; 1)Keep skin clean and dry, and 2) Observe location, size, and treatment of	F 686		

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F 686	Continued From page 83 skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc to MD. These care plans were not measurable, not Resident specific, not timely, as the wounds were documented as both found on admission, and no instruction was given in the care plan as to treatment, prevention, repositioning, or documentation. The MDS indicated devices were to be used for this Resident, however, none of those appear in the care plan which directs nurses in the specific care for the resident. On 10-24-18, the Resident was asked if wound care could be observed. He stated "not today, I am too tired, and they did it yesterday." The Resident was at dialysis all day 10-25-18, and was asked again 10-26-18, and he stated "they did it last night, and it hurts, I don't want it messed with." No wound doctor notes were found in the clinical record, and they were requested on 10-25-18 from the DON. She stated "I can't find any." The facility pressure ulcer policy was requested from the facility on 10-25-18. None was ever received. The facility administration was informed of the findings during an end of day briefing on 10-25-18, and 10-26-18, The facility stated they had nothing further to present about the findings at the time of exit.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		12/10/18

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F 689	Continued From page 84 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to ensure the facility was free from accident hazards for 1 resident (resident #41) of 33 residents in the survey sample and failed to ensure medication carts were locked and medications were not accessible to residents. 1. The facility staff failed to ensure a medication cart was locked on the first floor. 2. The facility staff failed to ensure medication disposed of in a sharps container was completely deposited into the container. 3. Resident #41's bed remained in the high position during the days of survey. 4. Medication was found on the floor of the first hall of the first floor with no staff present, and Residents were wandering freely in the hallway of Resident rooms. Also a medication cart was left unlocked and unattended on the second hall of the first floor. The findings included: 1. The facility staff failed to ensure a medication cart was locked on the first floor.	F 689	Cross Referenced to 12 VAC 5-371-220(A) 1.Medication cart locking mechanisms were checked for proper functionality. Noted medication was properly disposed of in a sharps container. Resident #41□s bed was checked for proper functioning, to ensure no mechanical defect was present, and was lowered. 2.Residents residing in this facility have the potential to be affected. 3.The medication carts will be incorporated into the facility□s preventative maintenance program ensuring no mechanical defects exist. Licensed nurses will be in-serviced on proper disposal of wasted medications in sharp□s containers and ensure medication carts are locked when unattended. Staff will be in-serviced on proper bed positioning to ensure residents remain free from accident hazards. Staff will be in-serviced on proper disposal of wasted medications. The Director of Nursing and/or Designee will complete medication cart lock checks daily for three	

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On 10/23/18 at 2:23 p.m., a medication cart was observed in front of room 107. The medication cart was unlocked. The drawers opened when pulled. No staff or residents were in the hall at this time. While standing at the cart waiting for staff to return, a staff in a white coat walked by the cart to the end of the hallway and then returned down the hall, passing the unlocked med cart a second time. It appeared that the staff noticed the unlocked medication cart, but did not lock the cart. The staff was asked to identify herself. The staff stated she was the Director of Nursing (DON) of a sister facility. Shortly after, Registered Nurse B (RN B) approached the cart and pushed the unlocked side against the wall and proceeded to leave the cart. RN B was notified that the cart was unlocked. RN B reached around and locked the cart. RN B was asked who was working the medication cart. She stated that Licensed Practical Nurse C (LPN C) was working the cart.

At the end of day meeting on 10/24/18, the Administrator, facility DON and Corporate Nurse were notified that the medication cart was observed unlocked and unattended. It was reviewed that the DON of a sister facility walked by the medication cart twice and did not lock the cart.

2. The facility staff failed to ensure medication disposed of in a sharps container was completely deposited into the container.

A medication pour and pass observation was conducted on 10/24/18 at 8:11 a.m. with Licensed Practical Nurse A (LPN A). While LPN A prepared

F 689

weeks, then weekly for five weeks, followed by monthly for one month.

4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.

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F 689	Continued From page 86	F 689		

the medications, this surveyor stood at the end of the medication cart where the sharps container was located. The opening of the sharps container was covered at an angle by a plastic flap that allowed for items to be placed into the container but would not allow them to be taken out. A small oblong pill that was yellowish orange in color laid on the plastic flap of the sharps container. This pill was visible to anyone who walked by the cart. LPN A entered the room to administer medications. After exiting the room, LPN A was shown the pill visible on the sharps container. When asked "what is this pill?", LPN A pushed the pill into the sharps container. He did not identify the pill.

At the end of day meeting on 10/24/18, the issue with the medication not properly disposed of in the sharps container was reviewed with the Administrator, facility DON and Corporate Nurse.

3. Resident #41's bed remained in the high position during the days of survey.

Resident #41 was admitted to the facility on 10-27-14 with diagnoses which included, but not limited to, congestive heart failure, traumatic brain injury and seizure disorder.

Resident #41's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 8-22-18. Resident #41 was coded with a Brief Interview of Mental Status score of "9" out of a possible 15 indicating moderate cognitive impairment. Resident #41 required extensive to total assistance of one to two staff members for

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bed mobility and bathing and toileting.

On 10/24/18 at 9:06 AM Resident #41 was observed in bed: the bed was in high position. The resident had a suction machine at the bedside.

On 10/25/18 at 10:27 AM Resident #41 was not in bed as he had been transferred to the hospital. The resident's bed remained in high position throughout the day on 10-24-18.

10/26/18 at 10:30 AM: An interview with LPN (licensed practical nurse) A was conducted, who had the resident on 10-24-18. When asked why the bed was in the high position, he stated, "I have to check the orders." When asked if the resident had a seizure history should the bed remain in high position rather than low, he stated, "No, it would be a safety issue."

On 10/24/18 at 4:22 PM, the facility Administrator and DON (director of nursing) were notified of above findings.

4. Medication was found on the floor of the first hall of the first floor with no staff present, and Residents were wandering freely in the hallway of Resident rooms. Also a medication cart was left unlocked and unattended on the second hall of the first floor.

On 10-23-18 at approximately 11:30 a.m., during initial tour of the facility, a small blue circular tablet, which was scored in the middle of the tablet, and had an imprint of "APO" on one side,

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and "MID 10" on the other side was observed by 2 surveyors laying on the floor in the middle of the hallway. The location on the hallway was in front of room 122. There were 4 Residents in the hallway ambulating, and wheeling in wheel chairs. One of the Residents, wandering in the hallway continuously, was a resident with serious intellectual disability, and child like demeanor.

The pill was immediately picked up by surveyors in a paper towel, and the Registered Nurse Unit manager (RN A) was approached at the nursing station and interviewed. RN A was asked to identify the pill, and identify who it belonged to, and who was responsible for administering it. RN A complied, and after a 5 minute absence from the unit, returned, and stated that the medication was "Midodrine". Midodrine is used to raise the blood pressure of individuals with orthostatic hypotension (low blood pressure typically upon standing). RN A stated that "4 Residents on the unit were receiving that medication". She gave surveyors the room numbers of the 4 Residents, and 3 of them were in the general location where the pill was found. The fourth resident was on a different hallway. The 3 Residents clinical records were reviewed and revealed that all 3 received the medication on exactly the same schedule, and RN B was responsible for administering the medications.

RN B was interviewed and stated "I gave the meds to the Residents as ordered, I don't know where that pill came from." RN B then walked into a resident room where the call bell had been activated.

Blood pressure records for the 3 Residents were reviewed for that day, and showed no abnormal

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F 689	Continued From page 89 readings. On 10-24-18 during medication pour and pass observations a "Code Blue" signal was called out over the intercom. RN B was passing medications on the second hall of the first floor, and when the alert was sounded, she pushed the medication cart to the wall and ran to the room where the alert was sounding. The cart was left open and unlocked, with Residents wandering freely in the hallway of resident rooms. Two surveyors were present during this observation, and after approximately 10 minutes, while watching the situation unfold, the Administrator walked to the nursing station at the end of the hallway. Surveyors approached the Administrator and told her that the cart was open and available to residents. She went to the cart and locked it. The Director of Nursing and Administrator were made aware of the incident immediately after the occurrences, on 10-23-18, and 10-24-18, and at the end of day debriefings on 10-24-18, 10-25-18, and 10-26-18. No further information was provided.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		12/10/18

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F 692	Continued From page 90 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review the facility staff failed to provide weight loss intervention, and to prevent further significant weight loss for one Residents (Resident #93) of the 33 residents in the survey sample. For Resident #93 the facility staff did not provide weight loss interventions for a Resident with diabetes, and wounds, and failed to intervene during a significant weight loss. The findings included: Resident #93 was admitted to the facility on 7-12-18. Diagnoses included; diabetes, heart disease, hypertension, stroke, gout, contractures, hypothyroidism, , depression, dementia, recurrent urinary tract infections (UTI's), hematuria, and anemia. Resident #93's most recent Minimum Data Set assessment was a 14 day re-entry assessment after hospitalization on 9-21-18 for hematuria and UTI, with readmission on 9-25-18. The assessment reference date was 10-9-18. The	F 692	Cross Referenced to 12 VAC 5-371-220(C)(5) 1.The Physician was notified for Resident #93 of weight loss during the survey. Resident was evaluated by Speech and Occupational Therapy on November 13, 2018 to determine appropriate food consistency and assistance needed with feeding. The Registered Dietician evaluated Resident on November 13, 2018 and made recommendations for diet supplement(s) required for residents current status. Orders were obtained based on recommendations. Residents weight and food intake will be monitored as ordered. The care plan has been updated to reflect interventions with weight. 2.Residents with weight loss/gain have the potential to be affected. 3.Nursing will review weights weekly to identify residents with weight changes and obtain reweighs as indicated to verify	

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F 692	Continued From page 91 Resident was coded with a Brief Interview of Mental Status score of unable to complete due to severe cognitive impairment. The Resident required extensive assistance to total dependence on staff for completion of activities of daily living. Section K, Swallowing/Nutritional Status, question K0300 asked "Loss of 5% or more in the last month or loss of 10% or more in the last 6 months." Resident #93 was coded as "2. Yes, not on a physician-prescribed weight-loss regimen." The Resident was coded as weighing 125 pounds in the assessment. The previous MDS assessments were also reviewed and revealed that the Resident was coded on all of them as at risk for weight loss, had a history of pressure ulcers, contractures, dementia, needed assistance with eating, was diabetic, and receiving insulin. The following MDS documents at section K, hospital records, and facility readmission and weight records review revealed the following; 7-12-18 - Admission assessment weight - 150 pounds (lbs). 7-19-18 - 149.1 lbs weights summary. 7-24-18 - 147.6 lbs weights summary. 7-30-18 - 146.9 lbs weights summary. 8-7-18 - 147 lbs, MDS no weight loss, and not on a weight loss program 9-6-18 - 147 lbs, MDS no weight loss, and not on a weight loss program. No weight taken from 9-6-18 to 9-25-18. 9-21-18 - out to the hospital for 4 days. 9-25-18 - returned from hospital weight 131 lbs. according to the hospital records, and readmission assessment. and 7 days later on 10-2-18, a 6 lb weight loss	F 692	accuracy of weight. Residents with significant weight loss/gain will be reviewed to verify evaluation by Registered Dietician, MD notification of recommendations, and orders obtained as appropriate. The IDT will review weights weekly in the Standards of Care meeting to verify Residents weight loss/gain is addressed with appropriate notifications, evaluations and interventions. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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F 692	Continued From page 92 was again noted. 10-2-18 - MDS 125 lbs, yes weight loss, and not on a weight loss program. 10-9-18 - MDS 125 lbs, yes weight loss, and not on a weight loss program. The Resident had lost 25 pounds (16.66%) from 7-12-18 to 10-2-18 (less than 3 months), and no further weights were recorded at the time of survey on 10-25-18, (2 weeks more). Registered Dietician (RD) assessments were reviewed and revealed only one assessment had been completed, and it was dated 7-12-18. The previous RD completed the assessment upon the Resident's admission, and no longer was employed by the facility. A new RD had begun, but when interviewed stated she had not yet assessed this Resident. The initial & only RD assessment revealed the following recommendations for the Resident: "at risk for weight loss", and recommended "assistance with feeding", had "increased nutrient needs", "Nutrition monitoring & evaluation", "Medical food supplement", "House supplement 120 cc (cubic centimeters) QID (4 times per day) @ medication pass for wounds",and "Multivitamin". Only the multivitamin had been ordered. None of the other recommendations were followed. The Resident was on a "controlled carbohydrate no salt added diet" to be "mechanically soft" in texture from admission and never changed. All Physician orders since admission were reviewed, and revealed the only 2 dietary orders and their dates of implementation included:	F 692		

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F 692	Continued From page 93 1. Resident needs assistance with eating ordered 7-12-18, and discontinued the same day. 2. Multivital tablet (multivitamin) ordered on admission 7-12-18, discontinued 7-13-18, and restarted on 9-28-18. Resident #93's lunch meal tray was observed on 10-23-18, in her room. The Resident was expected to eat independently, and she had consumed 25% when the tray was removed. Breakfast on 10-24-18 could not be observed because the Resident was "nothing by mouth" status after midnight, the night before, for a procedure she was having that morning at her physician's office. This indicated 2 more meals essentially missed from the Resident's diet. The meal card on Resident #28's tray read that she was to receive the prescribed diet. Nursing progress notes were reviewed and revealed that occasionally the staff would feed the Resident, and she would then most often consume 75 to 100% of the meal. All Physician's progress notes were reviewed and revealed that on 10-4-18, 8-14-18, and 7-12-18 were the only visits for the Resident. The 10-4-18 note documented "Weight stable, appetite good". Which indicated the doctor was unaware of the Resident's significant (16.66 %) weight loss in 3 months. On 10-25-18 the Residents care plan was reviewed and revealed that there was no weight loss care planned for this Resident. The care plan does not have any interventions for weight loss, even though the Resident was at risk from	F 692		

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F 692	Continued From page 94 her admission, having had dementia, wounds, diabetes, and the care plan does not denote her significant weight loss. A weight loss care plan was never developed. The failure of staff to recognize and intervene timely in a significant weight loss, and to develop a weight loss care plan was reviewed with the Administrator and Director of Nursing at the end of day meeting on 10-25-18, and 10-26-18. No further information was provided.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review, the facility staff failed to provide pain management for 1 resident (Resident #51) of 33 residents in the survey sample. Resident #51 did not have a standing X Ray as ordered by the pain management clinic. The findings included: Resident #51 was admitted to the facility on 4-18-17 with diagnoses which included, but not limited to, high blood pressure, depression and diabetes.	F 697	1.Resident #51□s x-ray order was d/c□ed by the Physician on November 14, 2018. Follow up on the x-ray determined that a provider was unable to be located that was able to perform the ordered x-ray. Facility will follow up pain management for reevaluation of pain and additional recommendations. 2.Residents residing in this facility have the potential to be affected. 3.The Director of Nursing and/or Designee will review consults for pain management for recommendations and verify recommendations have been	12/10/18

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F 697	Continued From page 95 Resident #51's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 9/3/18. Resident #51 was coded with a Brief Interview of Mental Status score of "15" out of a possible 15 indicating no cognitive impairment. Resident #51 required supervision to limited assistance of one staff member for bed mobility and bathing and toileting. The resident was coded as having frequent pain of a "4" out of a possible 10. On 10/24/18 at 9:29 AM Resident #51 was observed in her room. She complained that her pain could get up to a "10" and that the pain medication doesn't help enough. She complained of pelvic pain, and pain in the bladder area. Review of the clinical record revealed a physician's order dated 9-4-18 for "Bilateral standing hip X-rays to rule out osteoarthritis." On 9-10-18 a nurse's note read: "NP (nurse practitioner) in building inquiring about patient's scheduled X-ray results of bilateral hips.. This nurse placed a call to mobile imaging to request refax of results, per mobile representative "Patient was out of building at time of scheduled ay and order was canceled/not completed. X-ray rescheduled for tonight." On 9-10-18, a nurse's note read" "X-ray tech arrived to perform X-ray on resident. Resident informed X-ray tech that she had to have a standing X-ray. X-ray tech that she could not perform a standing X-ray." On 10-12-18, the nurse's note read: "Hip X-ray standing to rule out osteoporosis. Please	F 697	communicated with physician and completed as ordered by the attending. The Director of Nursing and/or Designee will verify consult recommendations have been obtained, communicated to physician, and completed during the morning clinical meeting. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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	495086	A. BUILDING ______ B. WING ______	C 10/26/2018

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F 697	Continued From page 96 schedule at outside facility. Both hips standing." On 10/26/18 at 9:18 AM An interview with RN (registered nurse) A was conducted. RN (A) stated, We attempted to get X-rays and the company said they could not do the test (standing), so yesterday we called the hospital and was told the resident would have to come into the hospital and sit and wait. We called the pain management NP and informed her. She will try to get her in a diagnostic center. RN (A) also stated she had talked with resident, and she said the pain was better. On 10/24/18 at 4:22 PM, the facility Administrator and DON (director of nursing) were notified of above findings.	F 697		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, and clinical record review, the facility staff failed to provide psychotherapy for grief, anxiety, and depression as recommended by the psychiatric nurse practitioner for one Resident	F 742	1.Resident #12 received a psychiatry consult on July 2, 1018. An appointment with Eden Counseling and Consultation for Resident #12 to receive psychotherapy services for functional assessment and	12/10/18

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F 742	Continued From page 97 (Resident #12) in a sample of 33 residents. The findings include: Resident #12, a 26 year old female, was admitted to the facility on 04/18/2018 following a hospital admission for influenza with wheezing, cough, fever, and systemic inflammatory response syndrome. Diagnoses include athetoid cerebral palsy, moderate intellectual disability (ID), depression, anxiety, asthma, and anemia. Resident # 12's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 07/25/2018. Resident # 12 did not have a Brief Interview of Mental Status (BIMS) conducted but cognitive skills for daily decision-making were coded as moderately impaired. Functional status for personal hygiene, dressing, mobility, and transfers were coded as extensive assistance for performance and support. Resident #12 was in a wheelchair and locomotion on and off unit was coded as requiring supervision and oversight. A mood interview was not conducted. On 10/24/18 at 8:30 AM, the Resident was observed rolling self in wheelchair in the hallway. The Resident was crying and asking to go to school and wanting to get on the school bus. The DON was in the hallway and was asked if the resident went to school. The DON stated, "No, she has finished school." The DON was then asked if the resident went to a day program and she stated she did not think so that, "She lives here." On 10/25/18, the clinical record was reviewed.	F 742	grief counseling is scheduled for December 3, 2018. Resident #12□s care plan has been updated to reflect new interventions to include psychotherapy services with grief counseling. 2.Residents needing psych services have the potential to be affected. 3.The Director of Nursing and/or Designee will review psych consults for recommendations and verify recommendations have been communicated with physician and completed as ordered by the attending. The Director of Nursing and/or Designee will verify consult recommendations have been obtained, communicated to physician, and completed during the morning clinical meeting. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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A physician's order dated 04/18/18 documented a psychiatry consult.

The initial psychiatric evaluation dated 07/02/18 documented, "She (resident) is aware of her mother's death and cries when she says, "Mommy died." Staff reports frequent crying episodes and attention seeking behavior. She seems restless, obsessively asking for help and can be disruptive with repetative (sic) verbalizations. These behaviors reflect underlying anxiety and depression associated with the loss of her mother and the security that she is not alone. She scored 10 on the cornell scale for depression in dementia which indicates probable major depression. Will start Citalopram to target her anxiety and depression. Psychotherapy would be beneficial if available."

A psychiatric follow-up evaluation dated 07/24/18 documented, "She was started on Citalopram to target her underlying anxiety and depression. According to staff, the crying episodes are significantly reduced." The note further documented, "Psychotherapy recommended. Re: Grief, anxiety, depression."

A progress note dated 08/22/18 documented, "Staff reports labile mood and behavior with crying one minute and laughing the next." It also documented, "According to staff, she actually had an increase in her tearfulness with the start of Citalopram. She is grieving the loss of her mother who recently passed. She was her primary caregiver and I am sure that she has a lot of emotions that she does not quite know how to deal with. Will increase citalopram to improve efficacy for any underlying anxiety and depression. My recommendation is to just give

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her some time as this is likely a juge (sic) adjustment for her and she lacks the maturity to be able to regulate her emotions." The entry also documented, "Consider psychotherapy."

A progress noted dated 09/11/18 documented, "there may be a bit of attention seeking associated with her crying spells. No agitation or behavioral dysregulation has been reported. She is easily redirected. She repetitively verbalizes anything that she is thinking and is quite needy for attention. She needs to be placed in a living situation that provides structure and guidance to assist her to become as independent as possible." The note goes on to say, "Psychotherapy recommended. Re: Grief.

The nurses notes were reviewed for the month of October 2018.
An entry dated 10/09/2018 documented, "Resident calling out to staff and stating she's going home on Saturday."

An entry dated 10/12/2018 documented Resident "calling out to staff with occasional crying stating that she was upset."

An entry dated 10/17/2018 documented Resident "calling out to staff stating she was going home by bus on Saturday and that she wanted to call (sister)."

An entry dated 10/18/2018 documented Resident "calling out to staff stating she was going home on Saturday."

On 10/25/18 at 1:55 PM, the Resident was asked did she like going to school. She stated, "Yes, no, I don't like school here."

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F 742	Continued From page 100 On 10/26/18 at approximately 11:30 AM, the social worker was asked about the process for getting psychotherapy services for the Resident if it was recommended and she stated she would put it in the book so (name) (the psychiatric nurse practitioner) would get it. When asked who would be responsible for placing the order, the social worker stated the nurses would. On 10/26/18 at approximately 2:00 PM, the Administrator was asked who arranges psychotherapy services, she stated "We would try to find someone." She went on to say that the psych notes go to the social worker. In summary, the facility staff failed to obtain psychotherapy services as recommended by the psychiatric nurse practitioner. On 10/26/18 at approximately 2:00 PM, the Administrator and the DON were notified of findings. The Administrator stated that the social worker was on maternity leave from 05/25/18 through 07/23/18. The Administrator also stated that the MDS (minimum data set) coordinator (an LPN) served as social worker in (social worker) absence. No further information or documentation was presented.	F 742		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 745		12/10/18

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Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide community living skills, day support and rehabilitation, self-help/personal care skills, a social skills development program, or transportation to specialized services as recommended on the PASARR II for one resident (Resident #12) in a sample of 33 residents.

The findings include:

Resident #12, a 26 year old female, was admitted to the facility on 04/18/2018 following a hospital admission for influenza with wheezing, cough, fever, and systemic inflammatory response syndrome. The Resident's mother/primary caregiver died of influenza/pneumonia the day before the Resident's hospital admission. Diagnoses include athetoid cerebral palsy, moderate intellectual disability (ID), depression, anxiety, asthma, and anemia.

Resident # 12's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 07/25/2018. Resident # 12 did not have a Brief Interview of Mental Status (BIMS) conducted but cognitive skills for daily decision-making were coded as moderately impaired. Functional status for personal hygiene, dressing, mobility, and transfers were coded as extensive assistance for performance and support. Resident #12 was in a wheelchair and locomotion on and off unit was coded as requiring supervision and oversight. Preferences for customary routine and activities were not coded.

On 10/24/18 at 8:30 AM, the Resident was observed rolling self in wheelchair in the hallway. The Resident was crying and asking to go to

F 745

1.Resident #12 received a psychiatry consult on July 2, 1018. The Social Services Director has reached out to and will continue to follow up with appropriate agencies for services, guardianship, and an ID waiver. Calls were placed to Adult Protective Services, the Community Services Board, local day support programs, and her eligibility worker between November 14 and November 16, 2018. An appointment with Eden Counseling and Consultation for Resident #12 to receive psychotherapy services for functional assessment and grief counseling is scheduled for December 3, 2018. Resident #12□s care plan has been updated to reflect new interventions to include the ID waiver process, psychotherapy services with grief counseling, and day school program search.

2.Residents with a Level 2 PASARR have the potential to be affected by this deficient practice.

3.The SSD and Activity Coordinator will be educated on implementing an effective community services, discharge and activity plan of care as appropriate for residents with Level 2 PASARRs. The Administrator and/or Designee will review Residents with Level 2 PASARR recommendations, monitor weekly until recommendations have been completed for that resident. This will be on an ongoing basis.

4.Any noted discrepancies will be

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school and wanting to get on the school bus. The DON was in the hallway and was asked if the resident went to school. The DON stated, "No, she has finished school." The DON was then asked if the resident went to a day program and she stated she did not think so that, "She lives here."

On 10/25/18, the clinical record was reviewed. The PASARR Level II dated 04/12/18 documented "Specialized services recommended at this time as determined by the Level II include community living skills, day support and habilitation (sic), self-help/personal care, social skills development, transportation to specialized services, and mobility aids."
The Level II assessor also documented, "As with any admission, discharge planning begins at the time of admission. I encourage the nursing facility to start discharge planning for (Resident) to be able to transition to a lesser restrictive setting if appropriate. It is recommended that the nursing facility work with (Resident) to maintain independent skills to the maximal extent possible while she is rehabilitating there in preparation for a transition back to a community setting when she is able. I encourage the nursing facility to work with the local Community Services Board to assist in identifying supports and services that she could benefit from."

Physician's order dated 04/18/18 documented, "May participate in activities (including out of building activities) per plan of care." An order dated 04/18/18 documented a psychiatry consult. An order dated 05/07/18 documented, "Discharge potential [within 31-90 days]."

The initial psychiatric evaluation dated 07/02/18

Plan of correction (F 745): immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.

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documented mood: "anxiety and depression are likely. Frequently tearful per staff. Restless, wanders, obsessive requests for help, attention-seeking, repetative (sic) verbalizations. Occasional disruptive behaviors. Grieving loss of mother. Loss of security." The note goes on to document Resident has poor concentration, insight, and judgement."

A psychiatric follow-up evaluation dated 07/24/18 documented, "She is attention seeking and tries to engage the nurses to help her with things that she is able to do for herself."

A progress note dated 08/22/18 documented, "Staff reports labile mood and behavior with crying one minute and laughing the next." It also documented, "According to staff, she actually had an increase in her tearfulness with the start of Citalopram. She is grieving the loss of her mother who recently passed. She was her primary caregiver and I am sure that she has a lot of emotions that she does not quite know how to deal with. Will increase citalopram to improve efficacy for any underlying anxiety and depression. My recommendation is to just give her some time as this is likely a juge (sic) adjustment for her and she lacks the maturity to be able to regulate her emotions." The entry also documented, "Consider psychotherapy."

A progress noted dated 09/11/18 documented, "there may be a bit of attention seeking associated with her crying spells. No agitation or behavioral dysregulation has been reported. She is easily redirected. She repetitively verbalizes anything that she is thinking and is quite needy for attention. She needs to be placed in a living situation that provides structure and guidance to

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assist her to become as independent as possible."

The nurse's notes were reviewed for the month of October 2018.
An entry dated 10/09/2018 documented, "Resident calling out to staff and stating she's going home on Saturday."

An entry dated 10/12/2018 documented Resident "calling out to staff with occasional crying stating that she was upset."

An entry dated 10/17/2018 documented Resident "calling out to staff stating she was going home by bus on Saturday and that she wanted to call (sister)."

An entry dated 10/18/2018 documented Resident "calling out to staff stating she was going home on Saturday."

There were four social services notes since the Resident's admission. The first entry dated 04/28/18 documented, "Summary: Resident was admitted from the hospital. Resident is alert. She is here to regain her strength and endurance. Her sister is involved with care. APS is also involved. Code status is Full Code. Discharge plan is either LTC (long-term care) here or a group home." An entry dated 05/23/18 documented, "SW (social worker) spoke with APS regarding this resident. APS was involved with this resident prior to admitting to this facility. APS is assisting with trying to get the resident's MCD (Medicaid) re-instated and also trying to assist with the resident getting the ID waiver for a group home which would be a more appropriate setting for the resident. SW will continue to work with APS to put

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a safe plan in place." An entry dated 07/30/18 documented, "SW and APS are working together to find a more appropriate setting for the resident. A group home would be more appropriate setting for her. Resident is currently on the waiting list for the ID waiver. SW will continue to work with APS regarding this resident." The last entry on 10/24/18 at 10:11 AM documented, "Late entry: (name) (APS) and SW spoke regarding placement for the resident. She stated that the resident's sister is working on a place for her in (out-of-state) with her. SW asked APS about the ID waiver and group home for the resident. She stated that the resident's sister does not want to move the resident twice and wants her to stay in the facility until placement is established out of state. SW will continue to work with APS for discharge placement."

On 10/25/2018 at 11:10 AM, the social worker was asked about the Resident's legal guardianship and she stated there was no legal guardian documentation. The social worker stated the Resident does not have a legal guardian but the sister is the next of kin. The social worker stated the sister knows the Resident has been crying about being here and the sister is working with adult protective services (APS) to get the Resident moved to a facility near her (out of state). When asked about enrolling the Resident in a day program, the social worker stated that an ID waiver is needed in order for her to participate in a day program or live in a group home. When asked if she could apply for the waiver, stated she could apply through the city "but the APS worker is spear-heading this."

On 10/25/18 at 1:55 PM, the Resident was asked

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F 745	Continued From page 106 did she like going to school. She stated, "Yes, no, I don't like school here." On 10/25/18 at 2:00 PM, the Resident was observed in the therapy hallway, giving gloves to the therapist (likes to pull gloves from box). The therapist stated that the Resident was social and would follow her when she would ambulate with other residents. On 10/25/18 at 2:55 PM, the APS worker familiar with the resident returned call. She stated that the Resident was initially admitted to LTC as her UAI showed she required full Activities of Daily Living (ADL) care. Her supervisor was also on the phone and she stated that initially the Resident was referred to APS for a community issue that she could not go into. She went on to state "We don't participate in the discharge planning, it should be the LTC facility." The APS worker also stated that the Resident had previously been in a day program in Portsmouth, which was not renewed since her mother died. She stated that the Resident had "not applied for an ID waiver" (necessary for placement in a group home). On 10/25/18 at 3:55 PM an interview with Activities Director was conducted. When asked what the Resident's activity preferences were, she stated the Resident liked puzzles, a squeeze ball, and a tablet that plays songs. She stated that the Resident joins us for activities but doesn't like to stay and we let her go. When asked if Resident participated in a day program when living in Portsmouth, stated she didn't think so. On 10/26/18 at approximately 10:00 AM, the certified nursing assistant (CNA) C stated she	F 745		

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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 745	Continued From page 107 had heard the Resident say she wants to go home. CNA C went on to say she thought the Resident needs to "be in one of those ID homes." On 10/26/18 at approximately 11:30 AM, the social worker was asked about the Resident participating in a day program and she stated "I haven't investigated how she can get into a day program." On 10/26/18 at 12:50 PM, a call was placed to the Resident's sister but there was no answer. In summary, the facility failed to provide specialized services for this 26 year old with intellectual disabilities. The Resident has been at the facility for over 6 months and there was no provision for community living skills, day support and rehabilitation, a social skills development program, or transportation to specialized services. On 10/26/18 at approximately 2:00 PM, the Administrator and the DON were notified of findings. The Administrator stated that the social worker was on maternity leave from 05/25/18 through 07/23/18. The Administrator also stated that the MDS (minimum data set) coordinator (an LPN) served as social worker in (social worker) absence. No further information or documentation was presented.	F 745		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other	F 807		12/10/18

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F 807	Continued From page 108 liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to ensure beverages were served according the plan of care for 1 resident (Resident #14) of 33 residents in the survey sample. Resident #14 was not served honey thickened beverages per the plan of care. The findings included: Resident #14, a 77 year old, was admitted to the facility on 3/22/17. Diagnoses included dysphagia, diabetes, stroke, failure to thrive, dementia with behaviors, and hypertension. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/30/18. He was coded with severe cognitive impairment and required extensive assistance with activities of daily living. On 10/24/18 at 8:35 am, Certified Nursing Assistant E (CNA E) had finished feeding Resident #14 his breakfast and taken him back to his room from the dining room. The meal tray was left on the table in the dining room. The tray included pureed foods, juice in a plastic cup and fat free milk in a purple carton. The carton was open. The tray ticket read: Skim Milk 8 ounces, coffee or hot tea 6 ounce honey thickened, orange juice 4 ounce honey thickened. Resident #14 had a physician order dated 1/15/18	F 807	1.Resident #14 is being provided the appropriate consistency diet/ beverages. The Licensed Nursing that administered the Ensure to Resident #14 was educated at the time of the survey. An order has been obtained to change the supplement to meet the Resident□s food/drink consistency requirements. 2.Residents on altered consistency diet/beverages have the potential to be affected. 3.The Director of Nursing and/or Designee will educate Certified Nursing Assistants on checking diet prior to feeding/drinking to ensure accuracy. Dining Services will be educated on tray accuracy. Licensed Nursing Staff will be educated on appropriate consistency of house supplements per dietary recommendation/order. The Director of Nursing and/or Designee will complete observation rounds to ensure nursing staff are providing the correct consistency supplement as ordered daily for seven days, then weekly for 6 weeks, followed by monthly for one month. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review	

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F 807	Continued From page 109 for "Controlled Carb/ NAS (no added salt) diet Pureed texture, Honey consistency, Controlled carb/ NAS diet with pureed meals and strict aspiration precautions for Nutritional Support" On 10/25/18 at 9:25 a.m., Resident #14's diet order and tray ticket was reviewed with the Dietary Manager. It was reviewed with the Dietary Manager that the breakfast tray ticket included milk that was not of a thickened consistency. It was reviewed that skim milk in a purple carton was observed opened on the breakfast tray. The Dietary Manager was asked how thickened milk was served to the residents. He stated that the facility bought pre-thickened milk which was packaged in individual containers and provided an example. When asked if the skim milk in the purple carton observed on Resident #14's cart was thickened, the Dietary manager stated no. It was reviewed that the other beverages listed on the tray ticket were indicated as "honey thickened" but the skim milk was not. It was reviewed that Resident #14 did not receive thickened milk on his tray. Later in the morning, the Dietary Manager approached this surveyor and stated that he had contacted the previous facility dietitian about Resident #14's diet order. The Dietary Manager stated that the previous dietitian told him that Resident #14's wife had requested regular milk to be put on the tray so she could add it to her husband's coffee and then thicken it afterward. When asked if the wife's request was documented in a nutrition note, the Dietary Manager stated no.	F 807	and further recommendation.	

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F 807	Continued From page 110 On 10/25/18 at 9:30 a.m., CNA E was asked how Resident #14 had eaten at breakfast earlier in the morning. She stated that he ate good. She stated when he does not eat well, she tells the nurse and Resident #14 will be given an Ensure supplement drink. Resident #14's physician orders included an order for "Other after meals and at bedtime 1 container of House Supplement PO (by mouth) thickened to honey thick consistency." On 10/25/18 at 9:45 a.m., Registered Nurse B (RN B) was working the medication cart. She was Resident #14's nurse. RN B was asked about the type of house supplement used at the facility. RN B stated that the house supplement was Ensure. She stated that they were pre-packaged individual servings of the nutritional drink. She stated that she kept them in a cooler on her cart and was getting ready to give one to Resident #14. When asked how she prepared the Ensure for Resident #14, she stated that she twisted off the cap off the package and put a straw in the opening to make it easier for Resident #14 to drink. She stated that he drank the Ensure right out of the container it came in. After the interview with RN B, CNA E was asked when Resident #14's wife usually comes to visit. CNA E stated that the wife usually comes at lunch time. When asked if the wife had been at the facility for breakfast the day prior, CNA E stated no. At the end of day meeting on 10/25/18, the Administrator, Director of Nursing and Corporate Nurse were notified that Resident #14 was not served skim milk and Ensure at a thickened	F 807		

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F 807	Continued From page 111 consistency. On 10/26/18 at 12:50 p.m., the new facility dietitian stated that Resident #14's wife wanted regular milk on the meal trays. When asked if the request was documented in the clinical record, the new facility dietitian stated no. The new facility dietitian was asked if the Ensure served to Resident's #14 was supposed to be thickened. She stated that she would need to check the product information. Shortly after the original conversation, the new facility dietitian returned and stated that the Ensure was not a pre-thickened product.	F 807		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/10/18

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F 880	Continued From page 112 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: (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	F 880		

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F 880	Continued From page 113 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 observation and staff interview the facility staff failed to ensure an effective infection control program was implemented for 2 residents (Resident's #42 and #17) of 33 residents in the survey sample. 1. For Resident #42, the facility staff: a. touched medications with gloved hands after touching unclean surfaces b. laid the opened Spiriva handihaler on the medication cart with the inside of the inhaler touching the medication cart surface c. took the box of Spiriva capsules and Symbicort inhaler box into the resident room, laying them on the uncleaned bedside table and returning the boxes to the cart drawer. 2. For Resident #17, the facility staff prepared medications in a medication cup, put the medications in her pocket when providing care to another resident, and then administered the medications that had been stored in her pocket. The findings included: 1. For Resident #42, the facility staff: a. touched medications with gloved hands after touching unclean surfaces b. laid the opened Spiriva handihaler on the medication cart with the inside of the inhaler touching the medication cart surface c. took the box of Spiriva capsules and	F 880	Cross Referenced to 12 VAC 5-371-180(A) 1.Residents #47 and #17 are receiving medications within acceptable infection control practices. 2.Residents in this facility have the potential to be affected. 3.Licensed Nursing Staff will be educated with competency on acceptable infection control practices for handling medications. The Director of Nursing and/or Designee will conduct medication pass observations rounds to validate staff□s use of appropriate infection control practices daily for seven days, then weekly for 7 weeks, followed by monthly for one month. The Director of Nursing and/or Designee will monitor infection control practices, conducting random medication pass observations weekly to validate Nurses are using appropriate infection control practices. 4.Any noted discrepancies will be immediately addressed, recorded and forwarded monthly for three months, or until compliance is sustained, to the Quality Assurance Committee for review and further recommendation.	

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F 880	Continued From page 114	F 880		

Symbicort inhaler box into the resident room, laying them on the uncleaned bedside table and returning the boxes to the cart drawer.

On 10/24/18 at 8:11 a.m., a medication pour and pass observation was conducted with Licensed Practical Nurse A (LPN A). LPN A donned a pair of gloves. He prepared seven pills wearing the same pair of gloves. Between each pill, LPN A opened the medication cart drawer and removed the necessary pill pack or bulk container. He poured the pill directly into his gloved hand and picked the pill up with his fingers and placed the pill into the medication cup. He repeated this process seven times. During the observation, LPN A's gloved hands touched the cart drawers and surfaces, computer and pill containers. These medications were administered to Resident's #42

The Spiriva handihaler is a round plastic dispenser that opens in half by a hinge so that a medication capsule can be inserted inside. LPN A opened the handihaler and laid it on the medication cart with the inside of the inhaler (where the medication capsule is to be inserted) touching the unclean medication cart surface. LPN A inserted the Spiriva capsule using the gloved hands that had previously touched multiple unclean surfaces. Resident #42 took a puff from the Spiriva handihaler.

When LPN A entered the resident room, he took the medication cup, box of Spiriva capsules and a box containing a Symbicort inhaler. He set the box of Spiriva capsules and the Symbicort box on the overbed table while he administered the medications from the medication cup. After the medication administration, LPN A returned the

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F 880	Continued From page 115	F 880		

box of Spiriva capsules and the Symbicort box to medication cart drawer.

On 10/25/18 at the end of day meeting, the Director of Nursing (DON), Administrator and Corporate Nurse were notified of the infection control issues identified. The DON agreed that LPN A should not have touched the individual medication pills with gloved hands after touching the unclean surfaces.

2. For Resident #17, the facility staff prepared medications in a medication cup, put the medications in her pocket when providing care to another resident, and then administered the medications that had been stored in her pocket.

On 10/24/18 at 8:32 p.m., a medication pour and pass observation was conducted with Licensed Practical Nurse B (LPN B). LPN B prepared Resident's #17's medications in a medication cup without issue. She also prepared a glass of water containing Miralax (for constipation) as ordered. As soon as LPN B had finished preparing Resident #17's medications, an emergency code was called on the overheard paging system. LPN B opened a drawer of the medication cart and put the glass of Miralax into the drawer. She put the cup of pills into her pocket and ran to assist with the emergency.

LPN B returned to the medication cart holding Resident #17's cup of pills in her hand. She administered the pills that had been in her pocket to Resident #17.

On 10/25/18 at the end of day meeting, the Director of Nursing (DON), Administrator and

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F 880	Continued From page 116 Corporate Nurse were notified of the infection control issues identified. The DON agreed that it was an issue that LPN B administered the medications that had been in her pocket.	F 880		