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SOUTHAMPTON MEMORIAL HOSP	100 FAIRVIEW DR FRANKLIN, VA 23851

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/16/18 through 10/18/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/16/18 through 10/18/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 129 certified bed facility was 103 at the time of the survey. The survey sample consisted of twenty-one current resident reviews and one closed record review.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 607	***F – 607*** *The facility sent an initial/final report to OLC and APS on 11/07/2018.* *The administrative and licensed nurses have been re-educated on the facility's Abuse and Neglect Policies. An outside consulting company presented in-service education on Abuse: Reporting and Conducting Investigations to the administrative and licensed nurses on October 26, 2018. A post-test on abuse was given to all license staff.*	

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

Esther Francis, RN LNHA 11-9-18

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 607	Continued From page 1 and clinical record review, the facility staff failed to implement abuse prevention policies regarding reporting an injury of unknown origin to the state agency. Resident #34, with severely impaired cognitive skills and total dependence upon staff for transfers and care, was diagnosed with a distal fibula fracture of unknown origin. This fracture of unknown origin was not reported to the state survey agency or other local agencies as required by facility's policy for abuse investigation/reporting. The findings include: Resident #34 was admitted to the facility on 1/8/16 with diagnoses that included high blood pressure, vitamin deficiency, osteoarthritis, restless leg syndrome and gastroesophageal reflux disease. The minimum data set (MDS) dated 8/2/18 assessed Resident #34 with short and long-term memory problems and severely impaired cognitive skills. MDS assessments dated 5/10/18 ad 8/2/18 listed Resident #34 as totally dependent on two people for transfers and total dependence of one person for eating, dressing and daily hygiene. Resident #34's clinical record documented a nursing note dated 7/16/18 stating, "Resident was taken over to radiology to have her left ankle and foot x-rayed." A note dated 7/17/18 at 1:32 p.m. documented, "...X-ray report was received and faxed to [physician]. See order for orthopedic consult. Tylenol was given at 1030 [10:30 a.m.] for pain..." Resident #34's radiology report dated 7/16/18 documented the resident was diagnosed with an acute distal fibular fracture. (Fibula is the lateral	F 607	*The 24 hour report has been reviewed to determine any resident who has experienced an injury of unknown origin for the past 30 days to ensure that the State Survey agency or other local agencies as required by facility's policy was notified.* *The 24 hour nursing report will be revised to include injury of unknown origin, notification of administrator and/or designee and initiation of investigation.* *The 24 hour sheet will be reviewed daily and signed by the RN Supervisors, DON and Administrator. If non-compliance is observed, the license nurse will be immediately re-educated on investigations of unknown origin. Findings of these audits will be reviewed daily by nursing administration. An analysis of the findings will be reported to the PI Committee monthly times 12 months for additional oversight, recommendations, and determination of the continued audits.*	

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F 607	Continued From page 2 and smaller of the two bones of the lower leg.) This x-ray report documented, "Acute minimally displaced distal diaphysis [shaft] fracture of the fibula without angulation." This report listed the resident had mild lateral soft tissue swelling and pain in the left foot/ankle. The resident was referred to an orthopedist and prescribed immobilization for four weeks with a "cam" boot as treatment. The clinical record documented a monthly nursing summary dated 7/1/18. This assessment documented Resident #34 required total dependence upon staff for bed mobility, transfers, dressing, eating, toileting and hygiene. This assessment listed the resident had "weak legs...little speech" and required the use of a total "maxi" lift for transfers. There was no documentation in the clinical record indicating a known cause of Resident #34's fractured fibula. On 10/16/18, a copy of the facility's investigation of the fracture was reviewed. The investigation report dated 7/16/18 documented the resident was noted with swelling, pain and redness of the left ankle on 7/16/18 at 10:38 a.m. The physician was notified and ordered an x-ray of the left foot/ankle. The report documented on 7/17/18 the x-ray report revealed the resident was diagnosed with an acute minimally displaced left fibula fracture. The investigation report documented interviews with the resident's nurses, certified nurses' aides and a family member. The investigation concluded no evidence of abuse. The report documented,"...it is possible where she could have banged her ankle against the chair, the rail, and/or possibly just slight twisting motion could have created the nondisplaced fracture."	F 607	*The facility's policies on Abuse and Neglect has been reviewed by all staff, will be done yearly and added to new employee orientation.* *This plan will be effective by 11/30/2018 and measures will be maintained to ensure ongoing compliance.*	

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F 607	Continued From page 3	F 607		

The facility investigation report documented no evidence of a known cause of Resident #34's fractured fibula. No report was received by the state agency as of 10/17/18 regarding Resident #34's fracture of unknown source.

On 10/16/18 at 1:10 p.m., the certified nurses' aide (CNA #1) routinely caring for Resident #34 was interviewed about the resident's fractured fibula. CNA #1 stated she did not know how the resident's ankle was broken. CNA #1 stated the resident was "total care," required a full body lift for transfers and was routinely seated in a reclining "geri-chair" when out of her room.

On 10/16/18 at 1:25 p.m., the licensed practical nurse (LPN #2) caring for Resident #34 was interviewed. LPN #2 stated Resident #34 was dependent upon staff for all of her care needs. LPN #2 stated the resident had restless leg syndrome and frequently moved her legs about when in bed or in her chair. LPN #2 stated Resident #34 did not ambulate and used a reclining geri-chair when out of bed.

On 10/17/18 at 10:03 a.m., the director of nursing (DON) was interviewed about why Resident #34's fracture of unknown origin was not reported to the state agency. The DON stated the administrator was responsible for reporting injuries/incidents to the state agency.

On 10/17/18 at 10:31 a.m., the administrator was interviewed about lack of reporting of Resident #34's fracture of unknown origin. The administrator stated she immediately started the investigation after finding out Resident #34's fibula was fractured. The administrator stated the

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F 607	Continued From page 4 resident's family member and staff had seen the resident throwing her legs off the geri-chair footrests. The administrator stated she thought she could wait about the reporting until they determined if the incident was considered abuse/neglect. The administrator stated she did not report the fracture of unknown cause because their review indicated the resident possibly hit her ankle when moving her legs about in bed or while in her geri-chair. The administrator stated, "I guess we thought we determined the cause and it was not abuse. That's been our practice." The facility's policy titled Abuse Investigating and Reporting (effective September 2017) stated, "All reports of resident abuse, neglect, and exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported...All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies...The State licensing/certification agency responsible for surveying/licensing the facility...The local/State Ombudsman...The Resident's Representative (Sponsor) of Record...Adult Protective Services (where state law provides jurisdiction in long-term care)...Law enforcement officials...The resident's Attending Physician...The facility Medical Director...Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source...will be reported within two hours if the	F 607		

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F 607	Continued From page 5 alleged events have resulted in serious bodily injury...If events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours..." These findings were reviewed with the administrator and director of nursing during a meeting on 10/17/18 at 1:30 p.m.	F 607	***F – 609*** *The facility sent an initial/final report to OLC and APS on 11/07/2018.* *The administrative and licensed nurses have been re-educated on the facility's Abuse and Neglect Policies. An outside consulting company presented in-service education on Abuse: Reporting and Conducting Investigations to the administrative and licensed nurses on October 26, 2018. A post-test on abuse was given to all license staff.* *The 24 hour report has been reviewed to determine any resident who has experienced an injury of unknown origin for the past 30 days to ensure that the State.* *Survey agency or other local agencies as required by facility's policy was notified.* *The 24 hour nursing report will be revised to include injury of unknown origin, notification of administrator and/or designee and initiation of investigation.*	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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. §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	F 609		

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F 609	Continued From page 6 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure an injury of unknown origin was reported to the state survey agency and adult protective services. Resident #34, with severely impaired cognitive skills and total dependence upon staff for transfers and care, was diagnosed with a distal fibula fracture of unknown origin. This fracture of unknown origin was not reported to the state survey agency or local adult protective services. The findings include: Resident #34 was admitted to the facility on 1/8/16 with diagnoses that included high blood pressure, vitamin deficiency, osteoarthritis, restless leg syndrome and gastroesophageal reflux disease. The minimum data set (MDS) dated 8/2/18 assessed Resident #34 with short and long-term memory problems and severely impaired cognitive skills. MDS assessments dated 5/10/18 ad 8/2/18 listed Resident #34 as totally dependent on two people for transfers and total dependence of one person for eating, dressing and daily hygiene. Resident #34's clinical record documented a nursing note dated 7/16/18 stating, "Resident was taken over to radiology to have her left ankle and foot x-rayed." A note dated 7/17/18 at 1:32 p.m. documented, "...X-ray report was received and faxed to [physician]. See order for orthopedic consult. Tylenol was given at 1030 [10:30 a.m.] for pain..."	F 609	*The 24 hour sheet will be reviewed daily and signed by the RN Supervisors, DON and Administrator. If non-compliance is observed, the license nurse will be immediately re-educated on investigations of unknown origin. Findings of these audits will be reviewed daily by nursing administration. An analysis of the findings will be reported to the PI Committee monthly times 12 months for additional oversight, recommendations, and determination of the continued audits.* *The facility's policies on Abuse and Neglect has been reviewed by all staff, will be done yearly will be done yearly and added to new employee orientation..* *This plan will be effective by 11/30/2018 and measures will be maintained to ensure ongoing compliance.*	

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F 609	Continued From page 7 Resident #34's radiology report dated 7/16/18 documented the resident was diagnosed with an acute distal fibular fracture. (Fibula is the lateral and smaller of the two bones of the lower leg.) This x-ray report documented, "Acute minimally displaced distal diaphysis [shaft] fracture of the fibula without angulation." This report listed the resident had mild lateral soft tissue swelling and pain in the left foot/ankle. The resident was referred to an orthopedist and prescribed immobilization for four weeks with a "cam" boot as treatment. The clinical record documented a monthly nursing summary dated 7/1/18. This assessment documented Resident #34 required total dependence upon staff for bed mobility, transfers, dressing, eating, toileting and hygiene. This assessment listed the resident had "weak legs...little speech" and required the use of a total "maxi" lift for transfers. There was no documentation in the clinical record indicating a known cause of Resident #34's fractured fibula. On 10/16/18, a copy of the facility's investigation of the fracture was reviewed. The investigation report dated 7/16/18 documented the resident was noted with swelling, pain and redness of the left ankle on 7/16/18 at 10:38 a.m. The physician was notified and ordered an x-ray of the left foot/ankle. The report documented on 7/17/18 the x-ray report revealed the resident was diagnosed with an acute minimally displaced left fibula fracture. The investigation report documented interviews with the resident's nurses, certified nurses' aides and a family member. The investigation concluded no evidence of abuse. The report documented,"...it	F 609		

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F 609	Continued From page 8	F 609		

is possible where she could have banged her ankle against the chair, the rail, and/or possibly just slight twisting motion could have created the nondisplaced fracture."

The facility investigation report documented no evidence of a known cause of Resident #34's fractured fibula. No report was received by the state agency as of 10/17/18 regarding Resident #34's fracture of unknown source.

On 10/16/18 at 1:10 p.m., the certified nurses' aide (CNA #1) routinely caring for Resident #34 was interviewed about the resident's fractured fibula. CNA #1 stated she did not know how the resident's ankle was broken. CNA #1 stated the resident was "total care," required a full body lift for transfers and was routinely seated in a reclining "geri-chair" when out of her room.

On 10/16/18 at 1:25 p.m., the licensed practical nurse (LPN #2) caring for Resident #34 was interviewed. LPN #2 stated Resident #34 was dependent upon staff for all of her care needs. LPN #2 stated the resident had restless leg syndrome and frequently moved her legs about when in bed or in her chair. LPN #2 stated Resident #34 did not ambulate and used a reclining geri-chair when out of bed.

On 10/17/18 at 10:03 a.m., the director of nursing (DON) was interviewed about why Resident #34's fracture of unknown origin was not reported to the state agency. The DON stated the administrator was responsible for reporting injuries/incidents to the state agency.

On 10/17/18 at 10:31 a.m., the administrator was interviewed about lack of reporting of Resident

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F 609	Continued From page 9 #34's fracture of unknown origin. The administrator stated she immediately started the investigation after finding out Resident #34's fibula was fractured. The administrator stated the resident's family member and staff had seen the resident throwing her legs off the geri-chair footrests. The administrator stated she thought she could wait about the reporting until they determined if the incident was considered abuse/neglect. The administrator stated she did not report the fracture of unknown cause because their review indicated the resident possibly hit her ankle when moving her legs about in bed or while in her geri-chair. The administrator stated, "I guess we thought we determined the cause and it was not abuse. That's been our practice." The facility's policy titled Abuse Investigating and Reporting (effective September 2017) stated, "All reports of resident abuse, neglect, and exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported...All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies...The State licensing/certification agency responsible for surveying/licensing the facility...The local/State Ombudsman...The Resident's Representative (Sponsor) of Record...Adult Protective Services (where state law provides jurisdiction in long-term care)...Law enforcement officials...The resident's Attending	F 609		

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F 609	Continued From page 10 Physician...The facility Medical Director...Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source...will be reported within two hours if the alleged events have resulted in serious bodily injury...If events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours..." These findings were reviewed with the administrator and director of nursing during a meeting on 10/17/18 at 1:30 p.m.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) for one of 22 residents in the survey sample, Resident # 94. Resident # 94's most recent MDS assessment coded the receipt Pneumococcal vaccine incorrectly. Findings include: Resident # 94 was admitted to the facility 5/15/13 with a readmission date of 8/9/18. Diagnoses for Resident # 19 included, but were not limited to: anemia, high blood pressure, and dementia. The most recent minimum data set (MDS) was a quarterly review dated 9/27/18. Resident # 94	F 641	**F- 641** *Resident #94* *MDS assessment was revised and coded correctly on 10/17/2018 to address the Pneumococcal Vaccine.* *A 100% review of all residents will be completed to ensure that the MDS address the Pneumococcal Vaccines is coded correctly.* *On October 30,2018 the MDS Coordinator attended an all-day educational program on MDS updates presented by VHCA.* *The DON and/or designee will complete a monthly review for 3 months of 100% of the residents who are assessed for Pneumococcal Vaccine.*	

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F 641	Continued From page 11 was coded with severe cognitive impairment with a total summary score of 04 out of 15. On 10/17/18 at approximately 2:30 p.m. during review of the clinical record, the above MDS assessment was reviewed. Section "O-0300 Pneumococcal Vaccine A. Is the resident's pneumococcal vaccine up to date?" was coded "Yes" at number 1. Further review of the clinical record failed to reveal any documentation the resident had received the vaccine. Per CMS's "RAI Version 3.0 Manual CH 3 Section CH 3: MDS Items [O] : Pneumococcal Vaccine" directs : "2. Review the resident's medical record and interview resident or responsible party/legal guardian and/or primary care physician to determine pneumococcal vaccination status, using the following steps: · Review the resident's medical record to determine whether a pneumococcal vaccine has been received. If vaccination status is unknown, proceed to the next step. · Ask the resident if he/she received a pneumococcal vaccine. If vaccination status is still unknown, proceed to the next step. · If the resident is unable to answer, ask the same question of a responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step. · If vaccination status cannot be determined, administer the appropriate vaccine to the resident, according to the standards of clinical practice." (1) On 10/17/18 at 5:10 p.m. RN (registered nurse) #	F 641	*The audit will review the MDS to ensure that MDS addresses that the correct code is entered. Areas of concern will be corrected and findings of the analysis will be used for further education to the MDS Coordinator and a report of the analysis will be submitted to the QI Committee for further oversight and recommendations.* *This plan will be effective 11/30/2018.*	

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F 641	Continued From page 12 2 , who was the MDS coordinator, was asked about the coding of the vaccine. She was also asked if the answer to that section automatically populated from previous assessments, or if the section was coded each time. RN # 2 was further asked for assistance in locating the date the resident had received the vaccine. RN # 2 stated "I have to answer that question every time; I usually get the information on admission or from nurses' notes...let me see what I can find..." On 10/18/18 during a meeting with facility staff beginning at 9:50 a.m. the administrator, DON (director of nursing), and the chief quality officer were informed of the above findings. The administrator was also informed RN # 2 had not presented any information about the vaccine. No further information was presented prior to the exit conference. (1) Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI)User's Manual Section O page O-12 October 2017.	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688	***F – 688*** *Resident #94* *Was evaluated by OT on 10/17/2018. OT recommended dropping current wheelchair to lowest position which was done 10/17/2018. Resident demonstrated ability to touch floor.*	

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F 688	Continued From page 13 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure proper wheelchair positioning for one of 22 residents in the survey sample. Resident #94 was observed seated in a wheelchair without footrests with her feet not reaching the floor. The findings include: Resident #94 was admitted to the facility on 5/15/13 with a re-admission on 8/9/18. Diagnoses for Resident #94 included dementia, pneumonia, gastrointestinal bleed, anemia and high blood pressure. The minimum data set (MDS) dated 9/27/18 assessed Resident #34 with severely impaired cognitive skills. This MDS listed the resident used a wheelchair for mobility with the extensive assistance of one person. On 10/16/18 at 9:49 a.m., Resident #94 was observed seated in her wheelchair in her room. The wheelchair had no footrests and the resident's feet were dangling, not reaching the floor. The resident's toes were pointed downward and were approximately 2 inches from the floor. The resident was observed in her wheelchair again with her feet dangling on 10/16/18 at 10:46 a.m., 11:14 a.m., 12:41 p.m. and at 2:05 p.m.	F 688	*All residents sitting in wheelchairs may have potentially been affected.* *A 100% review of all residents was completed 10/25/2018 by an Occupational Therapist. This review was to identify potential residents in wheelchairs without foot-rests with their feet not reaching the floor. No other residents were affected by this.* *The nursing staff will be educated to communicate to DON and/or therapy when residents' feet do not touch the floor or wheelchair pedals. The nursing staff will be educated on the risks associated with inappropriate positioning. Visual observation of 15 residents using wheelchairs for mobility per week x 6 weeks will be conducted to ensure residents are appropriately positioned in wheelchairs. If non-compliance is observed the staff member will be immediately re-educated. Findings of the observations will be reported to the DON for monitoring and further education and/or disciplinary actions.*	

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F 688	Continued From page 14 On 10/16/18 at 2:05 p.m., the certified nurses' aide (CNA #1) caring for Resident #94 was interviewed. CNA #1 stated the resident self-propelled at times in her wheelchair and usually had her feet on the floor. CNA #1 stated the resident did not routinely have footrests on the wheelchair. CNA #1 did not know why the resident's feet did not reach the floor. On 10/16/18 at 2:08 p.m., the licensed practical nurse (LPN #2) caring for Resident #94 was interviewed. LPN #2 stated the resident "scooted" and self-propelled at times in the wheelchair with her feet on the floor. Accompanied by LPN #2, Resident #94 was observed in the activity room with her feet not reaching the floor. LPN #2 stated she was not aware the resident's feet did not reach the floor and she would get therapy to evaluate the positioning. On 10/1718 at 1:53 p.m., the director of nursing (DON) was interviewed about Resident #94's positioning. The DON stated the resident did not self-propel but required someone to push her in the wheelchair for mobility. These findings were reviewed with the administrator and director of nursing (DON) during a meeting on 10/17/18 at 1:30 p.m.	F 688	*The analysis of the audits for wheelchair positioning will be compiled and submitted to the QI Committee for additional oversight, recommendation, and determination of the need for continued frequency of the audit.* *This plan will be effective by 11/30/2018 and measures will be maintained to ensure ongoing compliance.*	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758	***F – 758*** *Resident #78* *On 10/22/2018 attending Physician implemented a gradual dose reduction of Lorazepam and Sertraline.*	

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F 758	Continued From page 15 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758	*Other residents with orders for psychotropic meds may have been affected without a gradual dose reduction plan.* *Residents receiving psychotropic drugs are being reviewed for the Gradual Dose Reduction Program.* *All physicians will be educated on how to correctly complete the medication regimen review from the pharmacist.* *The DON and/or designee will complete a monthly review for 12 months of 100% of the medication regimen reviews sent to the physicians for GDR.* *The audit will be done monthly times 12 months to review the physician documentation and rationale for the continued use of, or for not completing a gradual dose reduction. Findings of the analysis will be used for further education to the physicians and a report of the analysis will be submitted to the QI Committee for further oversight and recommendations.* *This plan will be effective by 11/30/2018 and measures will be maintained to ensure ongoing compliance.*	

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F 758	Continued From page 16 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review, and staff interview, the facility staff failed to ensure one of 22 residents in the survey sample were free from unnecessary medication. There was no physician documented rationale for the continued use of, or for not completing a gradual dose reduction of Lorazepam and Sertraline. The findings include: Resident #78 was admitted to the facility on 7/4/15 with diagnoses including hypertension, dementia, anxiety and depression. The most recent minimum data set (MDS) dated 09/13/18 assessed Resident #78 as severely cognitive impaired, having long term and short term memory loss. Resident #78's clinical record was reviewed on 10/17/18 at 3:15 p.m. A pharmacy recommendation dated 7/30/18 documented the following: "Resident's current medication regimen includes Sertraline 100 mg (milligrams) daily and Lorazepam 0.5 mg (milligrams) bid (twice a day). Please consider a Gradual Dose Reduction to Sertraline 50 mg (milligrams) daily and Lorazepam 0.25 mg (milligrams) BID (twice a day)." On the form under the "Action taken" section, was documented "No Change" by the physician. This section was signed and dated 08/17/18. This section is where the physician can document their	F 758		

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F 758	Continued From page 17 instructions and rationale regarding the pharmacy recommendations. No rationale was provided for the continued use, nor was there a rationale for not completing a gradual dose reduction for the Lorazepam and Sertraline medications. On 10/17/18 at 3:43 p.m., the unit nurse supervisor (RN #3) was interviewed about the pharmacy consult recommendation. RN #3 stated the pharmacy sends copies of the consult sheets to the physician and to her (RN #3). RN #3 stated she then places the copy she receives in a binder in her office. RN #3 stated after the physician completes the form documenting their action regarding the pharmacy recommendations, she then receives a copy of the completed form from the physician at which time the physician's actions are carried out by the nursing department. RN #3 stated she keeps a copy of the completed pharmacy consult form in a binder in her office and a copy is placed on the resident's chart. This information was shared with the administrator and director of nursing during a meeting on 10/18/18 at 9:55 a.m. No other information was provided prior to the exit conference on 10/18/18 at 10:45 a.m.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759	***F – 759*** *The two staff members observed during the medication pass and pour observation have been observed by our outside pharmacy consultant on medication pass and pour on 10/15/2018 and 10/24/2018.*	

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F 759	Continued From page 18 Based on medication pass and pour observation, staff interview, and clinical record review, facility staff failed to ensure a medication error rate less than five percent. There were three errors out of 31 opportunities resulting in a medication error rate of 9.68%. 1. Resident #69 received her morning dose of Metformin (Glucophage) after eating breakfast and not per physician order. 2. Resident #12 was not administered Flonase and Miralax as ordered by the physician. Findings included: 1. Resident #69 was admitted to the facility 03/07/2011 with diagnoses of, but not limited to: Bronchitis, CVA (cerebrovascular accident), Diabetes, and Osteoarthritis. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/06/2018. Resident #69 was assessed as moderately impaired in her cognitive status with a total cognitive score of nine out of 15. During the medication pass and pour observation on 10/17/2018 at 9:29 a.m., Resident #69 was administered Metformin 500 mg (milligrams) by mouth by LPN #1 (licensed practical nurse). Resident #69 had just returned to her room from eating breakfast in the dining room prior to receiving her morning medications. Review of physician orders dated 10/01/18 through 10/31/18 included: "...Metformin HCL 500 mg TAB Give (1) tablet by mouth twice daily	F 759	*Resident #69 has not experienced any adverse effects from receiving her morning dose of Metformin after eating breakfast.* *This nurse has been re-educated on following physician orders.* *Resident #12 has not experience any adverse effect from receiving one spray from Flonase instead of two sprays. Resident preference is one spray not two. Attending physician notified on 10/17/2018 and order changed to one spray for Flonase 50mg daily.* *Resident #12 has not experienced any adverse effect from not consuming all of the Miralax mixture. The nurse has been re-educated on following physician orders and not leaving medication with residents, not unless they are assessed to self-administer medications.* *License staff have been observed by our outside pharmacy consultant on medication pass and pour. The outside pharmacy consultant will do medication audits weekly beginning 10/15/2018 times 4 week then monthly to ensure the nurses are following physician orders. If non-compliance is observed the license nurse will be immediately re-educated on the physician order.*	

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F 759	Continued From page 19 before meals..." scheduled at 7:30 a.m. and 4:30 p.m. LPN #1 and RN #1 (registered nurse) were both informed of the physician order and that the medication had not been given per order. They both stated, "okay." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 10/17/18 at 1:30 p.m. No further information was received by the survey team prior to the exit conference on 10/18/18. 2. A medication pass observation was conducted on 10/17/18 at 9:00 a.m. with licensed practical nurse (LPN) #2 administering medications to Resident #12. During this observation, LPN #2 administered one spray in each nostril of Flonase 50 mcg (micrograms) nasal spray. LPN #2 prepared one capful of Miralax powder mixed in a full cup of water. The resident took only a few sips of the Miralax mixture with LPN #2 in the room. LPN #2 left the remaining Miralax on the resident's bed table and proceeded to another part of the unit giving medications. LPN #2 did not ask the resident to consume all of the Miralax mixture. On 10/17/18 at 10:02 a.m., a half cup of the Miralax mixture was still on the resident's bed table and had not been consumed. Resident #12's clinical record documented a physician's order dated 9/28/18 for Flonase 50 mcg, two sprays in each nostril daily. The record documented a physician's order dated 5/2/18 for Miralax 17 grams mixed in 8 ounces of liquid daily. On 10/17/18 at 10:05 a.m., LPN #2 was interviewed about the incorrect dose of Flonase and incomplete administration of Miralax for Resident #12. LPN #1 stated the resident usually	F 759	*Findings of these audits will be provided to DON for additional monitoring and further education and/or disciplinary action.* *An analysis of the findings will be reported to the PI Committee for additional oversight, recommendations, and determination of the continued audits.* *All License Nurses will attend a medication administration educational in-service provided by an outside consultant.* *This plan will be effective by 11/30/2018 and measures will be maintained to ensure ongoing compliance.*	

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F 759	Continued From page 20 only wanted one spray of the Flonase. LPN #2 stated she usually went back and checked with the resident to see if she consumed all the Miralax. When asked if Resident #12 was assessed to self-administer medications, LPN #2 stated, "No." These findings were reviewed with the administrator and director of nursing during a meeting on 10/17/18 at 1:30 p.m.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761	***F – 761*** *The medication cart on the West unit has been removed from the unit. New medication cart was ordered on 08/13/2018 and delivered to the unit on 10/31/2018.* *The other 4 medication carts were checked and were maintained in safe operating condition.* *On 10/31/2018 all 5 medication carts were replaced with new medication carts.*	

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F 761	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, and staff interview, facility staff failed to ensure medications were stored in a locked area on one of five units, West Unit. Facility staff failed to ensure the medication cart was locked on the West Unit. Findings included: During the medication pass and pour observation on 10/17/2018 at 9:00 a.m., LPN #1 (licensed practical nurse) stated to this surveyor, "I just want you to know I have to lift the top of the medication cart to unlock it." LPN #1 was observed to lift the top of the cart and push a release button to unlock the medication cart at least five times. The medication cart was noted to have a large lock that required a key to open. However, the lock did not work properly and maintenance had shown the nurses how to bypass the lock by pushing the lock release button under the top cover. LPN #1 was able to lock the cart using a lever on the side, but had to lift the top of the cart to push the lock release button. The only key used was to open the narcotic storage drawer on the medication cart. RN #1 (registered nurse) was interviewed 10/17/18 at 9:43 a.m. regarding the medication cart. RN #1 stated, "A replacement cart has been ordered. They fixed it with a part that worked for awhile, but then it malfunctioned again, so a replacement cart has been ordered. I will have to get with [Name of Administrator] regarding the	F 761	*No residents were affected by the medication cart not locking on West unit. The Medication Administration Observation audit that is conducted by our outside pharmacy consultant and/or DON will be done weekly starting 10/31/2018 times 4 weeks then monthly to ensure that the medication carts are locked when unattended. If non-compliance is observed the license nurse will be immediately re-educated on locking the medication carts when unattended. Findings of these audits will be provided to DON for additional monitoring and further education and/or disciplinary action.* *An analysis of the findings will be reported to the PI Committee for additional oversight, recommendations, and determination of the continued audits.* *This plan will be effective by 11/30/2018 and measures will be maintained to ensure ongoing compliance.*	

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F 761	Continued From page 22 exact dates." LPN #1 was interviewed 10/17/18 at 10:03 a.m. regarding the medication cart. LPN #1 stated, "I don't know if there is a room for the cart to be locked in. I know it always sits here when I am giving meds." LPN #1 gestured to the nurse's station. Regarding narcotic storage, "There is a separate drawer with a different key to get into it." RN #1 provided a copy of the "Nursing Supervisor Report" dated "October 16, 2018." The report included, "...0045 [12:45 a.m.] Informed by EP [East Pavilion] nurse that one of their medication carts was currently locked and unable to be opened with request to call maintenance in. I went over and attempted to troubleshoot and unlock the cart before maintenance was called unsuccessfully. It appeared to be a mechanical issue in which a piece of the locking mechanism had come loose and therefore was not lifting the locking bar. Maintenance was then called to come in. I was also informed by the nursing staff that this particular cart had not locked/unlocked properly in quite some time and that the cart had been being left unlocked, with the side lever being kept up with "tape." This is a very serious safety issue in that any resident, visitor, or unauthorized staff member can open every medication drawer with the exception controlled medication. This is also likely a violation if discovered upon a state inspection per nursing staff. 0200 [2:00 a.m.] Received call from EP nurse who informed me that [Name] from maintenance had unlocked medication cart and showed her where the release mechanism is inside that can be pressed to unlock cart. This may be a temporary solution until the real issue is addressed..."	F 761		

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	495157	A. BUILDING _____ B. WING _____	10/18/2018

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F 761	Continued From page 23 At 10:15 a.m., RN #1 stated, "Maintenance came in last night and showed the nurse how to lift the top cover and push the release button to open the med cart. The new cart will ship on the 19th. The cart can be locked in the nursing supervisor's office I guess. No, we don't do that. It sits behind the nurse's desk." Maintenance work orders were reviewed for this specific medication cart from RN #1. This first work order was dated 02/18/2018, and subsequent work orders were dated 03/30/2018, 04/02/2018, 04/16/2018, 04/17/2018, 04/27/2018 and two were dated 10/17/2018. RN #1 also provided a copy of an email written by the pharmacy director and sent to the medical products representative that included: "...Sent: Wednesday, July 11, 2018 4:49 PM...Subject: Cart Repair Work List; EP WEST (SERIAL NUMBER 71044-E) Cart will lock but will not unlock. The rivets have been popped off the top and it has to be manually unlocked by hitting the button inside. The keypad does seem to be working because it beeps when you enter the code however it does not trigger the unlocking mechanism. The Battery has been replaced about 30 days ago. This did not fix the problem." Two subsequent emails dated July 12, 2018 written by the medical products representative to the pharmacy director included: "...8:37 a.m...It looks like our technician from Richmond, [Name], may be able to head down first thing in the morning. We are gathering information at this time, and will confirm shortly...1:46 p.m...Our technician is ready to go for tomorrow morning..." The Administrator stated during a meeting with the survey team on 10/17/2018 at 1:30 p.m., "We	F 761		

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F 761	Continued From page 24 have been locking the medication cart up in the supervisor's office when not in use or in an empty patient room. We just make sure the room door is locked. It took us awhile to get capital funds to replace the cart, but finally the funds were approved." This medication cart was observed behind the nurse's station several times on 10/16/18 and in the early morning of 10/17/18 with no staff person visible around the cart. No further information was received by the survey team prior to the exit conference on 10/18/18.	F 761		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883	***F – 883*** *Resident #94 was assessed and given the Pneumococcal Vaccine on 10/30/2018.* *All residents have been assessed and given the pneumococcal vaccine if they consented to the vaccine.* *The Pneumococcal Immunization Policy has been revised and the license nursing staff have been re-educated on this policy.* *The facility registered on 10/05/2018 with the Virginia Immunization Information System to help track immunizations prior to admission to the facility.*	

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F 883	Continued From page 25 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to correctly assess and document the pneumococcal vaccine status for one of 5 records reviewed: Resident # 94. Resident # 94's clinical record had no documentation of consent or refusal of the	F 883	*The Pneumococcal Immunization Spreadsheet has been implemented and can tract this vaccination.* *This audit is updated with new admissions and will be monitored weekly starting 10/22/2018 Times 6 weeks then monthly to ensure the pneumococcal vaccinations are being assessed and documented correctly. If non-compliance is observed the license nurse will be immediately re-educated on assessing residents for pneumococcal vaccinations. Findings of these audits will be provided to DON for additional monitoring and further education and/or disciplinary action. An analysis of the findings will be reported to the PI Committee for additional oversight, recommendations, and determination of the continued audits.* *This plan will be effective by 11/30/2018 and measures will be maintained to ensure ongoing compliance.*	

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F 883	Continued From page 26 Pneumococcal vaccine. Findings include: Resident # 94 was admitted to the facility 5/15/13 with a readmission date of 8/9/18. Diagnoses for Resident # 19 included, but were not limited to: anemia, high blood pressure, and dementia. The most recent minimum data set (MDS) was a quarterly review dated 9/27/18. Resident # 94 was coded with severe cognitive impairment with a total summary score of 04 out of 15. On 10/17/18 at approximately 2:30 p.m. during review of the clinical record, no information regarding the resident's pneumococcal vaccination status could be obtained. On 10/17/18 at 4:20 p.m. RN (registered nurse) # 4, who was in charge of the immunization program for the facility, was asked for assistance in locating the information. RN # 4 stated "She refused [the vaccine] in 2014; I'm not sure if the vaccine has been offered again...I have the vaccine forms here I can look and see what was done." RN # 4 then retrieved the form. The form was divided in two sections; on the top right side was "Influenza Vaccine (Administer October through March)" and the top left side had "Pneumococcal Vaccine (Administer Year-Round)" The Influenza portion was completed including date of administration 10/9/18. The Pneumococcal portion was blank. RN # 4 stated "I guess we should be offering the pneumococcal vaccine when we offer the flu each year?" RN # 4 was reminded the pneumococcal vaccine could be administered year-round, and since the status of the vaccine was not	F 883		

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F 883	Continued From page 27 documented, it was unclear when or if the vaccine had been offered or discussed with the resident or the resident's responsible party since 2014. On 10/17/18 at 5:30 p.m. RN # 3, who was the house supervisor, was also asked for any information on the status of Resident # 94's pneumococcal vaccine status. RN # 3 reviewed the information provided by RN # 4, then stated "I don't know what to say; I don't know if she [name of resident] was asked, refused, or what. I can't say; it's not on the form..." On 10/18/18 during a meeting with facility staff beginning at 9:50 a.m. the administrator, DON (director of nursing), and the chief quality officer were informed of the above findings. No further information was presented prior to the exit conference.	F 883		