| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495144 | A. BUILDING ______ B. WING ______ | 11/29/2018 |

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| PETERSBURG HEALTHCARE CENTER | 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 11/27/18 through 11/29/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 11/27/18 through 11/29/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.<br><br>The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 36 resident reviews. | F 000 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. | F 584 | Federal Tags<br>F 584<br>1. Resident #93 was provided a top sheet and new fitted sheet on 11/30/2018. Resident # 89 was provided with a top sheet on 11/30/2018. Resident #47 & #158 were provided with a new mattress and clean linen on 11/27/2018. Resident # 30 was provided a new mattress and clean linen on 11/27/2018. Resident #98 was provided with a top sheet on 11/28/2018. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 12-11-18

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 584 | Continued From page 1<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, resident interview and facility documentation review the facility staff failed to ensure a clean, homelike environment for 5 residents (Resident #93, 89, 47, 30 and 98) of 36 residents in the survey sample.<br><br>1. For Resident #93, the facility staff failed to provide a top sheet on the bed.<br><br>2. For Resident #89, the facility staff failed to provide a top sheet on the bed. | F 584 | 2. Current residents' mattresses were audited on 11/27/2018 by maintenance/ designee and replacements were given if needed on 11/27/2018. Current residents' beds were checked on 12/07/2018 to ensure linen was clean, top sheet was present, and linen was in good repair by housekeeping/ designee.<br>3. Nursing personnel were educated by the director of nursing/ designee on how to make a bed properly with a top sheet by 12/14/2018. Housekeeping were inserviced by Administrator/designee on mattress cleaning by 12/14/2018. Maintenance/ designee was inserviced on when to replace a mattress by 12/14/2018.<br>4. A weekly audit of facility mattresses, linen and made beds will be completed by the Unit Manager/ designee times twelve weeks. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |



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| F 584 | Continued From page 2<br>3. For Resident #47, the facility staff failed to provide a clean mattress and clean linen.<br><br>4. For Resident #30, the facility staff failed to provide a clean mattress and clean linen.<br><br>5. For Resident #98, the facility staff failed to provide a top sheet on the bed.<br><br>The findings included:<br><br>1. For Resident #93, the facility staff failed to provide a top sheet on the bed.<br><br>Resident #93, a 75 year old, was admitted to the facility on 11/2/18. Diagnoses included seizures, dementia, reflux, dysphagia, diabetes, hypertension. The most recent Minimum Data Set assessment was an admission assessment with an assessment reference date of 11/9/18. Resident #93 was coded with moderate cognitive impairment and required extensive assistance with activities of daily living.<br><br>On 11/27/18 at 12:35 p.m., Resident #93 was observed in bed. Her daughter was visiting. At this time, it was observed that the bedding included a very thin fitted sheet and a turquoise comforter with polka dots. The fitted sheet was see through. There was no top sheet on the bed. The daughter was asked if there was ever a top sheet on the bed. She stated no and issued a concern about the fitted sheet being very thin.<br><br>The bedding was observed as follows:<br><br>11/28/18 at 8:20 a.m. Resident #93 in bed. A fitted sheet, blanket with a deer design, and the | F 584 | | |



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| F 584 | Continued From page 3<br>turquoise polka dot comforter were observed. There was no top sheet on the bed.<br><br>11/28/18 at 2:15 p.m. Resident #93 was out of bed. The bed was made with a fitted sheet, the deer blanket and turquoise blanket. There was no top sheet on the bed.<br><br>11/29/18 at 9:35 a.m. Resident #93 was out of bed. The bed was made with a fitted sheet, the deer blanket and turquoise blanket. There was no top sheet on the bed.<br><br>Resident #93 lived on the 200 unit.<br><br>On 11/28/18 at 1:15 p.m., the laundry staff (Employee F) was interviewed. Employee F explained that linens were stocked on both units one time per shift. Employee F stated that 30 top sheets and 30 fitted sheets were stocked per shift. At this time, there were 32 clean top sheets available for use in the laundry room. On 100 unit, 1 top sheet was available for use and on the 200 unit, 5 top sheets were available for use.<br><br>On 11/29/18 at 9:45 a.m., an interview was conducted with Certified Nursing Assistant B (CNA B). CNA B was asked to explain the process for changing bed linen and making the bed. She stated that beds were changed on shower days and as needed. She stated the linens to be used included a bottom sheet, a draw sheet if needed, a top sheet and a blanket. CNA B was asked to observe Resident #93's bed. She identified that the top sheet was missing.<br><br>At the end of day meeting on 11/29/18, the Administrator and Director of Nursing were notified that staff were not using a top sheet when | F 584 | | |

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| F 584 | Continued From page 4<br>making the beds. When asked if the facility had enough linens to make the bed, the Administrator stated that she had recently purchased linens. She was asked to provide the receipts. The Administrator provided the receipts showing that she had purchased linens. The Administrator stated that the linens were available for staff use and she felt that the issue may be a training issue.<br><br>2. For Resident #89, the facility staff failed to provide a top sheet on the bed.<br><br>Resident #89, an 86 year old, was admitted to the facility on 5/13/18. Diagnoses included Alzheimer's disease, reflux, hypertension, depression, and dysphagia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/8/18. Resident #89 was coded with severe cognitive impairment and required extensive assistance with activities of daily living. She was not coded to have behaviors.<br><br>On 11/29/18 at 10:00 a.m., Resident #89 was observed lying across her bed in a fetal position. She was asleep on top of the covers. The bedding did not include a top sheet. Resident #89 lived on the 100 unit.<br><br>At the end of day meeting on 11/29/18, the Administrator and Director of Nursing were notified that staff were not using a top sheet when making the beds.<br><br>3. For Resident #47, the facility staff failed to | F 584 | | |

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| F 584 | Continued From page 5<br>provide a clean mattress and clean linen.<br><br>Resident #47 was a 67 year old who was admitted to the facility on 3/11/15. Resident #47's diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left side, Hyperlipidemia, and Major Depressive Disorder.<br><br>The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 10/11/18 was reviewed. It coded Resident #47 as having a Brief Assessment of Mental Status Score of 11, indicating mild cognitive impairment.<br><br>On 11/27/18 at 11:26 A.M., an interview was conducted with Resident #47. The Director of Nursing (DON Employee B) was present. Resident #47 stated that his mattress was damaged and that he wanted another one. In addition, another Resident who was identified and placed in the sample as Resident #158 was present. Both residents stopped the surveyor in the hallway, and complained about the condition of their beds. Resident #158 also stated that her "bed and mattress were dirty."<br><br>The Director of Nursing stated that she would look at the mattress along with the surveyor. When asked to describe the condition of the mattress, the DON stated, "It needs cleaning it has a dark stain maybe its food located in the center." The stains were approximately 12 inches in diameter, round in shape, blackish brown in color and appeared to be the colors of excrement and urine. When asked to describe the location of the stains, the DON stated, "The residents butt lays on that area in the middle. It does need cleaning." When asked how often the mattress cover is zipped off and washed, the DON stated, | F 584 | | |



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| F 584 | Continued From page 6<br>"I didn't know that it zips off." She then zipped it off, and noted that there was a hole in it. The cover was heavily soiled. When asked about the importance of having clean linen and a clean mattress, the DON stated, "The importance is that he has to have clean linen because of maintaining good skin condition."<br><br>4. For Resident #158, the facility staff failed to provide a clean mattress and linen.<br><br>Resident #158 was a 61 year old who was recently admitted to the facility on 11/16/18. Resident #158's diagnoses Muscle Weakness, and Chronic Obstructive Pulmonary Disease.<br><br>Resident #158 was able to understand and be understood by others. She was oriented to person, place, and situation.<br><br>On 11/27/18 at 11:26 A.M., an interview was conducted with Resident #47. The Director of Nursing (DON Employee B) was present. Resident #47 stated that his mattress was damaged and that he wanted another one. In addition, another Resident who was identified and placed in the sample a Resident #158 was present. Both residents stopped the surveyor in the hallway, and complained about the condition of their beds. Resident #158 also stated that her "bed and mattress were dirty."<br><br>The Director of Nursing stated that she would look at the mattress along with the surveyor. When asked to describe the condition of the mattress, the DON stated, "The blanket needs cleaning. It has stains on it. Maybe it's food. The mattress needs cleaning. It has something white | F 584 | | |

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| F 584 | Continued From page 7<br>spilled on it." The blanket had dark stains on it. The mattress had 2 light colored stains that were approximately 6 inches long on the upper left side.<br><br>On 11/28/18 at 11:00 A.M., a Group Interview was conducted. Nine residents attended the meeting. Eight out of nine residents complained about having a shortage of clean bed linen, and a shortage of top sheets in particular.<br><br>On 11/27/18 at 1:00 P.M., an interview was conducted with the Housekeeping Director (Employee M). He stated that the mattresses are cleaned monthly. He further stated that the nursing staff were supposed to alert housekeeping staff is the mattress is soiled. When asked about the holes in the mattress cover, he stated, "the mattress covers are waterproof but not ammonia proof." He implied that prolonged contact with urine could cause a hole in the mattress cover.<br><br>Mattress care guidance was provided by the manufacturer's instructions for the Gravity 7 Long Term Care Pressure Redistribution Mattress. It read, "Wipe down the mattress with a damp cloth pre-soaked with warm water containing a mild detergent. Approved intermediate level disinfectants may be used according to the cover material. Cover material: Polyfiber/Polyurethane Stretch. Chlorine bleach 1:10 is acceptable. The mattress top cover can be completely removed for laundry with water temperature up to 95 degrees F; however, it is recommended that the user still check with local policy to determine the time/temperature ratio required to achieve thermal disinfection. After cleaning, please avoid dust and proximity to dusty areas. All parts should | F 584 | | |

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| F 584 | Continued From page 8<br>be air dried thoroughly before use."<br><br>5. For Resident #98, the facility staff failed to provide a top sheet on the bed.<br><br>Resident # 98, a male, was admitted to the facility 11/6/2018 with diagnoses of but not limited to: Acquired absence of right upper limb above elbow, Severe sepsis, Chronic Viral Hepatitis C, Acute Kidney Failure, Heart Failure, Gastroesophageal Reflux Disease, Diabetes, and Hypertension.<br><br>Resident # 98's most recent MDS with an ARD of 11/13/2018 was coded as an admission assessment. Resident # 98's BIMS (Brief Interview for Mental Status) score was coded as 14 indicating no cognitive impairment. Resident # 98 was coded as needing limited assistance of one staff member to perform his activities of daily living. Resident # 98 was coded as being able to hear, speak, understand, and be understood.<br><br>On 11/27/2018 at 11:45 AM during the initial tour, observation showed the bed was made with no top sheet. There was a fitted sheet and a comforter on the bed.<br><br>On 11/27/2018 at 3:30 PM, observation showed the bed was made with a fitted sheet and comforter. There was no top sheet. Resident # 98 was not in his room.<br><br>On 11/28/2018 at 10:20 AM, observation showed no top sheet on the bed. Resident # 98 was sitting in a wheelchair in his room. Resident # 98 complained that the staff didn't "know how to make up a bed." Resident # 98 stated there was | F 584 | | |

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| F 584 | Continued From page 9<br>no top sheet.<br><br>On 11/98/2018 at 9:55 AM, observation showed the bed was made with a fitted sheet and comforter. There was no top sheet. Resident # 98 was not in his room.<br><br>Resident #98 lived on the 200 unit.<br><br>On 11/28/18 at 1:15 p.m., the laundry staff (Employee F) was interviewed. Employee F explained that linens were stocked on both units one time per shift. Employee F stated that 30 top sheets and 30 fitted sheets were stocked per shift. At this time, there were 32 clean top sheets available for use in the laundry room. On 100 unit, 1 top sheet was available for use and on the 200 unit, 5 top sheets were available for use.<br><br>On 11/29/18 at 9:45 a.m., an interview was conducted with Certified Nursing Assistant B (CNA B). CNA B was asked to explain the process for changing bed linen and making the bed. She stated that beds were changed on shower days and as needed. She stated the linens to be used included a bottom sheet, a draw sheet if needed, a top sheet and a blanket. CNA B was asked to observe Resident #93's bed. She identified that the top sheet was missing.<br><br>At the end of day meeting on 11/29/18, the Administrator and Director of Nursing were notified that staff were not using a top sheet when making the beds. When asked if the facility had enough linens to make the bed, the Administrator stated that she had recently purchased linens. She was asked to provide the receipts. The Administrator provided the receipts showing that she had purchased linens. The Administrator | F 584 | | |



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| F 584 | Continued From page 10<br>stated that the linens were available for staff use and she felt that the issue may be a training issue. | F 584 | | |
| F 600<br>SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure that three residents (#30, #158, #98) in the survey sample of 36 residents were free of physical and verbal abuse.<br><br>1. For Resident #30, the facility staff failed to ensure that she was free of physical and verbal abuse by CNA E.<br><br>2. For Resident #158, the facility staff failed to ensure that she was free of verbal abuse by CNA E. | F 600 | F 600<br>1. Residents #30, #158, & #98 allegation of abuse were identified and investigated. Staff members were identified and suspended pending investigation. Residents #30, #158, & # 98 had no further allegations of verbal and physically abuse as of 11/29/2018.<br>2. Current alert and oriented residents were interviewed to ensure no other residents were affected by Social Services Director/ designee on 11/29/2018. Current demented residents had skin assessments performed by Unit Managers/ designee on 11/29/2018.<br>3. Current staff were inserviced by Administrator/ designee abuse reporting and prevention by 12/14/2018. | |



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| F 600 | Continued From page 11<br>3. For Resident #98, the facility staff failed to ensure that he was free of verbal abuse by CNA E.<br><br>Findings included:<br><br>1. For Resident #30, the facility staff failed to ensure that she was free of physical and verbal abuse by CNA E.<br><br>Resident #30 was a 54 year old who was admitted to the facility on 10/3/17. Resident # 30's diagnoses included Dependence on Renal Dialysis, Pain, Hypertension, Gastro- Esophageal Reflux Disease, Muscle Weakness, and Major Depressive Disorder.<br><br>The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 9/27/18 was reviewed. It coded Resident #30 as having a Brief Interview of Mental Status Score of 15, indication that she was cognitively intact.<br><br>On 11/28/18 at 10:15 A.M., an interview was conducted with Resident #30 who stated that she had been physically and verbally abused by a staff member on night shift. She stated that the CNA was an African American woman in her 60's.<br><br>On 11/28/18 at 10:42 A.M., a second interview was conducted with Resident #30 in her room. The Facility Administrator (Employee A), and the Director of Nursing (Employee B) were present. Resident #30 stated that she had been verbally and physically abused by an "African American woman in her 60's who works on night shift." The DON identified the Certified Nursing Assistant as | F 600 | 4. Alert and oriented residents will be interviewed weekly times twelve weeks to ensure reports of abuse have been properly followed through on by Social Service Director/ designee. Demented residents will have skin assessments performed weekly times twelve to ensure any signs of abuse have been properly followed through on by Unit Managers/ deisgnee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| | 495144 | A. BUILDING ______ B. WING ______ | 11/29/2018 |

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| F 600 | Continued From page 12<br>CNA E. Resident #30 stated that on more that one occasion, CNA E handled her roughly, pulled on her arms in a painful manner, and spoke rudely to her on several occasions. She stated that this had been happening over the past three years, most recently on 11/26/18. She stated that she did not want CNA E to touch her anymore. Resident #30 stated that she had informed the nursing supervisor (LPN D).<br><br>On 11/28/18 at 10:50 A.M., an interview was conducted with the nursing supervisor (LPN D). She stated "I've heard that CNA (CNA E) speaking inappropriately with residents. I had to speak to her about it. I had to counsel her about her inappropriate manner of speaking in a rough manner with the residents. (Resident #30) told me that she reported (CNA E) to the 'people in the front offices'. " When asked why she didn't report the abuse allegations to the Director of Nursing (Employee B), or to the Administrator (Employee A), LPN D stated, "I didn't report it because I thought that the resident had done so."<br><br>On 11/29/18 at 2:00 P.M., an interview was conducted with the Administrator (Employee A). She was asked why the residents hadn't been protected from further abuse after the supervisor witnessed verbal abuse, and why the allegations of verbal and physical weren't investigated or reported to the state agency. The Administrator stated, "Staff are expected to report allegations to her or the Director of Nursing (Employee B). She further stated that allegations are supposed to be reported to the state agency and investigated, but that she and the DON hadn't been aware of the allegations. | F 600 | | |



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| F 600 | Continued From page 13<br>2. For Resident #158, the facility staff failed to ensure that she was free of verbal abuse by CNA E.<br><br>Resident #158 was a 61 year old who was recently admitted to the facility on 11/16/18. Resident #158's diagnoses Muscle Weakness, and Chronic Obstructive Pulmonary Disease.<br><br>Resident #158 was able to understand and be understood by others. She was oriented to person, place, and situation.<br><br>On 11/29/18 at 11:10 A.M., Resident #158 reported to the surveyor, the Administrator (Employee A) and the DON (Employee B) that she had been verbally abused a few times by a CNA who works on night shift. The resident described the CNA as being a dark skinned African American woman who is in her 60's. She stated that the CNA speaks to her in a "mean and hateful manner". She reported that the CNA stated, "Everybody says that I'm mean." The DON identified the CNA as being CNA E.<br><br>On 11/29/18 a review was conducted of facility documentation. It read, "Abuse, Neglect and Exploitation Policy. Date: 1/19/17. Protection from Abuse: In the event a staff member has been accused, they will be interviewed by the Executive Director and be immediately escorted from the facility."<br><br>3. For Resident #98, the facility staff failed to ensure that he was free of verbal abuse by CNA E and mistreatment by CNA C.<br><br>Resident # 98, a male, was admitted to the facility | F 600 | | |



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| F 600 | Continued From page 14 | F 600 | | |

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11/6/2018 with diagnoses of but not limited to: Acquired absence of right upper limb above elbow, Severe sepsis, Chronic Viral Hepatitis C, Acute Kidney Failure, Heart Failure, Gastroesophageal Reflux Disease, Diabetes, and Hypertension.

Resident # 98's most recent MDS with an ARD of 11/13/2018 was coded as an admission assessment. Resident # 98's BIMS (Brief Interview for Mental Status) score was coded as 14 indicating no cognitive impairment. Resident # 98 was coded as needing limited assistance of one staff member to perform his activities of daily living. Resident # 98 was coded as being able to hear, speak, understand, and be understood.

On 11/28/2018 at 10:20 AM, RN (Registered Nurse) B, was observed passing medications to Resident # 98. Resident # 98 was complaining to RN B. Resident # 98 told the surveyor that the facility staff "was terrible" and that they did not take care of him properly. Resident # 98 stated the facility staff said very mean things to him and did not help him when he needed help. When asked which specific staff member, Resident # 98 stated it was one lady who worked on the 11-7 shift. Resident # 98 stated that CNA (Certified Nursing Assistant) was mean and did not take care of him properly. He described the CNA as an "African American woman in her 60's who works on night shift." The DON identified the Certified Nursing Assistant as CNA E.

Resident # 98 also stated one CNA on the 3-11 shift refused to serve his food tray in the dining room. He gave the name of the CNA. Resident # 98 stated he did not eat one meal in the dining room one day and CNA would not serve him

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| F 600 | Continued From page 15<br>when he went to the dining room for his meal on subsequent days. Resident 98 stated the CNA did not treat him right. The Director of Nursing identified the CNA as CNA C.<br><br>Resident # 98 stated the facility staff was aware of how he was treated by the nursing staff members. Resident #98 stated he had talked with the Rehab staff about it and had talked with the administrator. When the surveyor asked Resident # 98 if he had told the facility staff about his experiences and concerns, he replied "yes" and stated he had discussed some things with the administrator. Resident # 98 stated that he understood the facility staff were often busy but he deserved to be treated right.<br><br>A second interview was conducted with Resident # 98 with the Administrator and Director of Nursing present. Resident # 98 repeated his concerns. The DON stated the staff member that Resident # 98 described as an "African American woman in her 60's who works on night shift" was identified as Certified Nursing Assistant (CNA) E. The DON stated the CNA who Resident # 98 identified by name and complained of her not serving his food tray in the dining room was identified as CNA C.<br><br>Review of the clinical record was conducted on 11/28/2018 at 2:25 PM.<br><br>Review of the nurses notes revealed no documentation of any episodes of conflict or of complaints about staff members.<br><br>On 11/28/2018 at 3 PM, an interview was conducted with the Administrator who stated she was not aware of any complaints of staff | F 600 | | |



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| F 600 | Continued From page 16<br>members being verbally abusive or refusing to provide food trays to Resident # 98. The Administrator stated she and the Social Worker had a discussion previously about concerns expressed by Resident # 98 that included portion sizes of food and questions about the location of some of his clothing. The Administrator stated she had never been informed of any complaints about allegations of verbal abuse or mistreatment.<br><br>On 11/28/2018 at 3:30 PM, an interview was conducted with the DON who stated she was not informed of any complaints of allegations of verbal abuse nor of mistreatment regarding Resident # 98. The DON stated she would have investigated immediately if she had been aware.<br><br>On 11/28/2018 at 5 PM during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The Administrator and DON stated residents should be free of verbal abuse and mistreatment and that all allegations of abuse and mistreatment should be investigated.<br><br>On 11/29/2018 during the end of day debriefing, the facility Administrator, DON and Regional Nurse (Admin J) presented a copy of an inservice presented to staff regarding abuse policies and procedures.<br><br>No further information was provided. | F 600 | | |
| F 607<br>SS=D | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that: | F 607 | F 607<br>1. Residents #30, & #98 allegation of abuse were identified and investigated. Staff members were identified and suspended pending investigation. Residents #30, & # 98 had no further allegations of verbal and physically abuse as of 11/29/2018. | |

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| F 607 | Continued From page 17<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement abuse policies for two residents (#30 and #98).<br><br>1. For Resident #30, the facility staff failed to implement abuse policies.<br><br>2. For Resident #98, the facility staff failed to implement abuse policies.<br><br>Findings included:<br><br>1. For Resident #30, the facility staff failed to implement abuse policies.<br><br>Resident #30 was a 54 year old who was admitted to the facility on 10/3/17. Resident # 30's diagnoses included Dependence on Renal Dialysis, Pain, Hypertension, Gastro- Esophageal Reflux Disease, Muscle Weakness, and Major Depressive Disorder.<br><br>The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date | F 607 | 2. Current alert and oriented residents were interviewed to ensure no other residents were affected by Social Services Director/ designee on 11/29/2018. Current demented residents had skin assessments performed by Unit Managers/ designee on 11/29/2018.<br>3. Current staff were inserviced by Administrator/ designee abuse reporting and prevention by 12/14/2018.<br>4. Alert and oriented residents will be interviewed weekly times twelve weeks to ensure reports of abuse have been properly followed through on by the Social Service director/ designee. Demented residents will have skin assessments performed weekly times twelve to ensure any signs of abuse have been properly followed through on by Unit Manager/ deisgnee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| F 607 | Continued From page 18<br>of 9/27/18 was reviewed. It coded Resident #30 as having a Brief Interview of Mental Status Score of 15, indication that she was cognitively intact.<br><br>On 11/28/18 at 10:15 A.M. an interview was conducted with Resident #30 who stated that she had been physically and verbally abused by a staff member on night shift. She stated that the CNA was an African American woman in her 60's.<br><br>On 11/28/18 at 10:42 A.M., a second interview was conducted with Resident #30 in her room. The Facility Administrator (Employee A), and the Director of Nursing (Employee B) were present. Resident #30 stated that she had been verbally and physically abused by an "African American woman in her 60's who works on night shift." The DON identified the Certified Nursing Assistant as CNA E. Resident #30 stated that on more that one occasion, CNA E handled her roughly, pulled on her arms in a painful manner, and spoke rudely to her on several occasions. She stated that this had been happening over the past three years, most recently on 11/26/18. She stated that she did not want CNA E to touch her anymore. Resident #30 stated that she had informed the nursing supervisor (LPN D).<br><br>On 11/28/18 at 10:50 A.M., an interview was conducted with the nursing supervisor (LPN D). She stated "I've heard that CNA (CNA E) speaking inappropriately with residents. I had to speak to her about it. I had to counsel her about her inappropriate manner of speaking in a rough manner with the residents. (Resident #30) told me that she reported (CNA E) to the 'people in the front offices'. " When asked why she didn't report the abuse allegations to the Director of | F 607 | | |

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| F 607 | Continued From page 19 | F 607 | | |

Nursing (Employee B), or to the Administrator (Employee A), LPN D stated, "I didn't report it because I thought that the resident had done so."

On 11/29/18 at 2:00 P.M., an interview was conducted with the Administrator (Employee A). She was asked why the residents hadn't been protected from further abuse after the supervisor witnessed verbal abuse, and why the allegations of verbal and physical weren't investigated or reported to the state agency. The Administrator stated, "Staff are expected to report allegations to her or the Director of Nursing (Employee B). She further stated that allegations are supposed to be reported to the state agency and investigated, but that she and the DON hadn't been aware of the allegations.

On 11/29/18 a review was conducted of facility documentation. It read, "Abuse, Neglect and Exploitation Policy. Date: 1/19/17. Protection from Abuse: In the event a staff member has been accused, they will be interviewed by the Executive Director and be immediately escorted from the facility."

2. For Resident #98, the facility staff failed to implement abuse policies.

Resident # 98, a male, was admitted to the facility 11/6/2018 with diagnoses of but not limited to: Acquired absence of right upper limb above elbow, Severe sepsis, Chronic Viral Hepatitis C, Acute Kidney Failure, Heart Failure, Gastroesophageal Reflux Disease, Diabetes, and Hypertension.

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| F 607 | Continued From page 20 | F 607 | | |

Resident # 98's most recent MDS with an ARD of 11/13/2018 was coded as an admission assessment. Resident # 98's BIMS (Brief Interview for Mental Status) score was coded as 14 indicating no cognitive impairment. Resident # 98 was coded as needing limited assistance of one staff member to perform his activities of daily living. Resident # 98 was coded as being able to hear, speak, understand, and be understood.

On 11/29/18 at 11:10 A.M., Resident # 98 reported to the surveyor, the Administrator (Employee A) and the DON (Employee B) that he had been verbally abused a few times by a CNA who works on night shift. The resident described the CNA as being a dark skinned African American woman who is in her 60's. He stated that the CNA speaks to him in a "mean and hateful manner". He reported that he told the Rehab staff about the CNA. The DON identified the CNA as being CNA E.

On 11/29/18 a review was conducted of facility documentation. It read, "Abuse, Neglect and Exploitation Policy. Date: 1/19/17. Protection from Abuse: In the event a staff member has been accused, they will be interviewed by the Executive Director and be immediately escorted from the facility."

The Administrator stated she was not aware of the allegation prior to 11/28/2018. The facility Administrator and DON were informed of the failure of the facility staff to implement abuse policies of investigation of allegations of abuse. Several staff members were aware of Resident # 98's allegation of abuse and mistreatment.

No further information was provided.

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| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure that two residents' (#30 and #98) allegations of physical and verbal abuse by staff, in the survey sample of 36 residents were reported to the state agency. | F 609 | F 609<br>1. Residents #30, #158, & #98 allegation of abuse were identified, investigated, and sent to the appropriate agencies. Staff members were identified and suspended pending investigation.<br>2. Current alert and oriented residents were interviewed to ensure no other residents were affected by Social Services Director/ designee on 11/29/2018. Current demented residents had skin assessments performed by Unit Managers/ designee on 11/29/2018.<br>3. Current staff were inserviced by Administrator/ designee abuse reporting and prevention by 12/14/2018.<br>4. Alert and oriented residents will be interviewed weekly times twelve weeks to ensure reports of abuse have been properly followed through on by the Social Service Director/ designee. Demented residents will have skin assessments performed weekly times twelve to ensure any signs of abuse have been properly followed through on by Unit Manager/ designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| F 609 | Continued From page 22<br><br>1. For Resident #30, the facility staff failed to ensure that allegations of abuse were reported to the state agency.<br><br>2. For Resident #98, the facility staff failed to ensure that allegations of abuse were reported to the state agency.<br><br>Findings included:<br><br>1. For Resident #30, the facility staff failed to ensure that allegations of abuse were reported to the state agency.<br><br>Resident #30 was a 54 year old who was admitted to the facility on 10/3/17. Resident # 30's diagnoses included Dependence on Renal Dialysis, Pain, Hypertension, Gastro- Esophageal Reflux Disease, Muscle Weakness, and Major Depressive Disorder.<br><br>The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 9/27/18 was reviewed. It coded Resident #30 as having a Brief Interview of Mental Status Score of 15, indication that she was cognitively intact.<br><br>On 11/28/18 at 10:15 A.M., an interview was conducted with Resident #30 who stated that she had been physically and verbally abused by a staff member on night shift. She stated that the CNA was an African American woman in her 60's.<br><br>On 11/28/18 at 10:42 A.M., a second interview was conducted with Resident #30 in her room. The Facility Administrator (Employee A), and the | F 609 | | |

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Director of Nursing (Employee B) were present. Resident #30 stated that she had been verbally and physically abused by an "African American woman in her 60's who works on night shift." The DON identified the Certified Nursing Assistant as CNA E. Resident #30 stated that on more that one occasion, CNA E handled her roughly, pulled on her arms in a painful manner, and spoke rudely to her on several occasions. She stated that this had been happening over the past three years, most recently on 11/26/18. She stated that she did not want CNA E to touch her anymore. Resident #30 stated that she had informed the nursing supervisor (LPN D).

On 11/28/18 at 10:50 A.M., an interview was conducted with the nursing supervisor (LPN D). She stated "I've heard that CNA (CNA E) speaking inappropriately with residents. I had to speak to her about it. I had to counsel her about her inappropriate manner of speaking in a rough manner with the residents. (Resident #30) told me that she reported (CNA E) to the 'people in the front offices'. " When asked why she didn't report the abuse allegations to the Director of Nursing (Employee B), or to the Administrator (Employee A), LPN D stated, "I didn't report it because I thought that the resident had done so."

On 11/29/18 at 2:00 P.M., an interview was conducted with the Administrator (Employee A). She was asked why the residents hadn't been protected from further abuse after the supervisor witnessed verbal abuse, and why the allegations of verbal and physical weren't investigated or reported to the state agency. The Administrator stated, "Staff are expected to report allegations to her or the Director of Nursing (Employee B). She further stated that allegations are supposed to be

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reported to the state agency and investigated, but that she and the DON hadn't been aware of the allegations.

2. For Resident #98, the facility staff failed to ensure that allegations of abuse were reported to the state agency.

Resident # 98, a male, was admitted to the facility 11/6/2018 with diagnoses of but not limited to: Acquired absence of right upper limb above elbow, Severe sepsis, Chronic Viral Hepatitis C, Acute Kidney Failure, Heart Failure, Gastroesophageal Reflux Disease, Diabetes, and Hypertension.

Resident # 98's most recent MDS with an ARD of 11/13/2018 was coded as an admission assessment. Resident # 98's BIMS (Brief Interview for Mental Status) score was coded as 14 indicating no cognitive impairment. Resident # 98 was coded as needing limited assistance of one staff member to perform his activities of daily living. Resident # 98 was coded as being able to hear, speak, understand, and be understood.

On 11/28/2018 at 4:00 PM, an interview was conducted with CNA (Certified Nursing Assistant) A who stated he witnessed an incident between Resident # 98 and CNA C on Monday, 11/26/2018 in the dining room. CNA A stated Resident # 98 was rude to CNA C about the food tray. CNA A stated he had never experienced any conflict with Resident # 98 and was surprised at the interaction he witnessed. CNA A stated CNA

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| F 609 | Continued From page 25<br>C worked 3-11 shift and that he saw her clock in prior to his coming to talk with the surveyor.<br><br>On 11/28/2018 at 4:25 PM, the DON stated CNA C had just written a witness statement and was suspended pending the investigation. The DON stated CNA C was upset because she felt Resident # 98 did not like her and thought she had done the right thing by ignoring his comments and asking a coworker to work with him instead.<br><br>Review of the Witness Statement from CNA C revealed statements "____is very confrontational. He were in the dining (sic) room eating lunch. After lunch, everyone else had left, so once he finished his meal I asked him if he needed to go to therapy he said no so I unlocked his w/c (wheelchair) to remove him from the dining room but he got upset and said I don't unlock his chair he is a human being I asked him, so I asked the other staff member to transport him to his room so it would not be any thing said out of the way to each other. After that I would go to other staff and ask them to transport him out of the dining room So that it would not be any confrontation because I know he doesn ' t like me. He would come to the dining room and make all kinds of remarks to me and about me. I just started ignoring his comments. I did think I did anything wrong because I asked another staff to transport him from the dining room to his room. I had never refused to do anything for ____(Resident # 98) or any other resident when asked." She reiterated that she asked her coworker to transport Resident # 98 out of the dining room to his room to "keep any confrontational situations from occurring." On another page of the witness statement, CNA C stated Resident # 98 "would | F 609 | | |

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| F 609 | Continued From page 26<br>come in the dining room complaining about the food and how this place is getting his money. Over this weekend he kept making remarks about me finally a resident spoke up for me. He made a statement to a co-worker that he know at least one person who want to poison him. I knew he was talking about me but I just kept ignoring him. I did say that you are not going to talk to me any kind of way." CNA C listed four staff members who were witnesses "on some of these occasions."<br><br>On 11/28/2018 at 5:10 PM, an interview was conducted with LPN (Licensed Practical Nurse) D who stated she had never experienced any problems with Resident # 98. LPN D stated she was not aware of any conflict with Resident # 98 and any staff members on the 3-11 shift on which she worked, but had "heard staff members from the 11-7 shift talking about issues of conflict with him." LPN D stated did not know see any of those concerns listed on the care plan.<br><br>On 11/29/2018 at 1:30 PM, a copy of an employee statement was presented to the surveyor. The statement dated November 20, 2018 from CNA (Certified Nursing Assistant ) E stated that on 11/17/2018, Resident # 98 was very verbally abusive and very demanding the entire shift. He made various racial comments and spoke to me aggressively and with angry. He accused me of not properly taking care of him and blamed me for things that happen on another shift.......I asked_____to work with him. He was very rude to her and threw a pillow which came in the hallway." The statement also said Resident # 98 "threatened to call the police and get this building shut down and get the state involved." | F 609 | | |



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| F 609 | Continued From page 27<br>On 11/29/2018 at 3:45 PM, an interview was conducted with RN (Registered Nurse) C who stated that on 11/20/2018, the Rehab staff reported to the her that Resident # 98 told them that staff was rude to him and did not give proper care. RN C stated she investigated the report by talking with the night shift who stated they had no problems with Resident # 98. RN C stated she did report the information to the Director of Nursing. RN C stated after her investigation she did not find any evidence to substantiate the allegation.<br><br>Review of the facility documentation and the clinical record revealed no documentation of facility staff members notifying the Administrator or DON prior to the surveyor discussing with them on 11/28/2018.<br><br>On 11/29/2018 at 3:50 PM, the Administrator presented a copy of the Facility Reported Incident that was submitted to the State Agency on 11/28/2018 at 12:15 PM after the meeting with Resident # 98. The Administrator stated CNA C was suspended pending investigation and CNA E was already on suspension as per documented on the FRI form.<br><br>On 11/29/2018 at 4:00 PM, the facility Administrator and DON were informed of the findings. The DON again stated she was unaware of the allegation of verbal abuse and mistreatment until 11/28/2018.<br><br>No further information was provided. | F 609 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g) | F 641 | F 641<br>1. Resident #3 had a modification completed on 11/28/2018 to include the Vistaril by the MDS coordinator/ designee. | |



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| F 641 | Continued From page 28<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility documentation review, the facility staff failed to ensure an accurate assessment for 1 of 36 residents sampled (Resident #3) by not including Vistaril (an antianxiety medication) in the resident's assessment.<br><br>The findings included:<br><br>Resident #3 was admitted 1/23/2014 with diagnoses that included: traumatic brain injury, dementia with behavioral disturbance, and psychosis.<br><br>A review of the resident's physician orders for January 2018 through June 2018 showed an order for Vistaril 25 milligrams twice a day for psychosis. A review of the resident's medication administration record for February 2018 and May 2018 showed that the Vistaril was administered daily as ordered.<br><br>A review of the Food and Drug Administration package insert for Vistaril(located at https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/011459s048,011795s025lbl.pdf) shows that Vistaril is considered an antianxiety medication. It states "For symptomatic relief of anxiety and tension associated with psychoneurosis and as an adjunct in organic disease states in which anxiety is manifested."<br><br>Resident #3 had two prior Minimum Data Set (MDS) assessments in 2018; a quarterly | F 641 | 2. Current residents with an ARD between November 15th through November 30th 2018 section N was audited to ensure medications were properly coded by MDS coordinator/ designee by 12/14/2018.<br>3. MDS coordinators will be educated by the Administrator/ designee on requirements for section N by 12/14/2018.<br>4. A weekly audit of section N of the MDS (that have been completed that week) for 12 weeks this will be conducted by the MDS coordinator to ensure medications are captured correctly times twelve weeks by the MDS coordinator/ designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| F 641 | Continued From page 29<br>assessment dated 2/26/2018, and a quarterly assessment dated 5/29/2018. For both of these assessments, Section N0410B was coded as zero days the resident received an antianxiety medication.<br><br>On 11/28/2018 at 12:35 PM, an interview was held with RN #1, the facility MDS coordinator. She was shown the medication administration records for February 2018 and May 2018, and the MDS assessments dated 2/26/2018 and 05/29/2018 and asked if she saw any issues. She replied "the Vistaril is not on the MDS." On 11/28/2018 at 1:20 PM, RN #1 returned to the surveyor and reported that both assessments had been corrected, and the corrections transmitted to the federal database.<br><br>A review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Effective October 2017 shows the following coding instructions for field N0410B:<br>Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic.<br><br>No further information was provided prior to exit. | F 641 | | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. | F 645 | F 645<br>1. Resident #94 & #49s PASARR was completed by the Social Service Director on 11/28/2018. | |

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| F 645 | Continued From page 30<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under | F 645 | 2. Current residents' PASARRs were audited and updated on 12/14/2018 by Social Service Director/ designee.<br>3. Social Services and admissions will be educated on PASARR requirements by Administrator/ Designee on or before 12/14/2018.<br>4. Weekly audits of new residents' PASARRs will be completed to ensure residents have PASARRs in chart times twelve weeks this will be completed by the Social Service Director/ Designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |



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| F 645 | Continued From page 31<br>paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review, the facility staff failed to obtain a PASARR prior to admission to the facility for two residents (Residents # 94 and # 49) in a survey sample of 36 residents.<br><br>1. For Resident # 94, the facility staff failed to obtain a PASARR screening prior to admission to the facility.<br><br>2. For Resident #49, the facility staff failed to obtain a PASARR prior to admission to the facility. | F 645 | | |

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| F 645 | Continued From page 32<br><br>Findings included:<br><br>1. For Resident # 94, the facility staff failed to obtain a PASARR screening prior to admission to the facility.<br><br>Resident # 94 was admitted to the facility on 8/18/2017 with diagnoses of but not limited to: Encephalopathy, Dysphagia, Bipolar Disorder, Tracheostomy, Acute and Chronic Respiratory Failure, Gastrostomy Tube, Convulsions, Persistent Vegetative State and Hypertension.<br><br>On 11/28/2018 at 2:30 PM, review of the clinical record was conducted.<br><br>Review of the clinical record revealed there was no PASARR Level 1 Screening in the electronic or paper clinical record.<br><br>On 11/29/2018 at 11:00 AM, an interview was conducted with the Social Worker who stated the Business Office did not have a PASARR<br><br>On 11/29/2018 at 4:30 PM during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings of no PASARR for Resident # 94.<br><br>On 11/29/2018 at 2:45 PM, an interview was conducted with the Social Worker who stated she completed the PASARR screening for Resident # 94 on 11/28/2018. The Social Worker, Administrator and Director of Nursing were advised that residents admitted to nursing facilities must have a Level 1 screening prior to admission. The Administrator stated the facility staff had audited clinical records and had begun | F 645 | | |

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| F 645 | Continued From page 33<br>completing PASARR screenings on all residents already admitted to the facility without a completed screening. The Administrator also stated the facility staff would ensure all future admissions had a PASARR prior to admission.<br><br>No further information was provided.<br><br>2. For Resident #49, the facility staff failed to obtain a PASARR prior to admission to the facility.<br><br>Resident #49 was a 70 year old who was admitted to the facility on 3/31/06. Resident # 49's diagnoses included Diabetes Mellitus Type 2, Schizophrenia, and Major Depressive Disorder. The Schizophrenia was diagnosed prior to admission to the facility.<br><br>The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 1/18/18 coded Resident #49 as having severely impaired cognition.<br><br>On 11/29/18, a review was conducted of Resident #49's clinical record. The record did not contain a PASARR.<br><br>On 11/29/18 at 2:00 P.M. an interview was conducted with the facility Administrator ( Employee A). When asked why Resident #49 did not have a PASARR, the Administrator stated, "It was supposed to be done prior to the resident being admitted to this facility." She stated the facility Social Worker is responsible for the assessment. | F 645 | | |

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| F 656 | Continued From page 34 | F 656 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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 | F 656 | F 656<br>1. Resident # 89's careplan was updated with targeted behaviors supporting use of Seroquel on 12/07/2018. Resident # 98's careplan was updated to include verbally abusive behaviors on 11/28/2018.<br>2. Current residents careplans were audited by UM/ designee on 12/14/2018 to ensure residents behaviors were reflected in their careplans.<br>3. License nurses will be educated on comprehensive careplans by DON/designee on or before 12/14/2018.<br>4. Weekly audits times 12 weeks will be completed on careplans by UM/designee to ensure behaviors are addressed in each resident's careplan. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |



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| F 656 | Continued From page 35 | F 656 | | |

entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed to review and revise the comprehensive care plan for 2 residents (Resident #89 and #98) of 36 residents in the survey sample.

1. For Resident #89, the targeted behaviors supporting the use of Seroquel were not included on the comprehensive care plan.

2. For Resident # 98, the facility staff failed to develop and implement a comprehensive care plan to include "verbally abusive behaviors" until 11/28/2018.

The findings included:

Resident #89, an 86 year old, was admitted to the facility on 5/13/18. Diagnoses included Alzheimer's disease, reflux, hypertension, depression, and dysphagia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/8/18. Resident #89 was coded with severe cognitive impairment and required extensive assistance with activities of daily living. She was not coded to have behaviors.

On 11/29/18 at 10:00 a.m., Resident #89 was observed lying across her bed in a fetal position. She was asleep on top of the covers.

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| F 656 | Continued From page 36<br><br>Resident #89's clinical record included two orders dated 6/6/18 for Seroquel:<br>1. Seroquel 50 milligrams 1 tablet by mouth at bedtime for psychosis.<br>2. Seroquel 50 milligrams 1 tablet three times a day for psychosis.<br><br>The November 2018 Treatment Administration Record (TAR) included the order, "Complete behavior progress note, if resident has behaviors during your shift. Every shift." The targeted behaviors were not included on the TAR.<br><br>Resident #89's comprehensive care plan was reviewed. A focus area dated 10/3/17 read, ____ has potential to demonstrate physical behaviors r/t (related to) Dementia. The interventions were dated 10/3/17 and included the following: analyze triggers, places, times and what de-escalates behavior, assess needs, evaluate side effects of meds, intervene before agitation escalates, document behavior, psych consult as needed. This focus was added to the care plan after Resident #89 tried to hit the CNA on 10/2/17.<br><br>The care plan also included the focus dated 1/23/18 that read, Use of Psychotropic drug places resident at risk for drug related side effects. Antidepressant: Lexapro, Antipsychotic: Seroquel. Specify Diagnosis for which drug has been prescribed: psychosis and depression. The interventions dated 1/23/18 included: administer medications as prescribed by the physician and implement the behavior interventions, evaluate on a periodic basis for gradual dose reduction or discontinuation, if applicable. The care plan did not include the types of behaviors that were exhibited by Resident #89 supported the use of | F 656 | | |

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| F 656 | Continued From page 37<br>Seroquel.<br><br>On 11/29/18 at the end of day meeting, the care plan issue was reviewed with the Administrator and Director of Nursing.<br><br>2. For Resident # 98, the facility staff failed to develop and implement a comprehensive care plan to include "verbally abusive behaviors" until 11/28/2018.<br><br>Resident # 98, a male, was admitted to the facility 11/6/2018 with diagnoses of but not limited to: Acquired absence of right upper limb above elbow, Severe sepsis, Chronic Viral Hepatitis C, Acute Kidney Failure, Heart Failure, Gastroesophageal Reflux Disease, Diabetes, and Hypertension.<br><br>Resident # 98's most recent MDS with an ARD of 11/13/2018 was coded as an admission assessment. Resident # 98's BIMS (Brief Interview for Mental Status) score was coded as 14 indicating no cognitive impairment. Resident # 98 was coded as needing limited assistance of one staff member to perform his activities of daily living. Resident # 98 was coded as being able to hear, speak, understand, and be understood.<br><br>On 11/28/2018 at 10:20 AM, Resident # 98 stated one CNA on the 3-11 shift refused to serve his food tray in the dining room. He gave the name of the CNA. Resident # 98 stated he did not eat one meal in the dining room one day and CNA would not serve him when he went to the dining room for his meal on subsequent days. Resident 98 stated the CNA did not treat him right. The Director of Nursing identified the CNA as CNA C. | F 656 | | |



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| F 656 | Continued From page 38<br>Resident # 98 stated the facility staff was aware of how he was treated by the nursing staff members. Resident # 98 stated he had talked with the Rehab staff about it and had talked with the administrator. When the surveyor asked Resident # 98 if he had told the facility staff about his experiences and concerns, he replied "yes" and stated he had discussed some things with the administrator. Resident # 98 stated that he understood the facility staff were often busy but he deserved to be treated right.<br><br>On 11/28/2018 at 4:00 PM, an interview was conducted with CNA Certified(d Nursing Assistant) A who stated he witnessed an incident between Resident # 98 and CNA C on Monday, 11/26/2018 in the dining room. CNA A stated Resident # 98 was rude to CNA C about the food tray. CNA A stated he had never experienced any conflict with Resident # 98 and was surprised at the interaction he witnessed. CNA A stated CNA C worked 3-11 shift and that he saw her clock in prior to his coming to talk with the surveyor.<br><br>On 11/28/2018 at 4:25 PM, the DON stated CNA C had just written a witness statement and was suspended pending the investigation. The DON stated CNA C was upset because she felt Resident # 98 did not like her and thought she had done the right thing by ignoring his comments and asking a coworker to work with him instead.<br><br>Review of the Witness Statement from CNA C revealed statements "____is very confrontational. He were in the dining (sic) room eating lunch. After lunch, everyone else had left, so once he finished his meal I asked him if he needed to go to therapy he said no so I unlocked his w/c | F 656 | | |

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| F 656 | Continued From page 39<br>(wheelchair) to remove him from the dining room but he got upset and said I don't unlock his chair he is a human being I asked him, so I asked the other staff member to transport him to his room so it would not be any thing said out of the way to each other. After that I would go to other staff and ask them to transport him out of the dining room So that it would not be any confrontation because I know he doesn ' t like me. He would come to the dining room and make all kinds of remarks to me and about me. I just started ignoring his comments. I did think I did anything wrong because I asked another staff to transport him from the dining room to his room. I had never refused to do anything for ____(Resident # 98) or any other resident when asked." She reiterated that she asked her coworker to transport Resident # 98 out of the dining room to his room to "keep any confrontational situations from occurring." On another page of the witness statement, CNA C stated Resident # 98 "would come in the dining room complaining about the food and how this place is getting his money. Over this weekend he kept making remarks about me finally a resident spoke up for me. He made a statement to a co-worker that he know at least one person who want to poison him. I knew he was talking about me but I just kept ignoring him. I did say that you are not going to talk to me any kind of way." CNA C listed four staff members who were witnesses "on some of these occasions."<br><br>On 11/28/2018 at 5:10 PM, an interview was conducted with LPN (Licensed Practical Nurse) D who stated she had never experienced any problems with Resident # 98. LPN D stated she was not aware of any conflict with Resident # 98 and any staff members on the 3-11 shift on which | F 656 | | |

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| F 656 | Continued From page 40 | F 656 | | |

she worked, but had "heard staff members from the 11-7 shift talking about issues of conflict with him." LPN D stated did not know see any of those concerns listed on the care plan.

On 11/29/2018 at 12:10 PM, received a copy of the care plan for Resident # 98. Review of the care plan revealed on page 7 of 10, Focus-"often have episodes where he exhibits verbally abusive behaviors r/t (related to) poor impulse control. The date initiated was: 11/28/2018, Revision: 11/28/2018.

Resident # 98 was admitted on 11/6/2018, the care plan was initiated on 11/13/2018 and revised on 11/16/2018 for urinary incontinence, on 11/26/2018 for focus concerns of cardiovascular status, Gastroesophageal and cardiovascular disease. There was no mention of behaviors as a focus on the care plan until 11/28/2018.

On 11/29/2018 at 1:30 PM, a copy of an employee statement was presented to the surveyor. The statement dated November 20, 2018 from CNA (Certified Nursing Assistant ) E stated that on 11/17/2018, Resident # 98 was very verbally abusive and very demanding the entire shift. He made various racial comments and spoke to me aggressively and with angry. He accused me of not properly taking care of him and blamed me for things that happen on another shift.......I asked_____to work with him. He was very rude to her and threw a pillow which came in the hallway." The statement also said Resident # 98 "threatened to call the police and get this building shut down and get the state involved."

On 11/29/2018 at 1:35 PM, the DON (Director of Nursing) stated she "just learned of those

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| F 656 | Continued From page 41<br>behaviors yesterday." The DON stated the care plan should have included any behaviors noted during the assessment period.<br><br>During the end of day debriefing, the facility Administrator and DON were informed of the findings.<br><br>No further information was provided. | F 656 | | |
| F 690<br>SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. | F 690 | F 690<br>1. Resident # 92's catheter bag was elevated off the floor on 11/28/2018.<br>2. Current resident with a foley catheter bag were all checked to ensure they were not on the floor on 11/28/2018.<br>3. Nursing staff will be educated on keeping foley catheter bags off the floor by DON/designee on or before 12/14/2018.<br>4. A weekly audit times twelve of residents who have a foley catheter bag will be completed by the Unit Manager/designee to ensure catheter bags are off the floor. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| F 690 | Continued From page 42<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review the facility staff to ensure the catheter bag was maintained in a manner to prevent the spread of infection for 1 resident (Resident #92) of 36 residents in the survey sample.<br><br>Resident #92's catheter bag was observed on the floor.<br><br>The findings included:<br><br>Resident #92, an 85 year old, was re-admitted to the facility on 11/1/18. Diagnoses included diabetes, peripheral vascular disease, hyperlipidemia, reflux, hypertension, dysphagia, depression, and chronic kidney disease. The most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 11/8/18. Resident #92 was coded with severe cognitive impairment and required extensive assistance with activities of daily living. He was coded to have an indwelling catheter.<br><br>On 11/28/18 at 8:15 a.m., Resident #92 was observed sleeping in bed. The bed was in the lowest position. The catheter bag was in a | F 690 | | |



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F 690 — Continued From page 43

privacy bag hanging from the bed frame. The bottom 1/3 of the privacy bag was touching the floor.

On 11/28/18 at 1:30 p.m. the catheter bag was observed on the floor.

At the end of day meeting on 11/28/18, the Administrator and Director of Nursing (DON) were notified that Resident #92's catheter bag was observed on the floor. The DON stated the catheter bag should not be on the floor due to risk of infection.

The facility policy titled "Catheter Care" was reviewed. The policy read, "CAUTI (Catheter Associated Urinary Tract Infection) is the most common adverse even associated with indwelling urinary catheters, including those that are asymptomatic." Section V of the Catheter Care section read, "Check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder."

F 755 SS=D — Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures

**Provider's Plan of Correction — F 755**

1. Resident #92 flagyl was administered on 10/07/2018.
2. Current residents MARs were audited to ensure medications were available by Unit Manager/ designee on 11/30/2018.
3. Nursing staff will be educated on what to do if a medication is not available by the Director of Nursing/ designee by 12/14/2018.

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| F 755 | Continued From page 44<br>that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to ensure medications were available for administration for 1 resident (Resident #92) of 36 residents in the survey sample.<br><br>For Resident #92, Flagyl (antibiotic) was unavailable for administration.<br><br>The findings included:<br><br>Resident #92, an 85 year old, was re-admitted to the facility on 11/1/18. Diagnoses included diabetes, peripheral vascular disease, hyperlipidemia, reflux, hypertension, dysphagia, | F 755 | 4. A weekly audit of residents' medications will be completed to ensure they are available times twelve weeks by the Unit Manager/designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| F 755 | Continued From page 45<br>depression, and chronic kidney disease. The most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 11/8/18. Resident #92 was coded with severe cognitive impairment and required extensive assistance with activities of daily living. He was coded to have an indwelling catheter.<br><br>On 10/4/18, Resident #92 was re-admitted from the hospital to the facility with an order for Flagyl 100 milligrams daily for 7 days.<br><br>According to the October 2018 Medication Administration Record (MAR), on 10/5/18 the first does of Flagyl was not administered. A "9" was documented on the MAR indicating "Other/ See Nurse Notes."<br><br>The Flagyl was discontinued on 10/6/18. The Flagyl was reordered and started on 10/7/18.<br><br>On 11/28/18 at the end of day meeting, the Administrator and Director of Nursing (DON) were asked about the Flagyl orders. It was reviewed with the DON that it appeared that the Flagyl was discontinued because it was unavailable.<br><br>On 11/29/18, the following typed summary note was provided by the facility staff:<br>"10/04/2018- Readmitted back to facility<br>10/06/2018- Awaiting for Flagyl from Pharmacy was not in first dose. MD (doctor) made aware D/C'D (discontinued) same day and was to restart when medication arrive.<br>10/07/2018- Medication arrived and Flagyl started." | F 755 | | |

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| F 755 | Continued From page 46<br>A list of medications available in the facility stat box was requested and provided. Flagyl was listed as a medication available for administration from the stat box.<br><br>No further information was provided. | F 755 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§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;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a | F 758 | F 758<br>1. Resident #89 had physician documentation completed on 11/29/2018 which documented appropriate diagnosis for Seroquel. Targeted behaviors were update in the careplan. A GDR was attempted on 11/04/2018, but was declined by the physician.<br>2. Residents being administered antipsychotics were audited to ensure they have appropriate diagnosis, targeted behaviors in careplan, and GDRs attempted or physician documentation why a GDR was not by Unit manager/designee by 12/14/2018.<br>3. Nursing staff will be inserviced on antipsychotic usage with appropriate diagnosis, targeted behaviors in careplans, and GDRs by DON/designee by 12/14/2018. | |



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| F 758 | Continued From page 47<br>diagnosed specific condition that is documented in the clinical record; and<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review the facility staff failed to ensure 1 resident (Resident #89) of 36 residents in the survey sample was free from unnecessary psychotropic medications.<br><br>Resident #89:<br>1) Did not have an appropriate diagnosis to support the use of Seroquel.<br>2) There were no documented target behaviors in the clinical record or in the comprehensive care plan that supported the use of Seroquel.<br>3) The facility had not attempted a Gradual Dose Reduction.<br><br>The findings included:<br><br>Resident #89, an 86 year old, was admitted to the facility on 5/13/18. Diagnoses included | F 758 | 4. A weekly audit of residents being administered antipsychotics will be completed times twelve by Unit Manager /designee to ensure appropriate diagnosis are used, targeted behaviors are in the careplan, and GDRs are being attempted.<br><br>Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 1/07/2019 |

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| F 758 | Continued From page 48<br>Alzheimer's disease, reflux, hypertension, depression, and dysphagia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/8/18. Resident #89 was coded with severe cognitive impairment and required extensive assistance with activities of daily living. She was not coded to have behaviors.<br><br>On 11/29/18 at 10:00 a.m., Resident #89 was observed lying across her bed in a fetal position. She was asleep on top of the covers.<br><br>Resident #89's clinical record included two orders dated 6/6/18 for Seroquel:<br>1. Seroquel 50 milligrams 1 tablet by mouth at bedtime for psychosis<br>2. Seroquel 50 milligrams 1 tablet three times a day for psychosis<br><br>The following statement about psychosis was accessed on 12/3/18 at 1:28 p.m. from the National Alliance on Mental Illness website: https://www.nami.org/earlypsychosis<br>"Psychosis is a symptom, not an illness"<br><br>The following information about Seroquel was accessed on 12/3/18 at 1:38 p.m. from the Food and Drug Administration website: https://www.fda.gov/downloads/Drugs/DrugSafety/ucm089126.pdf<br>"SEROQUEL may cause serious side effects, including:<br>1. risk of death in the elderly with dementia. Medicines like SEROQUEL can increase the risk of death in elderly people who have memory loss (dementia). SEROQUEL is not for treating psychosis in the elderly with dementia." | F 758 | | |



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| F 758 | Continued From page 49<br>"What is SEROQUEL?<br>SEROQUEL is a prescription medicine used to treat:<br>· schizophrenia in people 13 years of age or older<br>· bipolar disorder in adults, including:<br>° depressive episodes associated with bipolar disorder<br>° manic episodes associated with bipolar I disorder alone or with lithium or divalproex<br>° long-term treatment of bipolar I disorder with lithium or divalproex<br>· manic episodes associated with bipolar I disorder in children ages 10 to 17 years old"<br><br>The November 2018 Treatment Administration Record (TAR) included the order, "Complete behavior progress note, if resident has behaviors during your shift. Every shift." Targeted behaviors were not included on the TAR.<br><br>On 11/29/18 at the end of day meeting, the facility staff were asked to provide documentation of behavior monitoring. The following nursing notes were provided by the Director of Nursing (DON):<br><br>1/16/18- Resident came out of room in wheelchair kicking and swinging at CNA who was passing trays, resident yelling that she wanted her food<br><br>10/8/17- Resident was getting agitated this morning. Resident was trying to get out of bed without assistance, and yelling at roommate. Resident was given a prn (as needed medication)<br><br>10/6/17- Resident found on floor pulling bed alarm cord. Resident crying, anxious and combative | F 758 | | |

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| F 758 | Continued From page 50<br><br>10/5/17- Resident stated that there were rocks in her mouth and in her bed. Crying throughout the night and increased anxiety. prn Ativan administered.<br><br>10/2/17- Resident trying to hit Certified Nursing Assistant (CNA) and throw water. Resident given prn medication<br><br>8/17/17- Resident standing at the bedside of roommate, pulling on roommate and telling her, "get out of my bed"<br><br>According to the behavior notes provided by the DON, the most recent documented behavior was nine month ago in January 2018. The DON stated that Resident #89 had hallucinations. She referenced the note from 10/5/17 where Resident #89 stated she had rocks in her mouth and bed. It was reviewed with the DON that this note was written 13 months prior.<br><br>Resident #89's comprehensive care plan was reviewed. A focus area dated 10/3/17 read, ___ has potential to demonstrate physical behaviors r/t (related to) Dementia. The interventions were dated 10/3/17 and included the following: analyze triggers, places, times and what de-escalates behavior, assess needs, evaluate side effects of meds, intervene before agitation escalates, document behavior, psych consult as needed. This focus was added to the care plan after Resident #89 tried to hit the CNA on 10/2/17 as documented in the nursing note above.<br><br>The care plan also included the focus dated 1/23/18 that read, Use of Psychotropic drug places resident at risk for drug related side | F 758 | | |

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| F 758 | Continued From page 51<br>effects. Antidepressant: Lexapro, Antipsychotic: Seroquel. Specify Diagnosis for which drug has been prescribed: psychosis and depression. The interventions dated 1/23/18 included: administer medications as prescribed by the physician and implement the behavior interventions, evaluate on a periodic basis for gradual dose reduction or discontinuation, if applicable.<br><br>On 11/4/18, the pharmacist completed a Monthly Medication Review (MMR) for Resident #89. The pharmacist made the following recommendation, "Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter."<br><br>"This resident has been taking SEROQUEL 50 mg (milligram) QID (four times per day) since (6/2018) without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below:" An "X" was marked beside the following response, "The drug, dose, durations and indications are clinically appropriate; further reductions are contraindicated due to:______" This section was left blank. The form was initialed by the physician. It was not dated. The Assistant Director of Nursing (ADON) initialed the form and dated it on 11/14/18.<br><br>On 11/29/18 at 11:00 a.m., the ADON was asked to explain the process of reviewing pharmacy recommendations. She stated that the facility met monthly with the physician to discuss pharmacy recommendations. Resident #89's pharmacy recommendation was reviewed with | F 758 | | |



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| F 758 | Continued From page 52 the ADON. The ADON was asked where the physician documented a rationale for declining the recommendation. The ADON stated that she wrote a nursing note indicating that it was declined. It was reviewed with the ADON that the physician needed to document the reasons for declining the pharmacy recommendation at the time the recommendation was declined.<br><br>In summary, Resident #89 did not have an appropriate diagnosis to support the use of Seroquel. There were no targeted behaviors documented in the clinical record. According to documentation provided by the facility, Resident #89's most recent behavioral incident occurred 1/16/18 where she attempted to kick a CNA. Other than the episode documented on 10/5/17, there are no documented instances of hallucinations or delusions. Lastly, the facility did not attempt a GDR to verify that the resident was on the lowest effective dose. | F 758 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to ensure 1 resident (Resident #92) of 36 residents in the survey sample was free from significant medication error.<br><br>For Resident #92, Flagyl (antibiotic) was ordered on 10/4/18. The first does was not administered | F 760 | F 760<br>1. Resident # 92's Flagyl was administered on 10/07/2018. A medication error form was completed.<br>2. Current residents' medications were audited to ensure they were available on 11/30/2018 by Unit Manager/ Designee.<br>3. Licensed nurses will be educated on contents of the stat box and what to do if a medication is unavailable by Director of Nursing/ Designee on or by 12/14/2018. .<br>4. A weekly audit of residents' medications will be performed to ensure medications are available by the Unit Manager/ Designee times twelve weeks . Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| F 760 | Continued From page 53<br>until 10/7/18.<br><br>The findings included:<br><br>Resident #92, an 85 year old, was re-admitted to the facility on 11/1/18. Diagnoses included diabetes, peripheral vascular disease, hyperlipidemia, reflux, hypertension, dysphagia, depression, and chronic kidney disease. The most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 11/8/18. Resident #92 was coded with severe cognitive impairment and required extensive assistance with activities of daily living. He was coded to have an indwelling catheter.<br><br>On 10/4/18, Resident #92 was re-admitted from the hospital to the facility with an order for Flagyl 100 milligrams daily for 7 days.<br><br>According to the October 2018 Medication Administration Record (MAR), on 10/5/18 the first does of Flagyl was not administered. A "9" was documented on the MAR indicating "Other/ See Nurse Notes."<br><br>The Flagyl was discontinued on 10/6/18. The Flagyl was reordered and started on 10/7/18.<br><br>On 11/28/18 at the end of day meeting, the Administrator and Director of Nursing (DON) were asked about the Flagyl orders. It was reviewed with the DON that it appeared that the Flagyl was discontinued because it was unavailable.<br><br>On 11/29/18, the following typed summary note was provided by the facility staff: | F 760 | | |

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| F 760 | Continued From page 54<br>"10/04/2018- Readmitted back to facility<br>10/06/2018- Awaiting for Flagyl from Pharmacy was not in first dose. MD (doctor) made aware D/C'D (discontinued) same day and was to restart when medication arrive.<br>10/07/2018- Medication arrived and Flagyl started."<br><br>A list of medications available in the facility stat box was requested and provided. Flagyl was listed as a medication available for administration from the stat box.<br><br>No further information was provided. | F 760 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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 | F 761 | F 761<br>1. The B-1 100 milligram capsules were removed from the medication cart on 11/28/2018.<br>2. Facility medication carts were audited on 11/28/2018 to ensure no expired medications were present on 11/28/2018 by Unit Manager/ designee.<br>3. Licensed nurses will be educated on the use of the manufacturers' expiration dates by Director of Nursing/ Designee on or by 12/14/2018.<br>4. A weekly audit of medication carts will be completed to ensure no expired medications are in use by the Unit Manager/ Designee times twelve weeks. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |

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| F 761 | Continued From page 55<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure that expired drugs were not in use.<br><br>Findings include:<br><br>On 11/28/2018 at 2 PM, an inspection was made of the medication cart for the 100 hall. Note: This provider uses bulk stock medications for commonly used drugs; i.e. the provider uses a large bottle of Acetaminophen for all residents who take the standard dose.<br><br>This medication cart contained a bottle of Vitamin B-1 100 milligram capsules (manufactured by Gericare, serial # 851P04) with a manufacturer's expiration date of 10/2018.<br><br>At 2:15 PM on 11/28/2018, Employee B (the Director of Nursing) was shown this bottle. She was asked what the expiration date of the medication was, and she stated "October 2018, this is expired."<br><br>A review of the provider's Medication Administration Policy showed no process to audit the medication carts and remove any expired medications.<br><br>No further information was provided prior to exit. | F 761 | | |
| F 812<br>SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2) | F 812 | | |



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| F 812 | Continued From page 56<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility staff failed to ensure an air gap was in place in the main kitchen.<br><br>The drainage pipe from the ice machine in the main kitchen was flush against the floor drain. There was no air gap in place.<br><br>The findings included:<br><br>A tour of the main kitchen took place on 11/27/18 at 11:10 a.m. with the Dietary Manager. Upon inspection of the ice machine, it was observed that the drainage pipe from the ice machine was flush against the floor drain. There was no air gap in place to allow for back flow from the drain. After looking at the drainage pipe, the Dietary | F 812 | F 812<br>1. The facility's kitchen drainage pipe was secured above the floor on the ice machine to ensure there was an air gap on 11/28/2018.<br>2. Facility ice machines were audited on 11/28/2018 to ensure there was an air gap present by the maintenance director/ designee.<br>3. Dietary staff and Maintenance staff will be educated on ensuring there is an air gap present on ice machines by the Administrator/Designee on or before 12/14/2018.<br>4. A weekly audit will be performed by the maintenance director/ designee to ensure air gaps are present on ice machines times twelve weeks. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. | 01/07/2019 |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495144 | A. BUILDING ______ B. WING ______ | 11/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PETERSBURG HEALTHCARE CENTER | 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805 |

| (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 812 | Continued From page 57<br>Manager stated that there was a wire fixture that the pipe was supposed to rest on in order to elevate the pipe off the drain. She stated that it was there next to the pipe. She thought it probably got knocked out of place, leaving the drainage pipe against the floor drain.<br><br>At the end of day meeting on 11/28/18, the Administrator and Director of Nursing were notified of the issue. | F 812 | | |