STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495388	A. BUILDING _____ B. WING _____	C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

(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 on 10/18/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	F000 Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction prepared and executed as a means to continuously improve quality of care and to comply with all applicable State and Federal regulatory requirements.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/16/18 through 10/18/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 3 complaints were investigated during the survey. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 38 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Reid Schulz, LNHA	ADMINISTRATOR	NOV. 12, 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 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, facility document review and clinical record review, it was determined that the facility staff failed to provide care in a manner to promote dignity for two of 38 residents in the survey sample, Residents #86 and #33. 1. The facility staff failed to assist Resident #86 with changing a stained shirt immediately after lunch on 10/16/18. 2. The facility staff failed to maintain the resident's dignity during dining. The staff member was observed standing over a resident assisting	F 550	F 550 1. Resident #86's shirt was changed on 10/16/18. The facility has noted that a CNA assisted a resident in the dining room while standing up. 2. All residents could be affected by the deficient practice. An audit will be conducted during meal times to ensure no other residents have stains on their clothing and CNAs do not assist residents eat while standing. 3. Unit Managers, or designee, will re-educate certified nursing assistants on changing a residents' shirt once it is observed. CNAs will also be educated on sitting down while assisting residents with their meals. 4. The Interdisciplinary Team, or designee, will conduct meal observations daily x 5 days, then weekly x 4 weeks, then monthly x 2 months to ensure residents experience meal time in a dignified manner. All findings will be reported to The Quality Assurance Committee.	

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F 550	Continued From page 2 her with eating, Resident #33. The findings include: 1. The facility staff failed to assist Resident #86 with changing a stained shirt immediately after lunch on 10/16/18. Resident #86 was admitted to the facility on 6/25/16. Resident #86's diagnoses included but were not limited to heart failure, dementia and chronic kidney disease. Resident #86's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/22/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded Resident #86 as requiring extensive assistance of two or more staff with dressing. Resident #86's care plan initiated on 6/25/16 documented, "(Name of Resident #86) needs assistance with ADLs (activities of daily living) and function...Provide assistance for ADLs as needed..." On 10/16/18 at 1:06 p.m., CNA (certified nursing assistant) #2 was observed wheeling Resident #86 out of the dining room. Resident #86 was observed with a light brown stain (approximately three inches long and two inches wide) covering the chest portion of the resident's white long sleeve shirt. On 10/16/18 at 1:10 p.m., Resident #86 was observed in the hall near the nurse's station. The stain remained on the resident's shirt. On 10/16/18 at 2:35 p.m., Resident #86 was observed in the hall on the opposite side of the nurse's station. The stain remained on the resident's shirt. A nurse was standing at a medication cart and Resident #86 was in her line	F 550	5. November 19, 2018	

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F 550	Continued From page 3 of sight. On 10/17/18 at 2:53 p.m., an interview was conducted with CNA #1. CNA #1 was asked what should be done if a resident is assisted from the dining room and the resident has a stain on her shirt. CNA #1 stated he would change the clothing. When asked when he would change the clothing, CNA #1 stated, "Right away. As soon as possible." CNA #1 stated he wants residents to look presentable and no one wants food on them. When asked how he would feel if he was left in the hall with a stain on his shirt, CNA #1 stated, "Upset and wondering why I had that stain on myself." On 10/17/18 at 3:43 p.m., an interview was conducted with CNA #2. CNA #2 was asked if the CNAs observe residents to make sure they do not have stains on their clothing after meals. CNA #2 stated, "We should make sure no stains." When asked what should be done if she is assisting a resident from the dining room and the resident has a stain on her shirt, CNA #2 stated she lets the CNA assigned to care for the resident know about the stain because she has to return to the dining room to monitor other residents. CNA #2 was made aware of this surveyor's above observation on 10/16/18. When asked if she noticed the stain on Resident #86's shirt as she was wheeling the resident out of the dining room, CNA #2 stated, "I was already so busy. I did not even notice." On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 550		

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F 550	Continued From page 4 The facility policy titled, "Dignity and Respect" documented, "'Dignity' means that in their interactions with residents, staff carry out activities which assist the resident to maintain and enhance self-esteem and self-worth. 'Respect' means staff hold residents in high regard and provide care accordingly. For example...Providing timely and appropriate ADL care to meet toileting and other personal care needs..." No further information was presented prior to exit. 2. The facility staff failed to maintain the Resident #33's dignity during dining. The staff member was observed standing over the resident assisting her with eating. Resident #33 was admitted to the facility on 10/14/17 with diagnoses that included but were not limited to: Alzheimer's disease [a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability. (1)], anxiety disorder, depression, high blood pressure, and anemia [condition in which the hemoglobin content of the blood is below normal limits (2)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/14/18, coded the resident as unable to complete the questioning regarding mental status. The staff coded the resident as having both short and long-term memory difficulties and as severely impaired to make daily decisions. The resident was coded as having periods of inattention and disorganized thinking. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for	F 550		

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F 550	Continued From page 5 eating. The comprehensive care plan dated 10/30/17 and revised on 5/10/18, documented in part, "Focus: (Resident #33) requires assist with ADLs (activities of daily living) related to decreased mobility as a result of Alzheimer's." The "Interventions/Tasks" documented in part, "Assist with/provide ADL care as needed. Encourage to participate in self-care at highest level of functioning tolerated. Offer instruction in small tasks as needed by resident. The review of the ADL documentation for October 2018, evidenced documentation that the resident was coded as having received supervision of one staff member for all meals during the month of October. Observation was made of the dining room on 10/16/18 at 12:18 p.m. Resident #33 was sitting at a table with one other resident. CNA (certified nursing assistant) # 2 was observed serving Resident #33 her meal. CNA #2 set up the food and then, while standing over the resident, helped the resident to eat two bites of food. An interview was conducted with CNA #2 on 10/17/18 at 3:47 p.m. and was informed of the observation of her assisting Resident #33 with her meal on 10/16/18. When asked how staff should assist a resident with their meal, CNA #2 stated, "She (Resident #33) is actually an assist. We try to let her eat and she grabs the spoon herself and then feeds herself. I was just getting her started." When asked if a staff member should stand over a resident when assisting them with their meal, CNA #2 stated, "No, I should have been sitting when I was trying to get her	F 550		

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F 550	Continued From page 6 started." The facility policy, "Dignity and Respect" documented in part, "Promoting resident independence and dignity in dining (appropriate assistance and active devices, avoidance of plastic cutlery and paper/plastic dishware unless appropriate or necessary, appropriate/desired clothing protectors, dining room conducive to pleasant dining." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 10/17/18 at 6:33 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a	F 558		

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F 558	Continued From page 7 call bell was within reach for use for one of 38 residents in the survey sample, Resident #39. The facility staff failed to ensure the call bell was within Resident #39's reach. The findings include: Resident #39 was admitted to the facility on 3/29/16 with diagnoses that included but were not limited to: psychosis (1), high blood pressure, hypothyroidism (2), gastro-esophageal reflux disease (3), and anxiety disorder. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 8/17/18, coded the resident as scoring a two of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not capable of making daily cognitive decisions. The resident was coded as having the ability to understand and to make themselves understood. The resident was also coded as requiring limited assistance for dressing, eating, and personal hygiene. Review of the care plan initiated on 5/15/18 documented, "Be sure call light is within reach and encourage to use it for assistance as needed." On 10/16/18 at approximately 11:51 a.m., an observation was made. During the initial tour Resident #39 was sleeping in her bed, the call bell was approximately one and a half feet away secured to a chair. On 10/16/18 at approximately 2:12 p.m., a second observation made. Resident #39 was	F 558	F558 1. Resident #39's call bell was placed back in reach. 2. All residents have the potential to be affected by the deficient practice. An audit will be done on call bell placement to ensure call bells are within reach of the residents. 3. The Assistant Director of Nursing will re-educate staff on the Call Bell/Lighting system policy. 4. The interdisciplinary Team will conduct rounds 5 times a week, for three months to ensure call bells are within the residents' reach. All findings will be reported to the QA committee. 5. November 19,2018	

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F 558	Continued From page 8 sleeping in her bed; the call bell was approximately one and a half feet away secured to a chair. On 10/16/18 at approximately 2:15 p.m., an observation was made with LPN (licensed practical nurse) #5. LPN # 5 confirmed that Resident #39's call bell was not within reach. When asked if Resident #39 was able to use the call bell, LPN #5 replied "Yes." When asked where Resident #39's call bell should be, LPN #5 replied it should be within resident's reach. On 10/18/18 at approximately 8:35 a.m., an interview was conducted with CNA (certified nursing assistant) #3. When asked where Resident #39's call bell is supposed to be, CNA #3 replied "Within reach at all times." On 10/18/18 at approximately 9:43 p.m. an interview was conducted with LPN #1, Unit Manager. When asked how residents get the attention of staff if they need help, LPN #1 replied, "Use the call bell or come to nurse's station." When asked where a call bell should be placed, LPN #1 replied, "Within reach." When informed that Resident #39's call bell was observed on her chair and not within reach, LPN #1 stated, "It should be within her reach." On 10/18/18 at approximately 3:15 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. The facility policy entitled "Call- Bell/ Lighting System" documented, "B. The signal cord or button must be kept within the reach of the resident at all times."	F 558		

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F 558	Continued From page 9 No further information was provided prior to exit. 1. Psychosis occurs when a person loses contact with reality. The person may have false beliefs about what is taking place, or who one is (delusions), see or hear things that are not there (hallucinations). This information was obtained from the website: https://medlineplus.gov/ency/article/001553.htm. 2. Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html. 3. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		

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F 583	Continued From page 10 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain confidentiality of clinical records for two of 38 residents in the survey sample, Residents #95 and #43. 1. The facility staff failed to close and secure Resident #95's computerized clinical record prior to leaving the medication cart in the hall and entering the resident's room. 2. The facility staff failed to close and secure Resident #43's computerized clinical record prior to leaving the medication cart in the hall and entering the resident's room. The findings include:	F 583	F583 1. The facility has noted that resident #95 and #43's computerized clinical record was not secured during medication pass. 2. All residents have the potential to be affected by the deficient practice. An audit will be done on medication pass to ensure resident's computerized clinical records are secured. 3. The DON, or designee will re-educate licensed nurses on the privacy and confidentiality policy. 4. The Director of Nursing, or designee, will review a medication pass daily x one week, weekly x eight weeks, then monthly x 1 month to ensure resident's computerized clinical records are secure during med passes. All findings will be reported to the QA committee. 5. November 19, 2018	

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F 583	Continued From page 11 1. The facility staff failed to close and secure Resident #95's computerized clinical record prior to leaving the medication cart in the hall and entering the resident's room. Resident #95 was admitted to the facility on 9/21/18. Resident #95's diagnoses included but were not limited to high blood pressure, paralysis and diabetes. Resident #95's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/28/18, coded the resident as being cognitively intact. Resident #95's care plan initiated on 9/21/18 failed to document information regarding clinical record confidentiality. On 10/16/18 at 4:49 p.m., LPN (licensed practical nurse) #4 was observed preparing Resident #95's medications at a medication cart in the hall outside of the resident's room. LPN #4 prepared the medications and left the resident's computerized clinical record open on the medication cart. LPN #4 did not securely sign out of the clinical record. LPN #4 then entered Resident #95's room, walked behind a privacy curtain, and administered the medications. A staff member was observed walking by the medication cart while LPN #4 was in Resident #95's room. On 10/17/18 at 3:37 p.m., an interview was conducted with LPN #4. LPN #4 was asked what should be done before leaving a medication cart to enter a resident's room. LPN #4 stated one should make sure the computer screen is off. When asked why, LPN #4 stated, "Because of patient privacy, not to have anyone who's walking by to look at his or her information. LPN #4 was	F 583		

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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 583	Continued From page 12 made aware of this surveyor's observation on 10/16/18. LPN #4 stated she was very nervous and always turns the computer screen off. On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "PRIVACY AND CONFIDENTIALITY" documented, "PURPOSE: To provide the resident with his/her right to personal privacy and confidentiality of his/her clinical records. Confidentiality of the residents' Protected health information will be maintained in accordance with state and federal law and the company's HIPAA (Health Insurance Portability and Accountability Act) Compliance Plan." No further information was presented prior to exit. 2. The facility staff failed to close and secure Resident #43's computerized clinical record prior to leaving the medication cart in the hall and entering the resident's room. Resident #43 was admitted to the facility on 8/20/18. Resident #43's diagnoses included but were not limited to urinary tract infection, mood disorder and diabetes. Resident #43's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/18, coded the resident as being cognitively intact. Resident #43's care plan initiated on 8/20/18 failed to document information regarding clinical record confidentiality. On 10/16/18 at 4:52 p.m., LPN (licensed practical	F 583		

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	495388	A. BUILDING _____ B. WING _____	C 10/18/2018

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F 583	Continued From page 13 nurse) #4 was observed preparing Resident #43's medications at a medication cart in the hall outside of the resident's room. LPN #4 prepared the medications and left the resident's computerized clinical record open on the medication cart. LPN #4 did not securely sign out of the clinical record. LPN #4 then entered Resident #43's room and administered the medications with her back facing the medication cart in the hall. On 10/17/18 at 3:37 p.m., an interview was conducted with LPN #4. LPN #4 was asked what should be done before leaving a medication cart to enter a resident's room. LPN #4 stated one should make sure the computer screen is off. When asked why, LPN #4 stated, "Because of patient privacy, not to have anyone who's walking by to look at his or her information. LPN #4 was made aware of this surveyor's observation on 10/16/18. LPN #4 stated she was very nervous and always turns the computer screen off. On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 583		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the	F 622		

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F 622	Continued From page 14 resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified	F 622	F622 1. The facility has noted that Resident #94, #7, #109, #62, #74, and #110's comprehensive care plan goals were not sent to the hospital when the residents were transferred. 2. All residents discharged to the hospital have the potential to be affected by the deficient practice. Unplanned discharges will be reviewed over the past 7 days to ensure comprehensive care plan goals have been sent to the hospital with the patient. 3. The DON, or designee will re-educate licensed nursing staff on sending the comprehensive care plan goals with the patient when they are being transferred to the hospital. 4. Unplanned discharges will be reviewed during the clinical start up meeting daily for three months to ensure the comprehensive care plan goals were sent to the hospital with the patient. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 622	Continued From page 15 in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F 622		

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F 622	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure physician documentation in the clinical record and/or failed to evidence that all required documentation was provided to the receiving facility for facility initiated transfers to the hospital for six of 38 residents in the survey sample; Residents #94, #7, #109, #62, #74, and #110. 1. The facility staff failed to evidence that Resident #94's comprehensive care plan goals were sent to the receiving facility for a hospital transfer on 9/1/18 and 9/10/18. 2. The facility staff failed to evidence that Resident #7's comprehensive care plan goals were sent to the receiving facility for a hospital transfer on 9/4/18, 9/10/18, 9/15/18, and 10/2/18. 3. The facility staff failed to evidence documentation from the physician or nurse practitioner regarding how the facility was unable to meet the resident's health condition and failed to evidence documentation that the comprehensive care plan goals were sent to the receiving hospital upon transfer of Resident #109 on 9/20/18. 4. The facility staff failed to evidence documentation from the physician or nurse practitioner regarding how the facility was unable to meet the resident's health condition and failed to evidence documentation that the comprehensive care plan goals were sent to the receiving hospital upon transfer of Resident # 62 on 8/21/18.	F 622		

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F 622	Continued From page 17 5. The facility staff failed to ensure the physician documented the clinical record the reason for and why a facility-initiated transfer was necessary in for Resident #74 and failed to provide evidence that all required information (comprehensive care plan goals) was provided to hospital staff when Resident #74 was transferred to the hospital on 9/6/18. 6. The facility staff failed to evidence documentation from the physician or nurse practitioner of justification of why the facility was unable to meet the resident's health condition and failed to evidence documentation that the comprehensive care plan goals were sent to the receiving facility upon transfer for Resident #110 on 8/23/18. The findings include: 1. The facility staff failed to evidence that Resident #94's comprehensive care plan goals were sent to the receiving facility for a hospital transfer on 9/1/18 and 9/10/18. Resident #94 was admitted on 4/30/18 and readmitted on 9/19/18 with the diagnoses of but not limited to stroke, subdural hemorrhage, aphasia, dysphagia, pressure ulcer, atrial fibrillation, depression, dementia, anxiety disorder, aortic valve stenosis, chronic kidney disease, duodenal ulcer, alcohol dependence, heart failure, epilepsy, and diabetes. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 9/26/18. The resident was coded as being severely cognitively	F 622		

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F 622	Continued From page 18 impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 9/1/18 that documented Resident #94 was transferred to the emergency room. Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility for this transfer. A review of the clinical record revealed a nurse's note dated 9/10/18 that documented, "while writer was making rounds she went into room (number) ask {sic} resident how was he doing stated he has blood in his colostomy. Writer removed his colostomy bag and observed it was full bright red blood. Vitals 90/60-98%-16-104 (blood pressure-oxygen saturation-respiratory rate-heart rate) informed afternoon supervisor, called 911 resident left on stretcher to (hospital)." Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility. On 10/17/18 at 5:18 p.m., in an interview with LPN #1 (Licensed Practical Nurse), she stated that she sends the face sheet, med (medication) list, labs (laboratory tests), documentation from the record, change in condition form (eInteract form). LPN #1 stated the physician contact information is on the face sheet, the resident representative information is on face sheet, advanced directives is on the face sheet or on the orders, DNR (do not resuscitate) form is sent, the physician's order sheets has diet, allergies, code status and treatments on it. When asked about the comprehensive care plan goals being sent, LPN #1 stated that she was not aware of them being sent any. When asked how the facility	F 622		

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F 622	Continued From page 19 evidences that all this documentation was sent, LPN #1 stated, "That's a good question. We normally just make copies and put it together. I make two copies. One copy goes with them and we keep the other. I'm not sure what happens to the second copy." On 10/18/18 at 11:11 a.m., ASM #2 (Administrative Staff Member) the Director of Nursing stated that the comprehensive care plan goals are not sent. A review of the facility policy "Notification of Discharge" documented, "Unplanned/emergent discharges initiated by the facility: *When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provide to the resident and resident representative as soon as practicable. *When possible, provide the Discharge notice with the paperwork that accompanies the patient to the hospital. *If not possible, issue the notice to a responsible party/representative as soon as practicable following the hospital transfer and document in the medical record. *Notices for emergency transfers may be recorded as a list and sent to the State Ombudsman monthly as per the regulation referenced above. Resident initiated transfers/discharges: *The center is not required to issue a discharge notice when the resident/patient/representative initiated the discharge (i.e. AMA or without proper notice to the center to adequately plan for discharge, or resident sets an earlier discharge date than recommended.)...." A review of the facility policy, "Emergency	F 622		

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F 622	Continued From page 20 Transfer to Acute Care Hospital" documented, "Purpose: To provide a prompt, smooth transfer to an Acute Care Hospital to receive necessary care that is unavailable at the long-term care facility and to provide brief, accurate transfer information. Policy: 1. The decision to transfer a resident to an acute care hospital is made by the attending physician, nurse practitioner, Medical Director or the director of Nursing or Charge Nurse (in the absence of the attending physician, nurse practitioner, or Medical Director). 2. The family or Responsible Party must be notified. 3. The Emergency Transfer form and designated copies must be completed and must accompany the resident to the hospital. Procedure: 1. Obtain an order to transfer the resident. 2. Call ambulance for emergency (911). 3. Notify the family or Responsible Party. 4. Complete the Emergency Transfer form from the EMR. 5. The original Emergency Transfer form must accompany the resident to the Acute Care Hospital. A copy must be maintained on the medical Record at the facility. 6. The resident's DDNR [durable do not resuscitate] must accompany the resident." Neither policy specified what specific information must be provided to the hospital, including the comprehensive care plan goals. On 10/18/18 at 12:08 p.m., ASM #1 the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to evidence that Resident #7's comprehensive care plan goals	F 622		

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F 622	Continued From page 21 were sent to the receiving facility for a hospital transfer on 9/4/18, 9/10/18, 9/15/18, and 10/2/18. Resident #7 was admitted to the facility on 2/9/18 with the diagnoses of but not limited to chronic obstructive pulmonary disease, pneumonia, laceration of scalp, dysphagia, viral hepatitis C, inguinal hernia, polyneuropathy, mood disorder, depression, insomnia, diabetes, high blood pressure, and prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/2/18. The resident was coded as being mildly impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 9/4/18 that documented in part, "Resident was sent to the ER (emergency room) via (transport company)." Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility. A nurse's note dated 9/10/18 that documented, "while writer was making rounds she went into room (number) ask (sic) resident how was he doing stated he has blood in his colostomy. Writer removed his colostomy bag and observed it was full bright red blood. Vitals 90/60-98%-16-104 (blood pressure-oxygen saturation-respiratory rate-heart rate) informed afternoon supervisor, called 911 resident left on stretcher to (hospital)." Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility. A nurse's note dated 9/15/18 documented in part, "... informed supervisor of resident bleeding from stoma into his gastrostomy bag, resident became	F 622		

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F 622	Continued From page 22 concerned and requested to go back to the hospital. ems (Emergency Medical Services) service was called resident {sic} call {sic} family member and left message. resident {sic} left phone and charger at hospital. ems arrived between 9-9.30 {sic} resident left on stretcher to (hospital) spoke with (staff) and gave report." Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility. A nurses note dated 10/2/18, documented in part, "Resident was heard from the hallway yelling, "help, help, help." This writer quickly rushed in and observed resident lying on the floor on his left side with his face facing his wardrobe, and bleeding profusely from his mouth and his nose. The writer called other nursing staff for help. The 911-emergency call was initiated, and they arrived in no time and the resident was rushed to the R/E {sic} for evaluation at this time." Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility. On 10/17/18 at 5:18 p.m., in an interview with LPN #1 (Licensed Practical Nurse), she stated that she sends the face sheet, med list, labs, documentation from the record, change in condition form (eInteract form). LPN #1stated the physician contact information is on the face sheet, the resident representative information is on face sheet, advanced directives is on the face sheet or on the orders, DNR form is sent, the physician's order sheets has diet, allergies, code status and treatments on it. When asked about the comprehensive care plan goals being sent, LPN #1 stated that she was not aware of them	F 622		

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F 622	Continued From page 23 being sent any. When asked how the facility evidences that all this documentation was sent, LPN #1 stated, "That's a good question. We normally just make copies and put it together. I make two copies. One copy goes with them and we keep the other. I'm not sure what happens to the second copy." On 10/18/18 at 11:11 a.m., ASM #2 (Administrative Staff Member) the Director of Nursing, stated that the comprehensive care plan goals are not sent. On 10/18/18 at 12:08 p.m., ASM #1, the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to evidence documentation from the physician or nurse practitioner regarding how the facility was unable to meet the resident's health condition and failed to evidence documentation that the comprehensive care plan goals were sent to the receiving hospital upon transfer of Resident #109 on 9/20/18. Resident #109 was admitted to the facility on 11/11/16 with a recent readmission on 9/25/18, with diagnoses that included but were not limited to: stroke, heart attack, COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. (1)], diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change/Medicare 5 day	F 622		

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F 622	Continued From page 24 assessment, with an assessment reference date of 10/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The nurse's note dated, 9/20/18 at 9:46 p.m. documented, "Dinner time at 17:49 hours (5:49 p.m.) patient was noted unresponsive by CNA (certified nursing assistant) and called our for nurse. nurse was assessed and was noted verbally unresponsive. nurse could not arouse patient. patient was tapped on her back and shoulder several times but could not respond to tactile stimuli. Md (medical doctor) made aware. Md directed nurse to contact Rp (responsible party) as to what she wants to be the next step. patient daughter was notified of patient's condition. Rp instructed nurse to wait for an hour for her to get to facility and assess patient's condition and make decision as she is a DNR (do not resuscitate) code status. Ten minutes later Rp called and instructed nurse to send pt (patient) to ER (emergency room). EMS (emergency medical services) was called and at 19:04 (7:04 p.m.) patient was transported to (Name of hospital) medical center for further eval (evaluation). V/s (vital signs) 102/52 (blood pressure), p (pulse) = 65, R (respirations) = 17, Temp (temperature) = 93 AX (axillary)." This paragraph is typed exactly as written. The physician order dated 9/21/18, documented, "Send to ER for evaluation." The "Nursing Home to Hospital Transfer Form" dated 9/20/18 documented in part, the resident's name, responsible party contact information, the physician information, the facility contact	F 622		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

(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 622	Continued From page 25 information, allergies, code status and change in mental status. The Section, "Primary Goals of Care at Time of Transfer" documented a mark next to "Rehabilitation and/or Medical Therapy with intent of returning home." The box next to "Chronic long-term care." was not checked. Further review of the clinical record failed to reveal any documentation by the physician regarding this transfer to the hospital for Resident #109. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if the physician documents the reason for and necessity of hospital transfers of residents', LPN #1 stated, "It should be when they come in and do their physician note. They should. I have seen where the physician has come in and done a note on them." When asked if nurses provide hospital staff with residents' comprehensive care plan goals when residents are transferred to the hospital, LPN #1 stated, "No. Not that I'm aware of." On 10/18/18 at 11:11 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked if the physician documents the reason for and necessity of residents' hospital transfers. ASM #1 stated, "I don't think so." ASM #2 confirmed residents' comprehensive care plan goals are not provided to hospital staff when residents are transferred to the hospital. Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 10/17/18 at 6:25 p.m.	F 622		

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F 622	Continued From page 26 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 4. The facility staff failed to evidence documentation from the physician or nurse practitioner regarding how the facility was unable to meet the resident's health condition and failed to evidence documentation that the comprehensive care plan goals were sent to the receiving hospital upon transfer of Resident # 62 on 8/21/18. Resident #62 was admitted to the facility on 8/10/18 with a recent readmission on 8/28/18, with diagnoses that included but were not limited to: pneumonia, anxiety disorder, depression, difficulty sleeping, legally blind, high blood pressure and urinary tract infections. The most recent MDS (minimum data set) assessment a Medicare 14 day assessment, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making her daily cognitive decisions. The nurse's note dated, 8/21/18 at 9:26 a.m. documented, "Resident had significant change in condition. approval obtained from (Name of doctor) to send out via EMS (emergency medical services) to (name of hospital) ED (emergency department) for Altered Mental Status. Vitals obtained: BP (blood pressure) 174/84, P (pulse) 89, PO2 (Oxygen saturation) 93%, T (temperature) 100.4. RP (responsible party)	F 622		

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F 622	Continued From page 27 notified. Resident transported via stretcher accompanied by multiple EMS (emergency medical services) techs (technicians)." The "Nursing Home to Hospital Transfer Form" dated, 8/21/18 at 8:42 a.m., documented in part, the resident's name, responsible party contact information, the physician information, the facility contact information, allergies, code status and change in mental status. The Section, "Primary Goals of Care at Time of Transfer" documented a mark next to "Chronic Long Term Care." Further review of the clinical record failed to reveal any documentation by the physician regarding this transfer to the hospital for Resident #62. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if the physician documents the reason and necessity for residents' hospital transfers. LPN #1 stated, "It should be when they come in and do their physician note. They should. I have seen where the physician has come in and done a note on them." When asked if nurses provide hospital staff with residents' comprehensive care plan goals when residents are transferred to the hospital, LPN #1 stated, "No. Not that I'm aware of." On 10/18/18 at 11:11 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked if the physician documents the reason and necessity for residents' hospital transfers. ASM #1 stated, "I don't think so." ASM #2 confirmed residents' comprehensive care plan goals are not provided to hospital staff when residents are transferred to the hospital.	F 622		

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F 622	Continued From page 28 Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 10/17/18 at 6:25 p.m. No further information was provided prior to exit. 5. The facility staff failed to ensure the physician documented the clinical record the reason for and why a facility-initiated transfer was necessary in for Resident #74 and failed to provide evidence that all required information (comprehensive care plan goals) was provided to hospital staff when Resident #74 was transferred to the hospital on 9/6/18. Resident #74 was admitted to the facility on 8/18/17. Resident #74's diagnoses included but were not limited to dementia, diabetes and osteoporosis. Resident #74's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/17/18, coded the resident's cognition as severely impaired. Review of Resident #74's clinical record revealed the resident was transferred to the hospital on 9/6/18 due to a fall and left upper thigh pain. Review of Resident #74's clinical record failed to reveal documentation by the physician to explain the reason and necessity for the transfer. Further review of Resident #74's clinical record (including nurses' notes and a nursing home to hospital transfer form) failed to reveal evidence that the facility staff provided the resident's comprehensive care plan goals to hospital staff. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1.	F 622		

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F 622	Continued From page 29 LPN #1 was asked if the physician documents the reason and necessity for residents' hospital transfers. LPN #1 stated, "It should be when they come in and do their physician note. They should. I have seen where the physician has come in and done a note on them." When asked if nurses provide hospital staff with residents' comprehensive care plan goals when residents are transferred to the hospital, LPN #1 stated, "No. Not that I'm aware of." On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 10/18/18 at 11:11 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked if the physician documents the reason and necessity for residents' hospital transfers. ASM #2, stated, "I don't think so." ASM #2 confirmed residents' comprehensive care plan goals are not provided to hospital staff when residents are transferred to the hospital. No further information was provided prior to exit. 6. The facility staff failed to evidence documentation from the physician or nurse practitioner of justification of why the facility was unable to meet the resident's health condition and failed to evidence documentation that the care plan goals were sent to the receiving facility upon transfer for Resident #110 on 08/23/18. Resident #110 was admitted on 06/06/18. Resident #110's diagnoses included, but were not	F 622		

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F 622	Continued From page 30 limited to, Chronic Obstructive Pulmonary Disorder (COPD), Osteomyelitis, Epilepsy, Bipolar Disorder, and Major Depressive Disorder. The most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 09/26/18. The Brief Interview for Mental Status (BIMS) scored Resident #110 at 15, indicating no impairment. A review of Resident #110's medical record was conducted on 10/17/18. It was noted that Resident #110 was sent to the hospital on 08/23/18. No documentation of what was sent with Resident #110 to the hospital was found in the clinical record. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if the physician documents the reason and necessity for residents' hospital transfers. LPN #1 stated, "It should be when they come in and do their physician note. They should. I have seen where the physician has come in and done a note on them." When asked if nurses provide hospital staff with residents' comprehensive care plan goals when residents are transferred to the hospital, LPN #1 stated, "No. Not that I'm aware of." On 10/18/18 at 11:11 a.m., an interview was conducted with ASM (Administrative Staff Member) #2, the Director of Nursing. ASM #2 was asked if the physician documents the reason and necessity for residents' hospital transfers. ASM #2, stated, "I don't think so." ASM #2 also confirmed residents' comprehensive care plan goals are not provided to hospital staff when residents are transferred to the hospital.	F 622		

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F 622	Continued From page 31 The Administrator ASM (Administrative Staff Member) #1 and ASM #2, the Director of Nursing were informed of the findings at the end of day meeting on 10/18/18. No further documentation was provided.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		

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F 623	Continued From page 32 be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F 623	F623 1. The facility has noted that it did not send a written notification to resident #94, #7, #109, #62, #74, and #110s' representative when they transferred to a hospital. 2. All residents discharged to the hospital have the potential to be affected by the deficient practice. Unplanned discharges will be reviewed over the past 7 days to ensure a written notice is sent to the residents' representatives when they transfer to the hospital. 3. The Administrator, or designee will re-educate the social services department on the Emergency Transfer to Acute Care Hospital policy. 4. Unplanned discharges will be reviewed during the clinical start up meeting daily for three months to ensure a written notice was sent to the residents' representatives upon hospital transfers. Findings will be reported to the QA committee.	

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F 623	Continued From page 33 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide the required written notification to the resident representative and/or ombudsman upon hospital transfer for six of 38 residents in the survey sample; Residents #94, #7, #109, #62, #74, and #110. 1. The facility staff failed to evidence that written notification was provided to Resident #94's resident representative for a hospital transfer on 9/1/18 and 9/12/18.	F 623	5. November 19, 2018	

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F 623	Continued From page 34 2. The facility staff failed to evidence that written notification was provided to Resident #7's resident representative for a hospital transfer on 9/4/18, 9/10/18, 9/15/18, and 10/2/18. 3. The facility staff failed to evidence documentation of written notification to the responsible representative for a facility initiated transfer to the hospital for Resident #109 on 9/20/18. 4. The facility staff failed to evidence documentation of written notification to the responsible representative and written notification of the ombudsman of a facility initiated transfer to the hospital for Resident #62 on 8/21/18. 5. Resident #74 was transferred to the hospital on 9/6/18. The facility staff failed to provide written notification of the facility-initiated transferred to Resident #74's representative. 6. The facility staff failed to evidence documentation of written notification to the responsible representative for a facility initiated transfer to the hospital for Resident #110 on 08/23/18 The findings include: 1. The facility staff failed to evidence that written notification was provided to Resident #94's resident representative for a hospital transfer on 9/1/18 and 9/12/18. Resident #94 was admitted on 4/30/18 and readmitted on 9/19/18 with the diagnoses of but not limited to stroke, subdural hemorrhage,	F 623		

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F 623	Continued From page 35	F 623		

aphasia, dysphagia, pressure ulcer, atrial fibrillation, depression, dementia, anxiety disorder, aortic valve stenosis, chronic kidney disease, duodenal ulcer, alcohol dependence, heart failure, epilepsy, and diabetes. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 9/26/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 9/1/18 that documented Resident #94 was transferred to the emergency room. Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer.

A review of the clinical record revealed a nurse's note dated 9/13/18 that documented in part, "0620 (6:20 a.m.) Resident sent to (name of hospital) for further evaluation. DON [director of nursing], RP [responsible party], and MD [medical doctor] notified." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer.

On 10/17 at 4:42 p.m., in an interview with OSM #4 (Other Staff Member) Director of Social Services, she stated that she has no role in notifying the family of hospital transfers. OSM #4 stated that she does not follow up with a written notice.

A review of the facility policy "Notification of Discharge" documented, "Unplanned/emergent discharges initiated by the facility: *When a

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F 623	Continued From page 36 resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provide to the resident and resident representative as soon as practicable. *When possible, provide the Discharge notice with the paperwork that accompanies the patient to the hospital. *If not possible, issue the notice to a responsible party/representative as soon as practicable following the hospital transfer and document in the medical record. *Notices for emergency transfers may be recorded as a list and sent to the State Ombudsman monthly as per the regulation referenced above. Resident initiated transfers/discharges: *The center is not required to issue a discharge notice when the resident/patient/representative initiated the discharge (i.e. AMA or without proper notice to the center to adequately plan for discharge, or resident sets an earlier discharge date than recommended.)...." A review of the facility policy, "Emergency Transfer to Acute Care Hospital" documented, "Purpose: To provide a prompt, smooth transfer to an Acute Care Hospital to receive necessary care that is unavailable at the long-term care facility and to provide brief, accurate transfer information. Policy: 1. The decision to transfer a resident to an acute care hospital is made by the attending physician, nurse practitioner, Medical Director or the director of Nursing or Charge Nurse (in the absence of the attending physician, nurse practitioner, or Medical Director). 2. The family or Responsible Party must be notified. 3. The Emergency Transfer form and designated copies must be completed and must accompany the resident to the hospital. Procedure: 1. Obtain	F 623		

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F 623	Continued From page 37 an order to transfer the resident. 2. Call ambulance for emergency (911). 3. Notify the family or Responsible Party. 4. Complete the Emergency Transfer form from the EMR. 5. The original Emergency Transfer form must accompany the resident to the Acute Care Hospital. A copy must be maintained on the medical Record at the facility. 6. The resident's DDNR must accompany the resident." On 10/18/18 at 12:08 p.m., ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to evidence that written notification was provided to Resident #7's resident representative for a hospital transfer on 9/4/18, 9/10/18, 9/15/18, and 10/2/18. Resident #7 was admitted to the facility on 2/9/18 with the diagnoses of but not limited to chronic obstructive pulmonary disease, pneumonia, laceration of scalp, dysphagia, viral hepatitis C, inguinal hernia, polyneuropathy, mood disorder, depression, insomnia, diabetes, high blood pressure, and prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/2/18. The resident was coded as being mildly impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 9/4/18 that documented in part, "Received new order to send patient to the E/R	F 623		

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	495388	A. BUILDING _____ B. WING _____	C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 38 (emergency room) for evaluation. RP (responsible party) notified. Resident was sent to the ER via (transport company)." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer. A nurse's note dated 9/10/18 that documented, "while writer was making rounds she went into room (number) ask {sic} resident how was he doing stated he has blood in his colostomy. Writer removed his colostomy bag and observed it was full bright red blood. Vitals 90/60-98%-16-104 (blood pressure-oxygen saturation-respiratory rate-heart rate) informed afternoon supervisor, called 911 resident left on stretcher to (hospital)." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer. A nurse's note dated 9/15/18 documented in part, "... informed supervisor of resident bleeding from stoma into his gastrostomy bag, resident became concerned and requested to go back to the hospital. ems (Emergency Medical Services) service was called resident {sic} call {sic} family member and left message. resident {sic} left phone and charger at hospital. ems arrived between 9-9.30 {sic} resident left on stretcher to (hospital) spoke with (staff) and gave report." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer. A nurses note dated 10/2/18, documented in part, "Resident was heard from the hallway yelling,	F 623		

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F 623	Continued From page 39 "help, help, help." This writer quickly rushed in and observed resident lying on the floor on his left side with his face facing his wardrobe, and bleeding profusely from his mouth and his nose. The writer called other nursing staff for help. The 911-emergency call was initiated, and they arrived in no time and the resident was rushed to the R/E {sic} for evaluation at this time." "Resident alert, verbal and conscious at this MD (medical doctor), NP (nurse practitioner and RP (responsible party) notified." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer. On 10/17 at 4:42 p.m., in an interview with OSM #4 (Other Staff Member) Director of Social Services, she stated that she has no role in notifying the family of hospital transfers. OSM #4 stated that she does not follow up with a written notice. On 10/18/18 at 12:08 p.m., ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to evidence documentation of written notification to the responsible representative for a facility initiated transfer to the hospital for Resident #109 on 9/20/18. Resident #109 was admitted to the facility on 11/11/16 with a recent readmission on 9/25/18, with diagnoses that included but were not limited to: stroke, heart attack, COPD [general term for	F 623		

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F 623	Continued From page 40 chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. (1)], diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change/Medicare 5 day assessment, with an assessment reference date of 10/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The nurse's note dated, 9/20/18 at 9:46 p.m. documented, "Dinner time at 17:49 hours (5:49 p.m.) patient was noted unresponsive by CNA (certified nursing assistant) and called out for nurse. nurse was assessed and was noted verbally unresponsive. nurse could not arouse patient. patient was tapped on her back and shoulder several times but could not respond to tactile stimuli. Md (medical doctor) made aware. Md directed nurse to contact Rp (responsible party) as to what she wants to be the next step. patient daughter was notified of patient's condition. Rp instructed nurse to wait for an hour for her to get to facility and assess patient's condition and make decision as she is a DNR (do not resuscitate) code status. Ten minutes later Rp called and instructed nurse to send pt (patient) to ER (emergency room). EMS (emergency medical services) was called and at 19:04 (7:04 p.m.) patient was transported to (Name of hospital) medical center for further eval (evaluation). V/s (vital signs) 102/52 (blood pressure), p (pulse) = 65, R (respirations) = 17, Temp (temperature) = 93 AX (axillary)." This paragraph is typed exactly as written.	F 623		

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GAINESVILLE HEALTH AND REHAB CENTER	7601 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

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F 623	Continued From page 41 The physician order dated 9/21/18, documented, "Send to ER for evaluation." The "Nursing Home to Hospital Transfer Form" dated 9/20/18 documented in part, the resident's name, responsible party contact information, the physician information, the facility contact information, allergies, code status and change in mental status. The Section, "Primary Goals of Care at Time of Transfer" documented a mark next to "Rehabilitation and/or Medical Therapy with intent of returning home." The box next to "Chronic long-term care." was not checked. Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses notify residents' representatives when residents are transferred to the hospital. LPN #1 stated nurses contact residents' representatives via phone. When asked if nurses provide residents' representatives written notification of hospital transfers, LPN #1 stated, "That I would have to look into. Normally we contact via phone call." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 10/17/18 at 6:25 p.m. No further information was provided by the end of the survey. 4. The facility staff failed to evidence	F 623		

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F 623	Continued From page 42 documentation of written notification to the responsible representative and written notification of the ombudsman of a facility initiated transfer to the hospital for Resident #62 on 8/21/18. Resident #62 was admitted to the facility on 8/10/18, with a recent readmission on 8/28/18 with diagnoses that included but were not limited to: pneumonia, anxiety disorder, depression, difficulty sleeping, legally blind, high blood pressure and urinary tract infections. The most recent MDS (minimum data set) assessment a Medicare 14 day assessment, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making her daily cognitive decisions. The nurse's note dated, 8/21/18 at 9:26 a.m. documented, "Resident had significant change in condition. approval obtained from (Name of doctor) to send out via EMS (emergency medical services) to (name of hospital) ED (emergency department) for Altered Mental Status. Vitals obtained: BP (blood pressure) 174/84, P (pulse) 89, PO2 (Oxygen saturation) 93%, T (temperature) 100.4. RP (responsible party) notified. Resident transported via stretcher accompanied by multiple EMS techs (technicians)." The "Nursing Home to Hospital Transfer Form" dated, 8/21/18 at 8:42 a.m., documented in part, the resident's name, responsible party contact information, the physician information, the facility contact information, allergies, code status and change in mental status. The Section, "Primary Goals of Care at Time of Transfer" documented a	F 623		

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F 623	Continued From page 43 mark next to "Chronic Long Term Care." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer or notification to the ombudsman. On 10/17/18 at 4:42 p.m., an interview was conducted with OSM (other staff member) #4 (the director of social services). OSM #4 stated her role is to send the ombudsman notification of residents transferred to the hospital and of planned discharges. OSM #4 stated she went to a training and it was made clear then that she is supposed to notify the ombudsman of hospital transfers. OSM #4 stated she started these notifications for residents transferred to the hospital in September 2018. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses notify residents' representatives when residents are transferred to the hospital. LPN #1 stated nurses contact residents' representatives via phone. When asked if nurses provide residents' representatives written notification of hospital transfers, LPN #1 stated, "That I would have to look into. Normally we contact via phone call." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 10/17/18 at 6:25 p.m. 5. Resident #74 was transferred to the hospital on 9/6/18. The facility staff failed to provide written notification of the facility-initiated transferred to Resident #74's representative. Resident #74 was admitted to the facility on	F 623		

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F 623	Continued From page 44 8/18/17. Resident #74's diagnoses included but were not limited to dementia, diabetes and osteoporosis. Resident #74's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/17/18, coded the resident's cognition as severely impaired. Review of Resident #74's clinical record revealed the resident was transferred to the hospital on 9/6/18 due to a fall and left upper thigh pain. A nurse's note dated 9/6/18 documented Resident #74's family was notified and made aware. Further review of Resident #74's clinical record failed to reveal written notification of the transfer was provided to the resident's representative. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who documented the 9/6/18 note). LPN #1 was asked if nurses notify residents' representatives when residents are transferred to the hospital. LPN #1 stated nurses contact residents' representatives via phone. When asked if nurses provide residents' representatives written notification of hospital transfers, LPN #1 stated, "That I would have to look into. Normally we contact via phone call." On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 6. The facility staff failed to evidence documentation of written notification to the	F 623		

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F 623	Continued From page 45 responsible representative for a facility initiated transfer to the hospital for Resident #110 on 08/23/18 Resident #110 was admitted on 06/06/18. Resident #110's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disorder (COPD), Osteomyelitis, Epilepsy, Bipolar Disorder, and Major Depressive Disorder. Resident #110 required supervision of 1 staff member for bathing, and was independent in all other Activities of Daily Living (ADLs). The most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 09/26/18. The Brief Interview for Mental Status (BIMS) scored Resident #110 at 15, indicating no impairment. A review of Resident #110's medical record was conducted on 10/17/18. It was noted that Resident #110 was sent to the hospital on 08/23/18. A Progress Note dated 08/23/18 stated: "Resident was transferred to [HOSPITAL] @ [at] 1800 [6:00 p.m.] via stretcher. Resident vitals Temp. [temperature] 101.4, BP [blood pressure] 110/81, HR [heart rate] 114, R [respirations] 20, O2 [oxygen saturation - level of oxygen in the blood] 94. Resident was given Tylenol @ 1614 to reduce fever 102.9 and @ 1730 Temp. was 101.4. Resident reported L [left] arm and rib pain. She had swollen, reddened hard mass on upper left back. There was minimal drainage (less than 10 ml [milliliter]) in JP [Jackson-Pratt] drain. JP tubing was dislodged and stitches holding JP tube in place was detached from back. MD [medical doctor] and NP [nurse practitioner] aware." Further review of Resident #110's clinical record failed to reveal written notification of the transfer	F 623		

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F 623	Continued From page 46 was provided to the resident's representative. On 10/17/18 at 4:42 p.m., in an interview with OSM #4 (Other Staff Member) Director of Social Services, she stated that she has no role in notifying the family of hospital transfers. OSM #4 stated that she does not follow up with a written notice. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses notify residents' representatives when residents are transferred to the hospital. LPN #1 stated nurses contact residents' representatives via phone. When asked if nurses provide residents' representatives written notification of hospital transfers, LPN #1 stated, "That I would have to look into. Normally we contact via phone call." The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 10/18/18. No further documentation was provided.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		

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F 625	Continued From page 47 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide a written bed hold policy/notification to the resident and/or resident representative, within 24 hours of a transfer to the hospital for 6 of 38 residents in the survey sample; Residents #94, #7, #109, #62, #74, and #110. 1. The facility staff failed to evidence that written bed hold notification was provided to Resident #94's resident representative for a hospital transfer on 9/1/18 and 9/12/18. 2. The facility staff failed to evidence that written bed hold notification was provided to Resident #7's resident representative for a hospital transfer on 9/4/18, 9/10/18, 9/15/18, and 10/2/18. 3. The facility staff failed to evidence a written bed	F 625	F625 1. The facility has noted that it did not send a bed hold policy to resident #94, #7, #109, #62, #74, and #110 within 24 hours of discharge. Resident #109, #74, and #110 have returned to the facility. 2. All residents discharged to the hospital have the potential to be affected by the deficient practice. Unplanned discharges and leave of absences will be reviewed over the past 7 days to ensure the bed hold policy is given to residents leaving the facility. 3. The ADON, or designee, will re-educate licensed nurses and the admissions department on the bed hold policy. 4. Residents on a leave of absence and residents who have transferred to the hospital will be reviewed during clinical meeting daily for three months to ensure a bed hold policy has been given to them. Findings will be reported to the QA committee.	

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F 625	Continued From page 48 hold policy was provided to the resident and/or resident representative upon transfer to the hospital on 9/20/18 for Resident 109. 4. The facility staff failed to evidence a written bed hold policy was provided to the resident and/or resident representative upon transfer to the hospital on 8/21/18 for Resident #62. 5. The facility staff failed to provide Resident #74's representative written notification of the bed hold policy when the resident was discharged to the hospital on 9/6/18. 6. The facility staff failed to evidence a written bed hold policy was provided to the resident and/or resident representative upon transfer to the hospital on 08/23/18 for Resident 110. The findings include: 1. The facility staff failed to evidence that written bed hold notification was provided to Resident #94's resident representative for a hospital transfer on 9/1/18 and 9/12/18. Resident #94 was admitted on 4/30/18 and readmitted on 9/19/18 with the diagnoses of but not limited to stroke, subdural hemorrhage, aphasia, dysphagia, pressure ulcer, atrial fibrillation, depression, dementia, anxiety disorder, aortic valve stenosis, chronic kidney disease, duodenal ulcer, alcohol dependence, heart failure, epilepsy, and diabetes. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 9/26/18. The resident was coded as severely cognitively	F 625	5. November 19 2018	

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F 625	Continued From page 49 impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 9/1/18 that documented Resident #94 was transferred to the emergency room. Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer. Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification upon the hospital transfer. A review of the clinical record revealed a nurse's note dated 9/13/18 that documented in part, "0620 (6:20 a.m.) Resident sent to (name of hospital) for further evaluation. DON [director of nursing], RP [responsible party], and MD [medical doctor] notified." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification upon the hospital transfer. On 10/17/18 at 4:28 p.m., an interview was conducted with OSM #3 (Other Staff Member) the Admissions Assistant. OSM #3 stated that residents are provided with bed hold information upon admission, but that when they go to the hospital, she calls the family and asks if they want a bed hold but that she does not provide them with a written bed hold notice at that time. On 10/17/18 at 5:18 p.m., in an interview with LPN #1 (Licensed Practical Nurse), when asked if staff provides a copy of the written bed hold form when a resident is sent to the hospital, she stated that they do not include bed hold form.	F 625		

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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 625	Continued From page 50 A review of the facility policy "Notice of Bed Hold Policy" documented, "Policy: If a Resident is hospitalized, Medicaid and Medicare do not pay to hold the Resident's bed. If the Resident and/or his or her Responsible Party wish to hold the bed the Resident and/or Responsible Party will be responsible for charges to "hold" the bed at the published rate per day. All residents and their families must be informed that they have the right to be re-admitted at the time of the next available vacancy following the resident's discharge from the hospital. This information must be read and signed by the resident or his/her relative. Families may elect to reserve the bed while the recipient is hospitalized, but the facility cannot require that the bed be held. This applies to residents that are actually admitted to the hospital by a physician....Procedure: Nursing Services is responsible for:....2. Showing policy to resident BEFORE the resident goes to the hospital or out on therapeutic leave...." On 10/18/18 at 12:08 p.m., ASM #1 (Administrative Staff Member) the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to evidence that written bed hold notification was provided to Resident #7's resident representative for a hospital transfer on 9/4/18, 9/10/18, 9/15/18, and 10/2/18. Resident #7 was admitted to the facility on 2/9/18 with the diagnoses of but not limited to chronic obstructive pulmonary disease, pneumonia, laceration of scalp, dysphagia, viral hepatitis C,	F 625		

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F 625	Continued From page 51 inguinal hernia, polyneuropathy, mood disorder, depression, insomnia, diabetes, high blood pressure, and prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/2/18. The resident was coded as being mildly impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 9/4/18 that documented in part, "Received new order to send patient to the E/R (emergency room) for evaluation. RP (responsible party) notified. Resident was sent to the ER via (transport company)." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification upon the hospital transfer. A nurse's note dated 9/10/18 that documented, "while writer was making rounds she went into room (number) ask (sic) resident how was he doing stated he has blood in his colostomy. Writer removed his colostomy bag and observed it was full bright red blood. Vitals 90/60-98%-16-104 (blood pressure-oxygen saturation-respiratory rate-heart rate) informed afternoon supervisor, called 911 resident left on stretcher to (hospital)." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification upon the hospital transfer. A nurse's note dated 9/15/18 documented in part, "... informed supervisor of resident bleeding from stoma into his gastrostomy bag, resident became	F 625		

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F 625	Continued From page 52 concerned and requested to go back to the hospital. ems (Emergency Medical Services) service was called resident (sic) call (sic) family member and left message. resident (sic) left phone and charger at hospital. ems arrived between 9-9.30 (sic) resident left on stretcher to (hospital) spoke with (staff) and gave report." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification upon the hospital transfer. A nurses note dated 10/2/18, documented in part, "Resident was heard from the hallway yelling, "help, help, help." This writer quickly rushed in and observed resident lying on the floor on his left side with his face facing his wardrobe, and bleeding profusely from his mouth and his nose. The writer called other nursing staff for help. The 911-emergency call was initiated, and they arrived in no time and the resident was rushed to the R/E (sic) for evaluation at this time." "Resident alert, verbal and conscious at this MD (medical doctor), NP (nurse practitioner and RP (responsible party) notified." Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification upon the hospital transfer. On 10/17/18 at 4:28 p.m., an interview was conducted with OSM #3 (Other Staff Member) the Admissions Assistant. OSM #3 stated that residents are provided with bed hold information upon admission, but that when they go to the hospital, she calls the family and asks if they want a bed hold but that she does not provide them with a written bed hold notice at that time.	F 625		

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F 625	Continued From page 53 On 10/17/18 at 5:18 p.m., in an interview with LPN #1 (Licensed Practical Nurse), when asked if staff provides a copy of the written bed hold form when a resident is sent to the hospital, she stated that they do not include bed hold form. 3. The facility staff failed to evidence documentation of a written bed hold policy provided to the resident and/or resident representative upon transfer to the hospital on 9/20/18 for Resident 109. Resident #109 was admitted to the facility on 11/11/16 with a recent readmission on 9/25/18, with diagnoses that included but were not limited to: stroke, heart attack, COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. (1)], diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change/Medicare 5 day assessment, with an assessment reference date of 10/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The nurse's note dated, 9/20/18 at 9:46 p.m. documented, "Dinner time at 17:49 hours (5:49 p.m.) patient was noted unresponsive by CNA (certified nursing assistant) and called out for nurse. nurse was assessed and was noted verbally unresponsive. nurse could not arouse patient. patient was tapped on her back and shoulder several times but could not respond to tactile stimuli. Md (medical doctor) made aware.	F 625		

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F 625	Continued From page 54 Md directed nurse to contact Rp (responsible party) as to what she wants to be the next step. patient daughter was notified of patient's condition. Rp instructed nurse to wait for an hour for her to get to facility and assess patient's condition and make decision as she is a DNR (do not resuscitate) code status. Ten minutes later Rp called and instructed nurse to send pt (patient) to ER (emergency room). EMS (emergency medical services) was called and at 19:04 (7:04 p.m.) patient was transported to (Name of hospital) medical center for further eval (evaluation). V/s (vital signs) 102/52 (blood pressure), p (pulse) = 65, R (respirations) = 17, Temp (temperature) = 93 AX (axillary)." This paragraph is typed exactly as written. The physician order dated 9/21/18, documented, "Send to ER for evaluation." The "Nursing Home to Hospital Transfer Form" dated 9/20/18 documented in part, the resident's name, responsible party contact information, the physician information, the facility contact information, allergies, code status and change in mental status. The Section, "Primary Goals of Care at Time of Transfer" documented a mark next to "Rehabilitation and/or Medical Therapy with intent of returning home." The box next to "Chronic long-term care." was not checked. Further review of the clinical record failed to reveal any evidence that the resident or resident representative was provided with written bed hold notification upon the hospital transfer. On 10/17/18 at 4:27 p.m., an interview was conducted with OSM (other staff member) #3 (the admissions assistant). When asked if residents' representatives are provided information	F 625		

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F 625	Continued From page 55 regarding the bed hold policy when residents are discharged to the hospital, OSM #3 stated, "Every resident comes in and will sign an admission agreement with us. It shows the bed hold policy for Medicaid residents; then when they go out to the hospital, the next day I follow up with a phone call with the family to offer the bed hold." OSM #3 stated she documents whether or not residents' representatives accept the bed hold on a tracker on her census page. When asked if she provides written information regarding the bed hold policy when a resident is discharged to the hospital, OSM #3 stated she does not. On 10/17/18 at 5:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses do not provide bed hold information to residents' representatives when residents are discharged to the hospital. Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 10/17/18 at 6:25 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 4. The facility staff failed to evidence documentation of a written bed hold policy provided to the resident and/or resident representative upon transfer to the hospital on 8/21/18 for Resident #62. Resident #62 was admitted to the facility on 8/10/18, with a recent readmission on 8/28/18	F 625		

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F 625	Continued From page 56 with diagnoses that included but were not limited to: pneumonia, anxiety disorder, depression, difficulty sleeping, legally blind, high blood pressure and urinary tract infections. The most recent MDS (minimum data set) assessment a Medicare 14 day assessment, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making her daily cognitive decisions. The resident was coded as requiring supervision to requiring extensive assistance for her activities of daily living. The nurse's note dated, 8/21/18 at 9:26 a.m. documented, "Resident had significant change in condition. approval obtained from (Name of doctor) to send out via EMS (emergency medical services) to (name of hospital) ED (emergency department) for Altered Mental Status. Vitals obtained: BP (blood pressure) 174/84, P (pulse) 89, PO2 (Oxygen saturation) 93%, T (temperature) 100.4. RP (responsible party) notified. Resident transported via stretcher accompanied by multiple EMS techs (technicians)." The "Nursing Home to Hospital Transfer Form" dated, 8/21/18 at 8:42 a.m., documented in part, the resident's name, responsible party contact information, the physician information, the facility contact information, allergies, code status and change in mental status. The Section, "Primary Goals of Care at Time of Transfer" documented a mark next to "Chronic Long Term Care." Further review of the clinical record failed to reveal any evidence that the resident or resident representative was provided with written bed hold notification upon the hospital transfer.	F 625		

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F 625	Continued From page 57 On 10/17/18 at 4:27 p.m., an interview was conducted with OSM (other staff member) #3 (the admissions assistant). When asked if residents' representatives are provided information regarding the bed hold policy when residents are discharged to the hospital, OSM #3 stated, "Every resident comes in and will sign an admission agreement with us. It shows the bed hold policy for Medicaid residents; then when they go out to the hospital, the next day I follow up with a phone call with the family to offer the bed hold." OSM #3 stated she documents whether or not residents' representatives accept the bed hold on a tracker on her census page. When asked if she provides written information regarding the bed hold policy when a resident is discharged to the hospital, OSM #3 stated she does not. On 10/17/18 at 5:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses do not provide bed hold information to residents' representatives when residents are discharged to the hospital. Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 10/17/18 at 6:25 p.m. No further information was provided prior to exit. 5. The facility staff failed to provide Resident #74's representative written notification of the bed hold policy when the resident was discharged to the hospital on 9/6/18. Resident #74 was admitted to the facility on 8/18/17. Resident #74's diagnoses included but	F 625		

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F 625	Continued From page 58 were not limited to dementia, diabetes and osteoporosis. Resident #74's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/17/18, coded the resident's cognition as severely impaired. Review of Resident #74's clinical record revealed the resident was discharged to the hospital on 9/6/18 due to a fall and left upper thigh pain. Further review of Resident #74's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #74's representative when the resident was discharged. On 10/17/18 at 4:27 p.m., an interview was conducted with OSM (other staff member) #3 (the admissions assistant). When asked if residents' representatives are provided information regarding the bed hold policy when residents are discharged to the hospital, OSM #3 stated, "Every resident comes in and will sign an admission agreement with us. It shows the bed hold policy for Medicaid residents; then when they go out to the hospital, the next day I follow up with a phone call with the family to offer the bed hold." OSM #3 stated she documents whether or not residents' representatives accept the bed hold on a tracker on her census page. When asked if she provides written information regarding the bed hold policy when a resident is discharged to the hospital, OSM #3 stated she does not. On 10/17/18 at 5:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses do not provide bed hold information to residents' representatives when residents are discharged to the hospital.	F 625		

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F 625	Continued From page 59 On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 6. The facility staff failed to evidence documentation of a written bed hold policy provided to the resident and/or resident representative upon transfer to the hospital on 08/23/18 for Resident 110. Resident #110 was admitted on 06/06/18. Their most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 09/26/18. The Brief Interview for Mental Status (BIMS) scored Resident #110 at 15, indicating no impairment. Resident #110's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disorder (COPD), Osteomyelitis, Epilepsy, Bipolar Disorder, and Major Depressive Disorder. Resident #110 required supervision of 1 staff member for bathing, and was independent in all other Activities of Daily Living (ADLs). A review of Resident #110's medical record was conducted on 10/17/18. It was noted that Resident #110 was sent to the hospital on 08/23/18. A Progress Note dated 08/23/18 stated: "Resident was transferred to [HOSPITAL] @ [at] 1800 [6:00 p.m.] via stretcher. Resident vitals Temp. [temperature] 101.4, BP [blood pressure]	F 625		

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F 625	Continued From page 60 110/81, HR [heart rate] 114, R [respirations] 20, O2 [oxygen saturation - level of oxygen in the blood] 94. Resident was given Tylenol @ 1614 to reduce fever 102.9 and @ 1730 Temp. was 101.4. Resident reported L [left] arm and rib pain. She had swollen, reddened hard mass on upper left back. There was minimal drainage (less than 10 ml [milliliter]) in JP [Jackson-Pratt] drain. JP tubing was dislodged and stitches holding JP tube in place was detached from back. MD [medical doctor] and NP [nurse practitioner] aware." No documentation of what was sent with Resident #110 to the hospital was found in the clinical record. On 10/17/18 at 4:27 p.m., an interview was conducted with OSM (other staff member) #3 (the admissions assistant). When asked if residents' representatives are provided information regarding the bed hold policy when residents are discharged to the hospital, OSM #3 stated, "Every resident comes in and will sign an admission agreement with us. It shows the bed hold policy for Medicaid residents; then when they go out to the hospital, the next day I follow up with a phone call with the family to offer the bed hold." OSM #3 stated she documents whether or not residents' representatives accept the bed hold on a tracker on her census page. When asked if she provides written information regarding the bed hold policy when a resident is discharged to the hospital, OSM #3 stated she does not. On 10/17/18 at 5:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses do not provide bed hold information to residents' representatives when residents are discharged to the hospital.	F 625		

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F 625	Continued From page 61 The Administrator, ASM (administrative staff member) #1 and ASM #2, the Director of Nursing were informed of the findings at the end of day meeting on 10/18/18. No further documentation was provided.	F 625		
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 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	F 656		

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F 656	Continued From page 62 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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for two of 38 residents in the survey sample, Residents #109 and Resident #74. 1. The facility staff failed to implement Resident #109's comprehensive care plan for administering medication per the physician order. 2. The facility staff failed to implement Resident #74's comprehensive care plan for the observation of target behaviors related to the use of antipsychotic medication from 9/10/18 through 10/16/18. The findings include: 1. The facility staff failed to implement Resident #109's comprehensive care plan for administering medication per the physician order. Resident #109 was admitted to the facility on 11/11/16 with a recent readmission on 9/25/18, with diagnoses that included but were not limited	F 656	F656 1. The care plans for residents #74 and #109 have been updated regarding administration of medications. 2. All residents have the potential to be affected by this deficient practice. MDS and nursing will review care plans to ensure there are measurable goals and interventions based on the resident/patient orders and primary diagnosis. 3. The DON, or designee, will re-educate licensed nursing staff on care planning, medication administration with applied parameters, documentation when withholding medications and documentation of behavior monitoring.	

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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 656	Continued From page 63 to: stroke, heart attack, COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. (1)], diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change/Medicare 5 day assessment, with an assessment reference date of 10/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for her activities of daily living. The comprehensive care plan dated, 11/22/16 and revised on 10/9/18 documented in part, "Focus: (Resident #109) has coronary artery disease which impacts tolerance to activity and overall quality of life r/t (related to) hyperlipidemia (elevated fats in the bloodstream) and Hypertension (high blood pressure)." The "Interventions/Tasks" documented in part, "Give all meds (medications) as ordered by the physician. Observe for side effects. Report adverse reactions to MD (medical doctor). Take blood pressures ordered or indicated by s/s (signs/symptoms). Notify physician of any abnormal findings." The physician order dated, 9/25/18, documented, "Metoprolol Tartrate Tablet [used to treat high blood pressure and heart failure. (2)] 25 mg (milligrams); Give 2 tablet by mouth two times a day for HTN (high blood pressure), hold for HR (heart rate) < (less than) 60 or SBP (systolic blood pressure) < 115."	F 656	4. The DON, or designee, including MDS, will review new admissions at daily clinical meeting to ensure appropriate comprehensive care plans have been initiated and align with MD orders, patient primary diagnosis and condition. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 656	Continued From page 64 The October 2018 MAR (medication administration record) documented the above medication orders. The MAR documented the blood pressures on the following dates when the Metoprolol was documented as administered: 10/2/18 at 8:00 p.m. - 111/67 10/4/18 at 8:00 p.m. - 109/64 10/10/18 at 8:00 a.m. - 112/63 10/11/18 at 8:00 a.m. --108/50 10/14/18 at 8:00 a.m. - 113/68 Review of the nurse's notes failed to evidence documentation of holding the medication or any documentation of why it was administered when the blood pressure was below the physician ordered parameters for administration. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of a care plan. LPN #1 stated a care plan is like a preventative intervention and to set goals. LPN #1 stated a care plan is like a diary to tell staff what is going on with residents' activities of daily living. When asked how the staff ensures care plans are followed, LPN #1 stated nurses can go into the computer and pull up care plans and CNAs (certified nursing assistants) can ask their nurses any questions regarding the care plans. An interview was conducted with LPN (licensed practical nurse) #5, one of the nurses who administered the medication when the blood pressure was below the physician prescribed parameters; on 10/18/18 at 10:51 a.m., LPN #5 was asked to review the above physician order for Metoprolol. The MAR for October was	F 656		

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F 656	Continued From page 65 reviewed with LPN #5. When asked if the medication should have been administered on the above documented times and dates, LPN #5 stated, "No." When asked if this was following the physician order, LPN #5 stated, "No, Ma'am, it is not." The facility policy, "Comprehensive Care Planning Process" documented in part, "The facility must develop a comprehensive care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. An interdisciplinary assessment team shall develop a comprehensive assessment and care plan for each resident based on outcomes of assessments and input from the resident, family and interdisciplinary team members. The team serves as the authority for overseeing resident care services." "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care. (3) Administrative staff member (ASM) # 2, the director of nursing, was made aware of the above concerns on 10/18/18 at 11:20 a.m. ASM #1, the administrator, and ASM # 3, the regional director of operations, were made aware of the above concern on 10/18/18 at 11:43 a.m. No further information was provided prior to exit.	F 656		

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details
(3) Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77.

2. The facility staff failed to implement Resident #74's care plan for the observation of target behaviors related to the use of antipsychotic medication from 9/10/18 through 10/16/18.

Resident #74 was admitted to the facility on 8/18/17. Resident #74's diagnoses included but were not limited to dementia, diabetes and osteoporosis. Resident #74's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/17/18, coded the resident's cognition as severely impaired. Section N coded Resident #74 as having received antipsychotic medication seven out of the last seven days.

Resident #74's comprehensive care plan initiated on 9/7/17 documented, "(Name of Resident #74) is prescribed psychotropic medications r/t (related to) Anxiety, Insomnia, Depression, Restlessness/Agitation, Appetite and Psychosis...Observe target behaviors for decrease or escalation that may indicate need for medication review..."

Review of Resident #74's clinical record revealed a physician's order with a start date of 5/25/18 for

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F 656	Continued From page 67 Seroquel (1) 25mg (milligrams) by mouth at bedtime for psychosis. Review of Resident #74's September 2018 MAR (medication administration record) revealed the resident was administered Seroquel 25mg from 9/1/18 until the resident was discharged to the hospital on 9/6/18. Further review of Resident #74's September 2018 MAR from 9/1/18 until Resident #74's discharge to the hospital on 9/6/18 revealed the following documentation, "BEHAVIORS- MONITOR FOR THE FOLLOWING: SADNESS, ANXIETY, LOSS OF INTERER (sic), AGITATION, RESTLESSNESS. Document 'Y' if monitored and resident is free of above. 'N' if monitored and resident is not free from above, select chart code 'Other/See Nurses Notes' and must document findings. every shift." Resident #74's behaviors were documented as being monitored each shift from 9/1/18 until 9/6/18. Resident #74 was readmitted to the facility on 9/10/18. Review of Resident #74's clinical record revealed a physician's order dated 9/10/18 for Seroquel 25mg by mouth at bedtime. Review of Resident #74's September 2018 and October 2018 MARs revealed the resident was administered Seroquel 25mg from 9/10/18 through 10/16/18. Further review of Resident #74's September 2018/October 2018 MARs and nurses' notes failed to reveal documentation of behavior monitoring. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of a care plan. LPN #1 stated a care plan is like a preventative intervention and to set goals. LPN #1 stated a care plan is like a diary to tell staff what is going	F 656		

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F 656	Continued From page 68 on with residents' activities of daily living. When asked how the staff ensures it follows residents' care plans, LPN #1 stated nurses can go into the computer and pull up care plans and CNAs (certified nursing assistants) can ask their nurses any questions regarding the care plans. On 10/18/18 at 9:56 a.m., another interview was conducted with LPN #1. LPN #1 was asked the facility process for behavior monitoring for a resident prescribed an antipsychotic medication. LPN #1 stated, "That is something that is triggered in the MAR. With that medication (Seroquel), it should come up if they are having behaviors. You document yes or no and it should prompt you to write. You can put something in saying: yelling, kicking, hitting." When asked why targeted behaviors should be monitored for residents prescribed antipsychotic medications, LPN #1 stated, "To make sure the medication is working. To see if it is effective, not effective, if we need to look at something else for them. If it's not helping them and causing more agitation they may need something else." On 10/18/18 at 11:11 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. On 10/18/18 at 11:44 a.m., ASM #1 (the administrator) was made aware of the above concern. No further information was presented prior to exit. (1) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking,	F 656		

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F 656	Continued From page 69 loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html	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 observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for four of 38	F 658		

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F 658	Continued From page 70 residents in the survey sample, Resident #103, #53, #3 and #105. 1. The facility staff failed to clarify the physician orders for three different pain medications for Resident #103, to determine which, as needed pain medication should be administered based on pain level parameters to Resident #103. 2. The facility staff failed to clarify physician's orders for two different pain medications for Resident #53, to determine when and which, as needed pain medication should be administered based on pain level parameters. 3. The facility staff failed to clarify Resident #3's conflicting physicians orders for NPO (nothing by mouth) and for oral medications. 4. The facility staff failed to clarify the physician orders for which and when to administer two pain medications (Tramadol and Tylenol) based on pain level parameters for Resident #105. The findings include: 1. The facility staff failed to clarify the physician orders for three different pain medications for Resident #103, to determine which, as needed pain medication should be administered based on pain level parameters to Resident #103. Resident #103 was admitted to the facility on 9/26/18 with diagnoses that included but were not limited to: stroke, high blood pressure, chronic kidney disease, depression, gout [disease in which a defect in uric acid metabolism causes the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints. (1)],	F 658	F658 1. Resident #103 now has parameters for pain medication. Resident #53's pain medication has been clarified and now has parameters for pain. Resident #3's NPO order has been clarified. Resident #105 pain medication now has parameters. 2. All residents have the potential to be affected by this deficient practice. An audit of new orders for the past 7 days will be reviewed to ensure they include parameters when necessary. 3. The DON, or designee, will re-educate the licensed nursing staff on including parameters on necessary orders. 4. The Director of Nursing, or designee, will review new orders in the clinical start up meeting to verify no new orders need clarification for three months. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 658	Continued From page 71 and gastroesophageal reflux disease [GERD - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (2)]. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/3/18, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The physician orders dated, 9/26/18, documented the following pain medication orders: "1. Acetaminophen Tablet [used to treat fever and mild to moderate pain. (3)] 325 MG (milligrams), Give 2 tablets by mouth every 4 hours as needed for pain. 2. Oxycodone ER (extended release) [used to treat moderate to severe pain. (4)] Tablet 12 hour 20 MG. Give 1 tablet every 12 hours as needed for moderate to severe pain. 3. Norco Tablet 5-325 MG (hydrocodone-Acetaminophen) (used to treat moderate to moderately severe pain) (5), Give 1 tablet by mouth every 4 hours as needed for pain, hold for sedation." The September 2018 MAR (medication administration record) documented the above three medication orders. Further review of the September 2018 MAR revealed the following: Acetaminophen was administered on 9/26/18, at 7:46 p.m. for a pain level of "5" for c/o (complaint of) Left knee pain.	F 658		

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F 658	Continued From page 72 Norco Tablet was administered on 9/27/18, at 6:16 p.m. for a pain level of "5" for c/o left knee pain. Norco Tablet was administered on 9/28/18 at 6:13 p.m. for a pain level of "6" for c/o left knee pain. The Oxycodone was not administered in September. The October 2018 MAR documented the above orders for Acetaminophen and Norco and revealed the following: Acetaminophen was not administered. The Norco Tablet was administered on 10/1/18 at 10:24 a.m. for a pain level of "7." There was no documentation of the location of the pain. The Norco Tablet was administered on 10/13/18 at 8:14 p.m. for a pain level of "4." There was no documentation of the location of the pain. The comprehensive care plan dated 9/27/18, documented in part, "Focus: (Resident #103) has pain or potential for pain r/t (related to) osteoarthritis, GERD, GOUT." The "Interventions/Tasks" documented in part, "Administer pain medication as ordered. Report s/s (signs/symptoms) potential negative side effects. Assess pain level q (every) shift and PRN (as needed) and apply interventions as needed. Assist with alternate positioning and other diversional activities to relieve pain. Report break through pain and/or unrelieved pain for further assessment and treatment." An interview was conducted with RN (registered nurse) #2, the unit manager, on 10/18/18 at 8:53 a.m. The above three orders for pain medication were reviewed with RN #2. When asked how the nurse knows when and which one to give, RN #2 stated, "If a resident complains of pain the (the	F 658		

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nurse) needs to look at non-pharmacological interventions such as repositioning, heat, cold application, and distraction. If that doesn't work they should go with the lowest medication, try to stay away from narcotics. If you don't have to give narcotics, we don't. If the pain level is a 1-4, I'd give the Tylenol (Acetaminophen). If it's more moderate on a scale with the pain being 5 -10, I'd give the other medications." The MARs for September and October were reviewed with RN #2. RN #2 stated the staff should have started with the Tylenol but some resident's request which medication they want. When asked if the nurse can make that decision if the physician orders do not have parameters specified in the order and which medication to give based on the parameters, RN #2 stated they (nurses') can go by nursing judgement as to which one to give. When asked if it's in her scope of practice to make that decision, RN #2 stated, "Yes."

According to Lippincott's "Fundamentals of Nursing, 5th edition, page 553 documents the following statement, "Always clarify with the prescriber any medication order that is unclear or seems in appropriate."

Administrative staff member (ASM) # 2, the director of nursing, was made aware of the above concerns on 10/18/18 at 11:20 a.m.

ASM #1, the administrator, and ASM # 3, the regional director of operations, were made aware of the above concern on 10/18/18 at 11:43 a.m.

On 10/18/18 at 12:09 p.m. a request for the policy on clarifying physician orders was requested of ASM #1. At 1:22 p.m. ASM #1 informed the survey team the facility did not have a policy on

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F 658	Continued From page 74 clarifying physician orders. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (3) This information was obtained from the following website: https://livertox.nlm.nih.gov/Acetaminophen.htm. (4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/ (5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details. 2. The facility staff failed to clarify physician's orders for two different pain medications for Resident #53, to determine when and which, as needed pain medication should be administered based on pain level parameters. Resident #53 was admitted to the facility on 8/30/13 with a readmission on 2/23/18, with diagnoses that included but were not limited to: traumatic brain injury, memory deficit following non-traumatic intracerebral hemorrhage (bleeding), depression, high blood pressure, dementia, history of falling, generalized osteoarthritis (Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise) (1).	F 658		

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F 658	Continued From page 75 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/27/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score indicating the resident was moderately impaired to make daily cognitive decisions. Resident #53 was coded as having periods of inattention and disorganized thinking. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living, except eating in which she was independent after set up assistance provided. Resident #53 was coded as only requiring supervision for locomotion on the unit. The physician orders dated, 2/23/18, documented, "Acetaminophen Tablet (used to treat mild to moderate pain and fever) (2) 325 MG (milligrams), Give 2 tablet by mouth every 6 hours as needed for pain. Hydrocodone-Acetaminophen Tablet (used to treat moderate to moderately severe pain) (3) 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for pain." The July 2018 MAR (medication administration record) documented the above two medications. The Acetaminophen was documented as having been given on 7/1/18 at 6:11 p.m. for a pain level of "6." The Hydrocodone - Acetaminophen was documented as having been given on the following dates, times and pain levels: 7/4/18 at 4:54 a.m., pain level - 5 7/9/18 at 3:38 a.m., pain level - 4 7/10/18 at 12:45 a.m. - pain level - 4 7/14/18 at 1:00 p.m., pain level - 5	F 658		

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F 658	Continued From page 76 7/19/18 at 4:37 a.m., pain level - 5 7/20/18 at 3:21 a.m., pain level - 5 7/25/18 at 11:14 a.m., pain level - 6 7/26/18 at 8:31 a.m., pain level - 7 7/26/18 at 11:19 a.m., pain level - 5 7/27/18 at 1:07 p.m., pain level - 6 7/31/18 at 11:28 p.m., pain level - 5 The August 2018 MAR documented the above two medications. The Acetaminophen was not documented as having been given. The Hydrocodone - Acetaminophen was documented as having been given on the following dates, times and pain levels: 8/5/18 at 4:28 a.m., pain level - 5 8/5/18 at 11:20 p.m., pain level - 5 8/14/18 at 11:13 p.m., pain level - 5. The September 2018 MAR documented the above two medications. The Acetaminophen was not documented as having been given. The Hydrocodone - Acetaminophen was documented as having been given on 9/24/18 at 1:31 p.m., pain level - 7. The October 2018 MAR documented the above two medications. The Hydrocodone - Acetaminophen was not documented as having been given. The Acetaminophen was documented as having been given on 10/2/18 at 6:16 a.m. for a pain level of 4 and on 10/4/18 at 9:49 a.m. for a pain level of 5. The comprehensive care plan dated, 6/18/18 and revised on 9/11/18, documented in part, "Focus: (Resident #53) has the potential for actual pain r/t (related to) osteoarthritis and history of back fractures." The "Interventions" documented in part, "Administer pain medication per physician	F 658		

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F 658	Continued From page 77 order. Assess level of pain q (every) shift and PRN (as needed). Assist resident with alternative positioning as a non-phrenological intervention. Notify physician of unrelived (sic) or absence of decrease in the level of pain with currently ordered interventions." An interview was conducted with LPN (licensed practical nurse) #5 on 10/18/18 at 7:45 a.m. When asked if a resident complains of pain, what does the nurse do, LPN #5 stated, "We have the resident rate the pain and give them pain medication." The above orders were reviewed with LPN #5. When asked how the nurse knows which one of these medications to give, LPN #5 stated, "Generally, if it's mild to moderate pain, I would give the acetaminophen, moderate to severe pain I'd give the other one." When asked if it's in her scope of practice to decide which one to give, LPN #5 stated that it was in her scope of practice. An interview was conducted with RN (registered nurse) #1, the assistant director of nursing, on 10/18/18 at 7:52 a.m. When asked the process the nurse should follow when a resident complains of pain, RN #1 stated the nurse should assess the level of pain, the location, the intensity and then try non-pharmacological interventions. If that doesn't work the nurse should look at the pain medication scale. The above orders for pain medications were reviewed with RN #1. When asked how the nurse knows which one to give, RN #1 stated, "Some doctors do scales. At that point, neither one has parameters, we can use nursing judgment as pain is subjective. (Resident #52) may not give a pain scale so we look for nonverbal cues. We need to dose according to pain level. Since there are no parameters, RN #1	F 658		

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F 658	Continued From page 78 paused. When asked should there be parameters, RN #1 stated, "Ideally yes to guide the nurse." When asked if it was in the nurse's scope of practice to determine which one to give, RN #1 stated, "After an hours the nurse should go back to check the effect of the pain, if the Tylenol didn't help then they should call the doctor." Administrative staff member (ASM) # 2, the director of nursing, was made aware of the above concerns on 10/18/18 at 11:20 a.m. ASM #1, the administrator, and ASM # 3, the regional director of operations, were made aware of the above concern on 10/18/18 at 11:43 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. (2) This information was obtained from the following website: https://livertox.nih.gov/Acetaminophen.htm#overview. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details 3. The facility staff failed to clarify conflicting orders for oral medications and NPO (nothing by mouth) for Resident #3. Resident #3 was admitted on 06/28/2018. Resident #3's diagnoses included, but were not limited to, Hemiplegia, Hypertension, Dysphagia, Anxiety, Major Depressive Disorder, Delirium,	F 658		

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F 658	Continued From page 79	F 658		

and Placement of Gastrostomy. His most recent Minimum Data Set (MDS) Assessment was an Admission 14-Day Assessment with an Assessment Reference Date (ARD) of 07/05/18. Resident #3's Brief Interview for Mental Status (BIMS) score was a 13, indicating minor impairment. Resident #3 required extensive assistance of 2 or more staff for Transfers, Bed Mobility, and Toileting, as well as total dependence on 1 staff member for eating and bathing.

A review of Resident #3's record was conducted on 10/16/2018. It was noted that Resident #3 had a diagnosis of Hemiplegia (one sided weakness) and Dysphagia (difficulty swallowing). Resident #3's Physician Orders included a Diet of "NPO" (Nil Per Os, Nothing by Mouth) as well as tube feedings via his gastrostomy (tube inserted through the skin into the stomach, for feeding and administration of medications). Further review of the Physician Orders revealed an order for Depakote dated as starting on 09/05/18, which read as follows: "Depakote Sprinkles Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 capsule by mouth every 8 hours for Mood disorder."

Resident #3's Medication Administration Record documented the Depakote Sprinkles Capsule as being administered 50 times between 10/01/18 and 10/17/18.

On 10/17/18 at 5:15p.m., an interview was conducted with LPN #1, a Unit Manager. LPN #1 was asked what should be done if a Resident has an order for NPO, but a medication is ordered "by mouth". She replied that the nurse should contact the physician for clarification.

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F 658	Continued From page 80 The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 10/17/18. The Director of Nursing was asked what the facility's Nursing Standards were, and stated it was Lippincott. No further documentation was provided. Lippincott's Manual of Nursing Practice 9th Edition states in part, under the heading "Common Legal Claims for Departure from Standards of Care": "following medical orders that should not have been followed such as medication dosage errors". (Nettina, 2010) 4. The facility staff failed to clarify the physician orders for which and when to administer two pain medications (Tramadol and Tylenol) based on pain level parameters for Resident #105. Resident #105 was admitted to the facility on 9/22/18 with diagnoses that included but were not limited to: rheumatoid arthritis (1), pneumonia, depression, psychosis (2) and opioid abuse. The most recent MDS (minimum data set) assessment, a reentry assessment, with an assessment reference date of 10/05/18, coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The MDS also documented in section J0400 (Pain Frequency) that Resident #105 is in pain "Almost constantly." Physician order sheet (POS) dated, 10/1/18, documented two different medications to be used for pain management. "Tramadol HCL [hydrochloride- increases medication stability and solubility] 50 mg (milligrams) tablet, give 1 tablet	F 658		

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F 658	Continued From page 81 by mouth every six hours as needed for pain." (3) And "Tylenol (acetaminophen) 325 mg tablet, give 650 mg by mouth every six hours as needed for pain." (4) The September 2018 medication administration record (MAR) documented the above medication orders. Further review of the September 2018 MAR revealed the following: - Tramadol HCL Tablet 50 mg Give 0.5 tablet by mouth every 6 hours as needed for pain was administered on 9/1/18 at 10:06 p.m. for a pain level of 6, on 9/2/18 at 5:06 a.m. for a pain level of 5 and at 7:34 p.m. for a pain level of 6. On 9/7/18 at 2:12 p.m. for a pain level of 3. - Tylenol tablet 325 mg (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for Pain was administered on 9/2/18 at 9:36 p.m. for a pain level of 5, on 9/3/18 at 10:11 a.m. for a pain level of 5 and on 9/12/18 at 1:15 a.m. for a pain level of 5. The October 2018 medication administration record (MAR) documented the above medication orders. Further review of the MAR revealed the following: Tramadol HCL Tablet 50 mg Give 1 tablet by mouth every 6 hours as needed for pain was administered on 10/1/18 at 5:08 a.m. for a pain level of 5, on 10/2/18 at 4:33 a.m. for a pain level of 5, on 10/5/18 at 7:04 p.m. and 10/6/18 at 9:19 p.m. for a pain level of 7, on 10/11/18 at 10:21 p.m. and on 10/12/18 at 4:37 p.m. for a pain level of 6. The October 2018 MAR documented Resident #105 did not receive any Tylenol. On 10/18/18 at approximately 7:52 a.m., an interview was conducted with RN (registered nurse) #1, the ADON (associate director of	F 658		

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F 658	Continued From page 82 nursing). When asked if there should there be parameters on pain medication, RN #1 replied "Ideally yes; to guide the nurse." On 10/18/18 at approximately 9:41 a.m. an interview was conducted with LPN # 1, Unit Manager. After reviewing Resident #105's pain medication orders LPN #1 was asked how a nurse knows which pain medication to give, LPN #1 replied "I would ask the doctor to clarify the order." On 10/18/18 at approximately 3:15 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. On 10/18/18 at approximately 1:00 p.m., the director of nursing stated the facility follows Lippincott's "Nursing Procedures" as their standard of practice. According to Lippincott's "Fundamentals of Nursing, 5th edition, page 553 documents the following statement, "Always clarify with the prescriber any medication order that is unclear or seems in appropriate." No further information was provided prior to exit. 1. A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. 2. Psychosis occurs when a person loses contact with reality. The person may have false beliefs about what is taking place, or who one is	F 658		

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F 658	Continued From page 83 (delusions), see or hear things that are not there (hallucinations). This information was obtained from the website: https://medlineplus.gov/ency/article/001553.htm. 3. Used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. 4. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

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F 684	Continued From page 84 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and during the course of a complaint investigation, it was determined the facility staff failed to ensure that treatment and care was provided in accordance with professional standards of practice for two residents (#109, and #78) in a survey sample of 38 residents. 1. The facility staff failed to administer the resident's medications for high blood pressure according to the physician's orders for Resident #109. 2. The facility staff failed to remove Resident #78's right hand splint per physician's order on 10/16/18 and 10/17/18. The findings include: 1. The facility staff failed to administer the resident's medications for high blood pressure according to the physician's orders for Resident #109. Resident #109 was admitted to the facility on 11/11/16 with a recent readmission on 9/25/18, with diagnoses that included but were not limited to: stroke, heart attack, COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. (1)], diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change/Medicare 5 day	F 684	F684 1. Resident #109's doctor has been notified that the resident was not administered blood pressure medication according to the orders. Resident #78's doctor has been notified that the hand splint was not removed per the physician's orders. 2. All residents have the potential to be affected by this deficient practice. An audit of residents' orders and the Medication Administration report will be reviewed to ensure orders are being followed. 3. The ADON, or designee, will re-educate licensed nursing staff on following physician's orders.	

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F 684	Continued From page 85 assessment, with an assessment reference date of 10/2/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for her activities of daily living. The comprehensive care plan dated, 11/22/16 and revised on 10/9/18 documented in part, "Focus: (Resident #109) has coronary artery disease which impacts tolerance to activity and overall quality of life r/t (related to) hyperlipidemia (elevated fats in the bloodstream) and Hypertension (high blood pressure)." The "Interventions/Tasks" documented in part, "Give all meds (medications) as ordered by the physician. Observe for side effects. Report adverse reactions to MD (medical doctor). Take blood pressures ordered or indicated by s/s (signs/symptoms). Notify physician of any abnormal findings." The physician order dated, 9/25/18, documented, "Metoprolol Tartrate Tablet [used to treat high blood pressure and heart failure. (2)] 25 mg (milligrams); Give 2 tablet by mouth two times a day for HTN (high blood pressure), hold for HR (heart rate) < (less than) 60 or SBP (systolic blood pressure) < 115." The October 2018 MAR (medication administration record) documented the above medication orders. The MAR documented the blood pressures on the following dates when the Metoprolol was documented as administered: 10/2/18 at 8:00 p.m. - 111/67 10/4/18 at 8:00 p.m. - 109/64	F 684	4. The Unit Managers, or designee will review all new orders and the EMAR daily, for three months, in the clinical start up meeting to ensure orders are being entered correctly and medications are being administered as ordered. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 684	Continued From page 86 10/10/18 at 8:00 a.m. - 112/63 10/11/18 at 8:00 a.m. - 108/50 10/14/18 at 8:00 a.m. - 113/68 Review of the nurse's notes failed to evidence documentation of holding the medication or any documentation of why it was administered when the blood pressure was below the physician ordered parameters for administration. On 10/17/18 at 5:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of a care plan. LPN #1 stated a care plan is like a preventative intervention and to set goals. LPN #1 stated a care plan is like a diary to tell staff what is going on with residents' activities of daily living. When asked how the staff ensures care plans are followed, LPN #1 stated nurses can go into the computer and pull up care plans and CNAs (certified nursing assistants) can ask their nurses any questions regarding the care plans. "Dispensing medications is not a legal practice for registered nurses in most states. Whereas physicians and other health care providers prescribe and pharmacists dispense therapeutic agents, it is the nurse's legal domain to administer medications in a safe and timely manner."(3) Administrative staff member (ASM) #2, the director of nursing, was made aware of the above concern on 10/18/18 at 11:20 a.m. ASM #1, the administrator, and ASM # 3, the regional director of operations, was made aware of the above findings on 10/18/18 at 11:43 a.m. No further information was provided prior to exit.	F 684		

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F 684	Continued From page 87 COMPLAINT DEFICIENCY (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details (3) Fundamentals of Nursing, 5th edition, Lippincott, Craven and Hirmle. Page 557 3. The facility staff failed to remove Resident #78's right hand splint per physician's order on 10/16/18 and 10/17/18. Resident #78 was admitted to the facility on 4/5/17. Resident #78's diagnoses included but were not limited to paralysis, high blood pressure and anxiety disorder. Resident #78's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/18, coded the resident as being cognitively intact. Section G coded Resident #78 as requiring extensive assistance of two or more staff with bed mobility, transfers and dressing. Review of Resident #78's clinical record revealed an OT (occupational therapy) note dated 4/21/18 that documented, "Nursing informed to doff (sic.) (remove) resting hand splint in 4 hours..." A physician's order dated 7/2/18 documented, "Resident to wear resting hand splint one time a day 4 hours in AM and remove per schedule." Resident #78's October 2018 TAR (treatment administration record) documented for Resident #78's splint to be applied at 8:00 a.m. and	F 684		

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F 684	Continued From page 88 removed at 12:00 p.m. Resident #78's care plan initiated on 4/24/17 documented, "Splint to right upper extremities as ordered..." On 10/16/18 at 2:38 p.m., 10/17/18 at 12:28 p.m. and 10/17/18 at 1:41 p.m., a splint was observed on Resident #78's right hand. On 10/18/18 at 9:48 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated Resident #78's splint was ordered for contractures and confirmed the splint was supposed to be on at 8:00 a.m. and removed at 12:00 p.m. On 10/18/18 at 11:05 a.m., an interview was conducted with OSM (other staff member) #1 (the rehabilitation director). OSM #1 stated Resident #78's splint order was based on the COTA's (certified occupational therapy assistant's) recommendations. OSM #1 stated per review of the COTA's notes, it sounded like Resident #78 had a limitation in his range of motion and the splint was ordered to be removed after four hours based on the resident's tolerance of the splint and for the resident's skin integrity. On 10/18/18 at 11:55 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. On 10/18/18 at 12:09 p.m., a list of requested policies including following physician's orders and the use of splints was given to ASM #1. On 10/18/18 at 1:22 p.m., ASM #1 provided various policies and stated if any requested policies were not given then the facility did not have the policies.	F 684		

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F 684	Continued From page 89 No further information was provided prior to exit.	F 684		
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 staff interview, facility document review, and clinical record review, it was determined the facility staff failed to have a complete pain management program for two of 38 residents in the survey sample, Residents #103 and #53. 1. The facility staff failed to thoroughly assess and document the location of the pain being treated for Resident #103. 2. The facility staff failed to thoroughly assess and document the location of the pain being treated for Resident #53. The findings include: 1. The facility staff failed to thoroughly assess and document the location of the pain being treated for Resident #103. Resident #103 was admitted to the facility on 9/26/18 with diagnoses that included but were not limited to: stroke, high blood pressure, chronic kidney disease, depression, gout [disease in which a defect in uric acid metabolism causes the	F 697	F697 1. Nurses are assessing and documenting the location of the pain being treated for resident #103 and #53. 2. All residents have the potential to be affected by this deficient practice. An audit of residents with pain medication ordered in the last 7 days will be completed to ensure nurses are assessing and documenting the location of the pain being treated. 3. The Unit Managers, or designee, will re-educate licensed nursing staff on the Pain Management in the Long Term Care setting policy, and to include assessment and documentation of location of pain.	

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F 697	Continued From page 90 acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints. (1)], and gastroesophageal reflux disease [GERD - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (2)]. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/3/18, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The physician orders dated, 9/26/18, documented: "Norco Tablet 5-325 MG [(hydrocodone-Acetaminophen used to treat moderate to moderately severe pain. (3)], Give 1 tablet by mouth every 4 hours as needed for pain, hold for sedation." The October 2018 MAR (medication administration record) documented the resident received the Norco 10/1/18 at 10:24 a.m. for a pain level of "7/" There was no location of the residents pain documented in the eMAR (electronic medication administration record) or in the nurse progress notes. The Norco was administered on 10/13/18 at 8:14 p.m. for a pain level of "4." There was no location of the residents pain documented in the eMAR or in the nurse progress notes. The comprehensive care plan dated 9/27/18, documented in part, "Focus: (Resident #103) has pain or potential for pain r/t (related to)	F 697	4. Unit Managers, or designee, will review pain medication administered daily, in clinical start up, for three months to ensure there is an assessment and location documented. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 697	Continued From page 91 osteoarthritis, GERD, GOUT." The "Interventions/Tasks" documented in part, "Administer pain medication as ordered. Report s/s (signs/symptoms) potential negative side effects. Assess pain level q (every) shift and PRN (as needed) and apply interventions as needed. Assist with alternate positioning and other diversional activities to relieve pain. Report break through pain and/or unrelieved pain for further assessment and treatment." An interview was conducted with LPN (licensed practical nurse) #3 on 10/18/18 at 8:31 a.m. When asked what is assessed and documented when a nurse gives a pain medication, LPN #3 stated the nurse should document the pain level, the medication, any grimacing and where the pain is." The facility policy, "Pain Management in the Long Term Care Setting" documented in part, "Procedure: 2. Document the location, quality, duration and intensity of a pain." "Because clients initially are inclined to describe where the pain or discomfort is located, it is logical and efficient to start with measurement of pain location." (4) Administrative staff member (ASM) #2, the director of nursing was made aware of the above concern on 10/18/18 at 11:20 a.m. ASM #1, the administrator, and ASM # 3, the regional director of operations, were made aware of the above concern on 10/18/18 at 11:43 a.m. No further information was provided prior to exit.	F 697		

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F 697	Continued From page 92 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details (4) Lippincott's Fundamentals of Nursing, 5th edition, Craven and Hirnle, page 1186. 2. The facility staff failed to assess and document the location of the pain being treated for Resident #53. Resident #53 was admitted to the facility on 8/30/13 with a readmission on 2/23/18, with diagnoses that included but were not limited to: traumatic brain injury, memory deficit following non-traumatic intracerebral hemorrhage (bleeding), depression, high blood pressure, dementia, history of falling, generalized osteoarthritis [Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise. (1)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/27/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score indicating the resident was moderately impaired to make daily cognitive decisions. Resident #53 was coded as having periods of inattention and disorganized thinking. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living, except eating	F 697		

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F 697	Continued From page 93 in which she was independent after set up assistance provided. Resident #53 was coded as only requiring supervision for locomotion on the unit. The physician orders dated, 2/23/18, documented, "Acetaminophen Tablet [used to treat mild to moderate pain and fever. (2)] 325 MG (milligrams), Give 2 tablet by mouth every 6 hours as needed for pain. Hydrocodone-Acetaminophen Tablet [used to treat moderate to moderately severe pain (3)] 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for pain." The July 2018 MAR (medication administration record) documented the above two medications. The Acetaminophen was documented as given on 7/1/18 at 6:11 p.m. for a pain level of "6." There was no documentation in the eMAR (electronic medication administration record) or the nurse's notes regarding the assessment and location of the resident's pain being treated. The Hydrocodone - Acetaminophen was documented as given on the following dates, times for pain levels as follows: 7/4/18 at 4:54 a.m., pain level - 5 - no location of pain documented 7/9/18 at 3:38 a.m., pain level - 4 - no location of pain documented 7/10/18 at 12:45 a.m. - pain level - 4 - no location of pain documented 7/14/18 at 1:00 p.m., pain level - 5 - no location of pain documented 7/19/18 at 4:37 a.m., pain level - 5 - no location of pain documented 7/20/18 at 3:21 a.m., pain level - 5 - no location of pain documented 7/25/18 at 11:14 a.m., pain level - 6 - no location	F 697		

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F 697	Continued From page 94 of pain documented 7/26/18 at 8:31 a.m., pain level - 7 - no location of pain documented 7/26/18 at 11:19 p.m., pain level - 5 - no location of pain documented 7/27/18 at 1:07 p.m., pain level - 6 - no location of pain documented 7/31/18 at 11:28 p.m., pain level - 5 - no location of pain documented The August 2018 MAR documented the above two medication orders. The Acetaminophen was not documented as given. The Hydrocodone - Acetaminophen was documented as given on the following dates, times with pain levels as follows: 8/5/18 at 4:28 a.m., pain level - 5 - no location of pain documented 8/5/18 at 11:20 p.m., pain level - 5 - no location of pain documented 8/14/18 at 11:13 p.m., pain level - 5 - no location of pain documented. The September 2018 MAR documented the above two medication orders. The Acetaminophen was not documented as given. The Hydrocodone - Acetaminophen was documented as given on 9/24/18 at 1:31 p.m., pain level - 7 - with no location of the resident's pain documented. The October 2018 MAR documented the above two medication orders. The Hydrocodone - Acetaminophen was not documented as given. The Acetaminophen was documented as given on 10/4/18 at 9:49 a.m. for a pain level of 5 - with no location of the resident's pain documented. The comprehensive care plan dated, 6/18/18 and revised on 9/11/18, documented in part, "Focus:	F 697		

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F 697	Continued From page 95 (Resident #53) has the potential for actual pain r/t (related to) osteoarthritis and history of back fractures." The "Interventions" documented in part, "Administer pain medication per physician order. Assess level of pain q (every) shift and PRN (as needed). Assist resident with alternative positioning as a non-phrenological intervention. Notify physician of unrelived (sic) or absence of decrease in the level of pain with currently ordered interventions." An interview was conducted with RN (registered nurse) #1, the assistant director of nursing; on 10/18/18 at 8:21 a.m., RN #1 was asked to review the above MARs, eMAR notes and nurse's notes. When asked where the location of the pain being treated was documented, RN #1 stated, "The nurses should document where the pain is located. They have the option to document it in the eMAR note or they can write a separate nurse's note." Administrative staff member (ASM) #2, the director of nursing was made aware of the above concern on 10/18/18 at 11:20 a.m. ASM #1, the administrator, and ASM # 3, the regional director of operations, were made aware of the above concern on 10/18/18 at 11:43 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. (2) This information was obtained from the following website: https://livertox.nih.gov/Acetaminophen.htm#overview.	F 697		

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F 697	Continued From page 96 (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide dialysis care and services for one of 38 residents in the survey sample, Resident #18. The facility staff failed to maintain ongoing communication with the dialysis facility regarding dialysis care for Resident #18. The findings include: Resident #18 was admitted to the facility on 12/21/2016 with a readmission date of 12/13/17. Resident #18's diagnosis included but were not limited to: high blood pressure, depression, hyperlipidemia (1) and end stage renal failure (ESRD) (2) requiring hemodialysis (3). The most recent MDS (minimum data assessment), an admission assessment, with an assessment reference date of 7/30/18, coded the resident as having a score of 15 out of 15 on the	F 698		

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F 698	Continued From page 97 BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis. Physician's orders dated 10/1/18 documented, "Dialysis M-W-F (Monday, Wednesday, and Friday) at (Name of Dialysis Center). Chair time 6:30 a.m." The October 2018 TAR (treatment administration record) documented Resident #18 attended "Dialysis on M (Monday), W (Wednesday) and F (Friday)." Resident #18's comprehensive care plan dated 12/30/16 documented, "Encourage resident to go to scheduled dialysis appointments." On 10/17/18 at approximately 5:45 p.m., Resident #18's dialysis communication book was reviewed. The dialysis communication book was noted to be filled with blank logging sheets. On 10/17/18 at approximately 5:50 p.m., Resident #18's dialysis communication book was reviewed with LPN #1 (licensed practical nurse), Unit Manager. LPN #1 confirmed that Resident #18's dialysis communication book was in fact filled with blank logging sheets. On 10/17/18 at approximately 5:52 p.m., an interview was conducted with LPN #1, Unit Manager. When asked what goes with a resident to dialysis, LPN #1 stated "their (resident's) weights, vital signs and any significant blood work."	F 698	F698 1. The facility is now communicating to the dialysis center that provides services to resident #18 2. All residents on dialysis have the potential to be affected by this deficient practice. An audit of other residents on dialysis will be completed to ensure the facility is communicating with their dialysis center. 3. The Unit Managers, or designee, will re-educate licensed nursing staff on the facility's dialysis policy. 4. The Unit Managers, or designee, will review residents' who are on dialysis charts weekly, for 12 weeks, to ensure communication is occurring between the facility and the dialysis center. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 698	Continued From page 98 On 10/17/18 at approximately 6:00 p.m., an interview was conducted with LPN #2. When asked why ongoing communication is needed between the facility and dialysis center that Resident #18 attends, LPN #2 stated so both the dialysis center and the facility can be aware of changes with the resident. On 10/18/18 at approximately 11:47 a.m., an interview was conducted with LPN #1, Unit Manager. She presented documents from the dialysis center, titled "Tracking My Numbers" dated July 2018 and November 2017. "Tracking My Numbers" contained various laboratory values for Resident #18. When asked if there was documentation indicating on-going communication between facility and dialysis center for Resident #18, LPN #1 replied "No." The facility dialysis policy documented, "6. Complete the Dialysis Communication Form and send with the resident to the Dialysis Center. Review the communication form on return to the nursing home for any changes in condition, medication or treatment." On 10/18/18 at approximately 3:15 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit. 1. Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid	F 698		

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F 698	Continued From page 99 disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. 2. The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. 3. Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		

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GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

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F 725	Continued From page 100 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident representative interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide sufficient nursing staff for one of 38 residents in the survey sample, Resident #86. The facility staff failed to schedule a sufficient number of CNAs (certified nursing assistants) to ensure Resident #86 was assisted with ADL (activities of daily living) care in a timely manner on 10/14/18. The findings include: On 5/31/18, the Office of Licensure and Certification received a complaint that alleged the facility had a severe staff shortage on evenings and weekends. No particular resident was named in the complaint. Resident #86 was admitted to the facility on 6/25/16. Resident #86's diagnoses included but were not limited to heart failure, dementia and chronic kidney disease. Resident #86's most recent MDS (minimum data set), a quarterly	F 725	F725 1. The facility has noted that resident #86 was assisted out of bed at a later time than the RP preferred on 10/14/18. 2. All residents have the potential to be affected by this deficient practice. An audit of the as worked schedule for the past 7 days will be done to ensure the building was appropriately staffed. 3. The DON, or designee, will re-educate the nursing staff on patients and responsible party's preferences. 4. An Interdisciplinary team member, or designee, will tour the building daily, for three months to ensure residents' needs are being met. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 725	Continued From page 101 assessment with an ARD (assessment reference date) of 9/22/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded Resident #86 as requiring extensive assistance of two or more staff with bed mobility, transfers, personal hygiene and dressing. Resident #86's comprehensive care plan initiated on 6/25/16 documented, "(Name of Resident #86) needs assistance with ADLs and function...Provide assistance for ADLs as needed..." On 10/16/18 at 2:13 p.m., a telephone interview was conducted with Resident #86's representative. Resident #86's RR (resident representative) stated there was not as much staff at the facility on weekends. Resident #86's RR stated her sister arrived to the facility at 2:00 p.m. this past weekend and Resident #86 was still in bed and there was food in the bed. Resident #86's RR stated her sister was concerned but she (the RR) was fine with the situation because the staff does all they can and are very attentive and nice. On 10/17/18 at 2:53 p.m., an interview was conducted with CNA #1 (the CNA who cared for Resident #86 on the day shift during the past weekend [10/13/18 and 10/14/18]). CNA #1 was asked if there was any concerns regarding Resident #86's care during the past weekend. CNA #1 stated Resident #86 has dementia, is combative and requires the assistance of two staff. CNA #1 stated he knows Resident #86's daughter prefers the resident to be assisted out of bed after breakfast but on 10/14/18, he was busy because there were only four CNAs (including him) on the unit and each CNA was assigned to care for 15 residents. CNA #1 stated	F 725		

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F 725	Continued From page 102 he did not have enough time to get Resident #86 cleaned up and out of bed until after lunch. Review of the facility nursing staff schedule for 10/14/18 confirmed four CNAs were scheduled for the name of unit Resident #86 resided on that day. On 10/17/18 at 3:57 p.m., an interview was conducted with OSM (other staff member) #2 (the staffing coordinator). OSM #2 stated the (name of the unit Resident #86 resides on) unit has 60 beds and the unit should be staffed with six CNAs if the unit is full. OSM #2 was asked to confirm if the (name of the unit Resident #86 resides on) was full on 10/14/18. On 10/17/18 at 4:06 p.m., OSM #2 confirmed the (name of the unit Resident #86 resides on) was full and contained 60 residents on 10/14/18. OSM #2 was asked how many CNAs should have been scheduled on that unit on that day. OSM #2 stated six CNAs should have been scheduled; but confirmed only four CNAs were scheduled. When asked why, OSM #2 stated this was due to openings for CNA positions in the master schedule. OSM #2 stated she tried to call in as needed CNAs and offered overtime for staff to work on 10/14/18 but she could only secure four CNAs for the (name of the unit Resident #86 resides on) for that day. On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 10/18/18 at 11:11 a.m., an interview was conducted with ASM #2. ASM #2 was asked how	F 725		

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F 725	Continued From page 103 many CNAs should be scheduled on the (name of the unit Resident #86 resides on). ASM #2 stated, "We try to do six, six and four (six CNAs on day shift, six CNAs on evening shift and four CNAs on night shift)." When asked why the unit should be scheduled with that number of CNAs, ASM #2 stated, "To make a manageable workload for the CNAs." The facility policy titled, "STAFFING" documented, "3. The facility will employ on a full-time or part-time basis qualified licensed nurses and certified nurse aides on all shifts, seven days per week, in sufficient numbers to meet the assessed nursing care needs of all residents..." No further information was presented prior to exit. COMPLAINT DEFICIENCY	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		

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F 758	Continued From page 104 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure one of 38 residents in the survey sample, Resident #74, was free of unnecessary psychotropic medication.	F 758	F758 1. The facility is now monitoring #74's behaviors for the use of antipsychotic medication. 2. All residents on psychotropic medication have the potential to be affected by this deficient practice. An audit of residents on psychotropic medications will be completed to ensure their behavior is being monitored. 3. The Unit Managers, or designee, will re-educate the licensed nursing staff on the Antipsychotic Medication Usage policy to include monitoring. 4. The Unit managers, or designee, will review the medication administration report daily, for three months, to ensure patients on antipsychotic medication's behavior is being monitored. Findings will be reported to the QA committee. 5. November 19, 2018	

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F 758	Continued From page 105 The facility staff failed to monitor Resident #74's behaviors for the use of antipsychotic medication from 9/10/18 through 10/16/18. The findings include: Resident #74 was admitted to the facility on 8/18/17. Resident #74's diagnoses included but were not limited to dementia, diabetes and osteoporosis. Resident #74's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/17/18, coded the resident's cognition as severely impaired. Section N coded Resident #74 as having received antipsychotic medication seven out of the last seven days. Review of Resident #74's clinical record revealed a physician's order with a start date of 5/25/18 for Seroquel (1) 25mg (milligrams) by mouth at bedtime for psychosis. Review of Resident #74's September 2018 MAR (medication administration record) revealed the resident was administered Seroquel 25mg from 9/1/18 until the resident was discharged to the hospital on 9/6/18. Further review of Resident #74's September 2018 MAR from 9/1/18 until Resident #74's discharge to the hospital on 9/6/18 revealed the following documentation, "BEHAVIORS- MONITOR FOR THE FOLLOWING: SADNESS, ANXIETY, LOSS OF INTERER (sic), AGITATION, RESTLESSNESS. Document 'Y' if monitored and resident is free of above. 'N' if monitored and resident is not free from above, select chart code 'Other/See Nurses Notes' and must document findings. every shift." Resident #74's behaviors were documented as being monitored each shift from 9/1/18 until 9/6/18.	F 758		

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F 758	Continued From page 106 Resident #74 was readmitted to the facility on 9/10/18. Review of Resident #74's clinical record revealed a physician's order dated 9/10/18 for Seroquel 25mg by mouth at bedtime. Review of Resident #74's September 2018 and October 2018 MARs revealed the resident was administered Seroquel 25mg from 9/10/18 through 10/16/18. Further review of Resident #74's September 2018/October 2018 MARs and nurses' notes failed to reveal documentation of behavior monitoring. Resident #74's comprehensive care plan initiated on 9/7/17 documented, "(Name of Resident #74) is prescribed psychotropic medications r/t (related to) Anxiety, Insomnia, Depression, Restlessness/Agitation, Appetite and Psychosis...Observe target behaviors for decrease or escalation that may indicate need for medication review..." On 10/18/18 at 9:56 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked about the facility process for behavior monitoring for a resident prescribed an antipsychotic medication. LPN #1 stated, "That is something that is triggered in the MAR. With that medication (Seroquel), it should come up if they are having behaviors. You document yes or no and it should prompt you to write. You can put something in saying: yelling, kicking, hitting." When asked why targeted behaviors should be monitored for residents prescribed antipsychotic medications, LPN #1 stated, "To make sure the medication is working. To see if it is effective, not effective, if we need to look at something else for them. If it's not helping them and causing more agitation they may need something else."	F 758		

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F 758	Continued From page 107 On 10/18/18 at 11:11 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. On 10/18/18 at 11:44 a.m., ASM #1 (the administrator) was made aware of the above concern. The facility policy titled, "ANTIPSYCHOTIC MEDICATION USAGE" documented, "Antipsychotic medications are used (sic) eliminate or reduce specific and identified behavioral symptoms- which have been quantifiably documented and for which underlying causes have been ruled out..." No further information was presented prior to exit. (1) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment	F 758		

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F 758	Continued From page 108 program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		

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F 761	Continued From page 109 Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to safely secure medications in one of five medication carts, the Fairview one hall medication cart. The facility staff failed to lock the Fairview one hall medication cart while leaving the cart unattended to administer medications to residents. The findings include: On 10/16/18 at 4:49 p.m., LPN (licensed practical nurse) #4 was observed preparing medications at the Fairview one hall medication cart. The medication cart was located in the hall outside of a resident's room. LPN #4 failed to lock the medication cart before entering the resident's room. The medication cart remained unlocked while LPN #4 was behind a privacy curtain administering medications to a resident. The medication cart was not in LPN #4's line of sight. During this observation, a staff member was observed walking past the medication cart. On 10/16/18 at 4:52 p.m., LPN #4 was observed preparing medications at the Fairview one hall medication cart. The medication cart was located in the hall outside of another resident's room. LPN #4 failed to lock the medication cart before entering the resident's room. The medication cart remained unlocked while LPN #4 administered medications to the resident in the room. LPN #4's back was facing the medication cart and the cart was not in LPN #4's line of sight. On 10/17/18 at 3:37 p.m., an interview was	F 761	F761 1. The facility has noted that LPN #4 did not lock her medication cart when administering meds to a resident. 2. All residents have the potential to be affected by this deficient practice. A medication pass audit will be done to ensure medication is secured during med pass. 3. The DON, or designee, will re-educate the licensed nursing staff on the Medication Storage policy to include locking medication carts. 4. The Director of Nursing, or designee, will review a medication pass daily x one week, weekly x eight weeks, then monthly x 1 month to ensure medication is stored securely during medication pass. All findings will be reported to the QA committee. 5. November 19, 2018	

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F 761	Continued From page 110 conducted with LPN #4. LPN #4 was asked what should be done before leaving the medication cart to enter a resident's room. LPN #4 stated the medication cart should be locked and nurses should make sure there are no medications on top of the cart. When asked why the medication cart should be locked, LPN #4 stated, "It's because anyone can open those drawers and get any medication. It's very important to lock the carts. You have people who are confused and will go ahead and do things they are not supposed to. It's very important to lock the cart. Always." LPN #4 was made aware of this surveyor's above observations on 10/16/18. LPN #4 stated she was very nervous and always locks the medication cart. On 10/17/18 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "Medication Storage" documented, "2. Only licensed nurses, the Consultant Pharmacist, and those authorized to administer medications (e.g. medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access." No further information was presented prior to exit.	F 761		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		

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F 804	Continued From page 111 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview and staff interview, it was determined the facility staff failed to serve food at a palatable temperature. The findings include: On 10/17/18 at approximately 11:05 a.m., an observation was made of the tray line in the kitchen. The holding temperatures were taken of all of the food from the tray line by OSM (other staff member) #8 using a calibrated facility thermometer. The temperature of the food in Fahrenheit was as follows: Pork Chops - 194 degrees Scalloped Potatoes - 208 degrees Puree meat - 160 degrees Puree Spinach - 172 degrees Spinach - 188 degrees Rice - 165 degrees Broth - 148 degrees The trays left the kitchen and arrived at Clairmont 2 unit at 1:10 p.m. The last resident was served at 1:30 p.m. Testing of temperature was conducted at 1:30 p.m. by OSM (other staff member) #7 using a calibrated facility thermometer. The test tray consisted of pork chop, pureed meat, spinach, puree spinach and scalloped potatoes. The recorded serving	F 804	F804 1. The facility has noted that the food temp was lower than 135 degrees F when delivered to a resident. 2. All residents have the potential to be affected by this deficient practice. Dietary will complete a test tray audit to ensure the food is at a palatable temperature. 3. The Dietary Manager will re-educate the dietary staff on appropriate temperature of food on the tray line and timely delivery of trays to the residents' rooms. 4. Dietary manager will complete a test tray audit 5x a week for 4 weeks, then 2x per week for 6 weeks. Weekly follow up to be completed by dietary district manager or designee. Concerns will be address by Dietary manager or designee. Findings will be reported to the QA committee. 5. November 19. 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495388	A. BUILDING _____ B. WING _____	C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 804	Continued From page 112 temperatures in Fahrenheit was as follows: Pork Chops - 118 degrees (dropped 76 degrees from initial holding temperature) Scalloped Potatoes - 117 degrees (dropped 91 degrees from initial holding temperature) Puree meat - 114 degrees (dropped 46 degrees from initial holding temperature) Puree Spinach - 108 degrees (dropped 64 degrees from initial holding temperature) Spinach - 122 degrees (dropped 66 degrees from initial holding temperature) Two surveyors and OSM #7, the Dietary Manager tested the temperatures of the test tray. When asked to describe the food's temperature, OSM #7 stated, "It could be hotter." When asked what the temperature of the food should be, OSM #7 stated closer to 135 degrees. On 10/16/18 at approximately 3:30 p.m., a group interview was conducted with five current cognitively intact facility residents. When asked if they were satisfied with the food being served, all residents complained of the hot food being too cold. On 10/18/18 at approximately 1:24 p.m., ASM (administrative staff member) #1 the Administrator was informed of the above concern. On 10/18/18 at approximately 3:15 p.m., ASM #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was obtained prior to exit.	F 804		

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/16/18 through 10/18/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Three complaints were investigated during the survey. The census in this 120 licensed bed facility was 114 at the time of the survey. The survey sample consisted of 38 resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 250 G - cross references to Federal deficiency 656 12 VAC 5 - 371 - 200 B. 1 - cross references to Federal deficiency 658 12 VAC 5 - 371 - 220 B - cross references to Federal deficiency 697 12VAC5-371-150. Resident Rights cross reference to F550. 12VAC5-371-150. Resident Rights cross reference to F583. 12VAC5-371-210. Nurse Staffing cross reference to F725. 12VAC5-371-300. Pharmaceutical Services cross reference to F761. 12 VAC 5-371-340 A. cross references to Federal deficiency 804	F 001		

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

State of Virginia

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