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	495189	A. BUILDING _____ B. WING _____	C 11/01/2018

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REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/30/2018 through 11/01/2018. 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 An unannounced Medicare/Medicaid standard survey was conducted 10-30-18 through 11-1-18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements for Nursing Facilities. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 26 Resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		12/12/18

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

Electronically Signed | 11/19/2018

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility failed to ensure resident rights were implemented for one of 26 residents. (Resident #14) For Resident #14 the facility failed to assist in obtaining a Responsible Party or Power of Attorney for a resident with Dementia and severe cognitive impairment. The findings included:	F 550	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged	

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F 550	Continued From page 2 Resident # 14 an 89 year old woman was admitted to the facility on 9/9/2015 with diagnoses of but not limited to Dementia, Major Depressive Disorder, Cognitive Communication Deficits, adult failure to thrive, and muscle weakness. The Resident's most recent (Minimum Data Set) MDS with an ARD (Assessment Reference Date) of 08/11/2018 coded Resident as having a (Brief Interview of mental status) BIMS score of 99 indicating severe cognitive impairment. According to MDS information Resident #14 has been in the facility since May of 2017 with a BIMS of 99 with no POA or Guardian Ad Litem. Prior to 2017 MDS data showed that the Resident had a BIMS of 15 indicating no cognitive impairment. On 10/29/2018, Resident #14 was observed propelling herself in a wheel chair in the hallway. Attempts to speak with Resident#14 were met with conversation that followed no logical pattern. The Resident unable to follow simple conversation. On 10/30/2018 during the clinical record review it was noted that Resident #14 was her own responsible party. On 10/31/2018 at 3:00 PM, an interview was conducted with the DON and the Administrator about Resident #14's status as own responsible party. The DON stated, "I don't think she is able to make medical decisions but when she came in the nephew and his wife made her sign the paperwork." When she was asked who decides her medical care the DON stated "Well we always call the	F 550	deficiencies cited have been or will be completed by the dates indicated. F550 1- A POA has been secured for Resident #14. 2- The Administrator or Designee will review current residents with Dementia and severe cognitive impairment to determine if they have a Responsible Party of Power of Attorney in place. 3-The Administrator or designee will educate the Admission Director and the Discharge planner on ensuring that residents have a Responsible Party or POA in place 4- The Administrator or designee will review residents with Dementia and severe cognitive impairment upon admission and on a Quarterly basis to ensure that the resident has a Responsible Party or POA in place. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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F 550	Continued From page 3 nephew". When she was asked if the nephew is her POA or RP the DON stated "No he isn't". When asked who is the resident's social worker, the Administrator stated that they did not have one as the previous one quit and they had hired someone who will start in a month. When asked if any efforts have been made to secure a POA for this Resident the DON responded no. On 10/31/18 the Administrator was made aware of the lack of POA for this Resident and no further information was provided.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to determine if it was safe for Resident to self-administer Afrin Nasal Spray for one Resident (Resident #1) in a sample of 26 residents. The findings include: Resident #1, an 80 year old female was admitted to the facility on 10/19/2018. Diagnoses included hypertension, atrial fibrillation, atherosclerotic heart disease, generalized muscle weakness, anxiety, and dementia. The Resident was	F 554	F554 1-The Afrin Nasal Spray for Resident #1 was removed from the resident□s bedside and given to the family to take home. 2-The Unit Manager or designee will review current residents to ensure that no medications are at the bedside without an order or self-medication administration evaluation	12/12/18

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F 554	Continued From page 4 admitted to skilled care recovering from a motor vehicle accident where she sustained a left radial/ulnar fracture and chest bruising. On 10/30/2018 at 4:10 PM, the Resident was not in her room but a container of unsealed Afrin nasal spray was observed on Resident's tray table at the bedside. On 10/31/2018 at 8:40 AM, the Resident was observed in bed, fully dressed, and she just finished eating her breakfast. The Afrin nasal spray was observed next to her food tray and when the Resident was asked about it, she stated that was her "nose spray." The clinical record was reviewed. There was not an order for Afrin nasal spray on the current physician's order documentation. Afrin nasal spray was not listed on the medication administration record. Medication self-administration was not addressed on the care plan. The nurse's notes do not address medication self-administration. On 10/31/2018 at 11:00, Afrin nasal spray was observed on Resident's tray table. The DON was asked if the Resident had a medication self-administration assessment. The DON stated the Resident "doesn't have a self-administration assessment."	F 554	3-The Staff Development Coordinator will educate Licensed Nursing staff on assessment of Self-Administration of Medication and maintenance of medications at the bedside. 4-The Unit Manager or designee will complete audits of residents admitted to the facility to ensure that appropriate measures are taken if residents wish to have medications at the bedside. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		12/12/18

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F 645	Continued From page 5	F 645		

§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was

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F 645	Continued From page 6 transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility failed to ensure that a PASARR Screening was done for 1 Resident (#14) in a survey sample of 17 Residents. For Resident #14 the facility failed to ensure PASARR Screening obtained prior to admission. The findings include:	F 645	F645 1-. The facility has contacted the Ascend Management agency to assist with completion of the PASARR for resident #14. 2- The Administrator or designee will review current residents to ensure that a	

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F 645	Continued From page 7 Resident #14 an 89 year old woman was admitted to the facility on 9/9/2015 with diagnoses of but not limited to Dementia, Major Depressive Disorder, Cognitive Communication Deficits, adult failure to thrive, and muscle weakness. Resident most recent (Minimum Data Set) MDS with an ARD (Assessment Reference Date) of 08/11/2018 coded Resident as having a (Brief Interview of mental status) BIMS score of 99 indicating severe cognitive impairment. On 10/29/2018 during clinical record review it was discovered that the PASARR screening was not done prior to admission nor during the time since admission. On 10/30/2018 during end of day conference Administrator notified that Resident #14 had no PASARR. He stated he would look in the social workers office. On 10/31/2018 the Unit Manager stated "We have looked and cannot find a PASARR for Resident #14." No further information was provided.	F 645	PASARR Screening is in place and will address any issues noted. 3-The Administrator or designee will educate the Admissions Director and Discharge Planner on the requirement of obtaining PASARR Screenings. 4-The Admissions Director or designee will review residents prior to admission to the facility to ensure that the PASARR screening is in place and if not will take appropriate measures to obtain the PASARR screening. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		12/12/18

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F 656	Continued From page 8 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, clinical record review and facility documentation the facility failed to develop and implement a comprehensive care plan that is Resident Centered for 1 Resident (#102) in a	F 656	F656 1-The care plan was revised for Resident #102 to include provisions for the total	

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F 656	Continued From page 9 survey sample of 26 Residents. For Resident #102 the facility failed to address total knee replacement surgical care, hip pin removal, and discharge planning in the comprehensive care plan. The Findings Include: Resident #102 an 84 year old woman admitted to the facility on 10/23/2018 with diagnoses of but not limited to Osteoporosis, Hypertension, Diabetes, chronic kidney disease and acute kidney failure. Resident #102 was a new admission and therefore did not have an MDS (Minimum Data Set). On 10/29/2018 the resident observed in bed with Knee Immobilizer in place to Left knee. On 10/30/2018 at 2:30 PM an interview was conducted with Resident #102 and Family members that were visiting. The Resident stated that she went to the hospital for a total knee replacement. Family member stated that Resident #102 had a hip surgery "A while ago" and they had to remove the pin from the prior surgery so they did them both at the same time. On 10/30/2018 during a review of the clinical record it was noted that the care plan did not mention the diagnosis of total knee replacement. Instead the care plan mentions "Hip Replacement." The Progress notes dated 10/23/2018 (the admission date) at 2207 (10:07 PM) read,	F 656	knee replacement surgical care, hip pin removal and discharge planning. 2-The Unit Manager or designee will review all residents with surgical care needs and ensure that this is included in the care plan. The Director of Nursing or designee will review current resident care plans to ensure that discharge planning is included in the care plan. 3-The Staff Development Coordinator will educate all Licensed Nursing staff and members of the Interdisciplinary team on the requirements for updating the care plan for surgical care needs and discharge planning needs. 4-The Unit Manager or designee will complete audits on a weekly basis of residents with surgical needs to ensure that the care plan includes provisions in the care for the residents. The Discharge Planner or designee will review the resident care plans on a monthly basis care plan to ensure that the discharge planning is addressed on the care plan with a device and an order is in place as appropriate. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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"Reason for admission per Resident/ POA is Osteoarthritis surgery of Left Knee."

On 10/31/2018 a review of the care plan was conducted and it was found that under the category Focus the care plan states "Resident has limited physical mobility r/t [related to] Surgery"

Under the Goals it states "Devices: bariatric w/c [wheel chair] with cushion, walker, Reacher, assist bars x2, LLE [Left Lower Extremity] immobilizer.
Ambulation: The resident is able to (Specify),
Locomotion: The resident is able to (SPECIFY)

Under Focus " The resident has had an actual fall with (SPECIFY no injury, minor injury, serious injury.) Poor Balance Unsteady gait"

Under Goals it stated- "The resident will resume usual activities without further incident."

Under the category Focus- "The resident has a left hip fracture r/t fall"

Under the category Goal - The resident will be free from complications related to hip Fracture such as contracture embolism and immobility"

The review showed that the facility failed to fill in the areas of care plan that state "(SPECIFY)" therefore care plan is not complete. The care plan did not address all of the Resident's issues and did not address Discharge Planning at all.

On 10/31/2018 at 2:45 PM an interview was conducted with the DON and she stated that the Resident did have a fractured hip, in the past.

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F 656	Continued From page 11 This admission was for a total knee replacement. She further stated that she could see where the care plan did not address care of the Left knee with the immobilizer and incisional care. She stated that under Ambulation and Locomotion there should be instructions of how far and how often to ambulation is and the method either with or without a walker. Locomotion should address using a wheelchair or a stretcher. When asked about the areas that say "(SPECIFY)" she stated "Yes they should be detailed and patient centered." During the end of day conference the Administrator was notified about the care plan and no further information was provided.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and during a complaint investigation, the facility staff failed to follow the professional standards of nursing for 1 Resident (Resident #11) in the survey sample of 26 residents. For Resident #11, the facility staff failed to obtain finger stick blood sugar parameters. The Findings included:	F 658	F658 1-The order for obtaining finger stick blood sugars and sliding scale insulin order was clarified on 11/15/18. The finger stick blood sugar results are being recorded appropriately on the medication and treatment administration record. 2-The Unit Manager or designee will	12/12/18

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F 658	Continued From page 12 Resident #11 was admitted to the facility on 3-15-18. Resident #11's diagnoses included; Diabetes Mellitus, Hypertension, high cholesterol, anemia, and chronic kidney disease resulting in hemodialysis, The most recent Minimum Data Set for Resident #11, was a Quarterly Assessment with an Assessment Reference Date of 8-9-18. This MDS coded Resident #11 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. The Resident was also coded as requiring only supervision, and some physical assistance from 1 staff person for Activities of daily living such as transferring, hygiene, dressing, and bathing. The Resident was coded as always continent of bowel and bladder. On 10-31-18 a review was conducted of Resident #11's clinical record. The record revealed the following signed physician's order issued 5-22-18; Novolog flex pen solution (insulin Aspart) 100 units per milliliter inject as per sliding scale. Sliding scale insulin is given according to fingerstick blood sugar (FSBS) testing. The physician's order did not specify to complete a FSBS, however, sliding scale insulin cannot be given without a FSBS completed. The FSBS testing was specified on the Medication Administration Record (MAR), but was not in the physician's orders. The insulin appeared only in the physician's order and not on the MAR. The sliding scale insulin order stated If blood sugar measured 0-100 inject 0 units, if 200-299	F 658	review the Medication and Treatment Administration records of all residents receiving Insulin and finger stick blood sugar checks to ensure that the order is transcribed correctly and that the finger stick blood sugar results and insulin administration is documented correctly on the Medication Administration Record. 3-The Staff Development Coordinator will educate all Licensed Nursing Staff on documentation requirements of medications and treatments on the Medication and Treatment Administration record and the process to follow for transcribing orders. 4-The Unit Manager or designee will complete a weekly audit of the Medication Administration records of all current residents to ensure that the medications and finger stick blood sugar results are administered and documented correctly. The Unit Manager or designee will complete a weekly audit of any new Physician orders to ensure that the orders are transcribed correctly.	

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inject 3 units, if 300-399 inject 5 units, if 400-450 inject 7 units, subcutaneously. The insulin was ordered before meals and at bedtime, which was four times per day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. The insulin order did not appear on the MAR.

Both the FSBS and resulting insulin sliding scale administration should have been documented on the physician's orders and MAR as an exact copy of each other. This error was not clarified nor corrected at the time of survey.

According to Resident #11's Medication Administration Records neither the FSBS nor insulin were administered on 10-8-18, and 10-21-18 at 6:00 a.m.

Review of the Nursing progress notes revealed no clarification of the omitted days.

Resident #11's care plan review revealed that all medications must be given as ordered, and revealed no instructions as to hypoglycemia protocol, nor FSBS's, and insulin administration.

The facility policy for medications and treatments stated they would be administered according to physicians orders.

On 10-31-18 an interview with the DON (Director of Nursing) was held, and was asked why insulin and FSBS were omitted, and the MAR and doctor's orders didn't match, she stated she was not sure, and would get an order to clarify it.

The DON stated the Nursing Reference used for the facility standards of nursing care was "Lippincott". Guidance given from Lippincott,

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F 658	Continued From page 14 Fundamentals of Nursing, read: Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary. To prevent medication or treatment errors, follow the six rights of medication administration consistently every time you administer medications or treatments. Many errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation The Administrator, Registered Nurse Regional consultant, and the Director of Nursing were informed of the staff failure to administer physician's orders for Finger Stick Blood Sugars for Resident #11 at a briefing on 11-1-18 at 2:00 p.m. The facility stated they had no further information to be provided to surveyors.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		12/12/18

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F 684	Continued From page 15 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, the facility staff failed to apply hand splints for one Resident, (Resident #30) in a sample of 26 residents. For Resident #30, the facility staff failed to provide hand splints as ordered by the physician. The findings included; Resident #30, a 59-year old female, was admitted to the facility on 08/30/2017. Diagnoses include cerebrovascular disease, respiratory failure, hemiplegia, contractures, dysphagia, and diabetes. Resident #30 is in a vegetative state on hospice care with a tracheostomy, oxygen therapy, gastrostomy tube, and enteral feedings. Resident #30's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/17/2018 was coded as a quarterly review. The Brief Interview of Mental Status was not completed but cognitive skills for daily decision-making was coded as severely impaired. The MDS quarterly review also indicated Resident #30 received passive range of motion and had a splint or brace applied. On 10/30/18 at 12:15 PM, the Resident was observed lying in bed with the head of the bed elevated 45 degrees. The Resident had contractures in both hands and there were no hand splints applied. On 10/30/18 at 3:55 PM, The Resident was	F 684	F684 1- The hand splints for Resident #30 are in place as per the plan of care. 2-The Unit Manager or designee will review all residents with splints to ensure that the splints are applied for the resident as indicated per the plan of care. 3-The Staff Development Coordinator will educate all Licensed Nursing staff Certified Nursing Assistantd on the requirements for ensuring that splints are applied as indicated on the plan of care. 4-The Unit Manager or designee will complete audits on a weekly basis of residents with splints to ensure that they are applied as indicated on the plan of care. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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observed to have the hand splints applied to each hand.

On 10/31/18 at 08:51 AM, the hand splints were not applied to either hand.

On 10/31/18 at 11:04 AM , the hand splints were not applied to either hand.

On 11/01/2018 at 08:40 AM, LPN A and surveyor were at Resident's bedside and observed hand splints were not applied. When asked about the importance of hand splints for this Resident, LPN A stated they were for "contracture management."

The clinical record was reviewed. An active physician order dated 05/21/2018 documented, "Patient to wear resting hand splint on bilateral hand at all times. Remove at PM for ADL care to check skin integrity, then replace. Remove at AM for ADL care to check skin integrity, then replace."

The care plan was reviewed. For the focus of limited physical mobility r/t (related to) contractures dated 05/22/2018, interventions documented, "Patient to wear resting hand splint on bilateral hand at all times."

The treatment administration record was reviewed. The hand splints were coded as administered on days, evenings, and nights throughout the month of October 2018, including October 30 and October 31, when it was observed Resident #30 did not have hand splints applied.

On 11/01/18, the Administrator and DON were notified of the findings and they offered no further information.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility failed to ensure that 1 Resident (#36) was free from accident/hazard in a survey sample of 26 Residents. For Resident #36 the facility failed to ensure that Resident received adequate supervision to prevent accidental rolling off of bed. The findings included; Resident # 36 a 92 year old woman was admitted to the facility on 12/31/2014 with diagnoses of but not limited to hypoglycemia, Bradycardia Alzheimer's Disease, Transient Ischemic Attack (Stroke), Major depressive disorder and muscle weakness. The most current MDS (Minimum Data Set) prior to fall was coded as a Quarterly MDS with an ARD (Assessment Reference Date) of 6/10/2018. Her MDS coded the Resident as having a (Brief Interview of Mental Status) BIMS of 99 indicating the resident has severe cognitive impairment. Her MDS also coded her under Functional Status	F 689	F689 1- Resident #36 has not had any falls and is receiving adequate supervision during care to prevent rolling out of the bed. 2- The Unit Manager or Designee will review all residents to determine who needs two person assistance during ADL care to prevent the residents from rolling out of the bed. Those residents identified as needing two person assist will have a sign placed above the resident□s bed. The DON will review incidents that occurred since 11/2/18 to ensure that there is clear and accurate documentation of the incident.. 3- The Staff Development Coordinator or Designee will educate all licensed nursing staff and Certified Nursing Assistants on following the plan of care which indicates the assistance needed during care to avoid residents rolling out of the bed and	12/12/18

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F 689	Continued From page 18 Section G - #4 Total Dependence- Requiring Full staff participation and coded her as a # 3 for Support- Two Person Physical Assist for Personal Hygiene, Toileting, Dressing, Bed Mobility and Transfers. On 10/20/2018 during clinical record review it was noted that the Nursing Progress Notes state on 8/24/2018 at 08:26 am the nurse wrote, "CNA reported to me the resident rolled out of bed while she was providing ADL care. I went to resident's room to assess resident. Resident was in bed has an abrasion to Left forearm pink/red wound bed no bleeding noted, has bruise to left upper arm, and a bump in the middle of forehead. Notified (Nurse Practitioner) NP [Name of NP] and she stated to keep an eye on resident and to notify if anything changes. Notified [responsible party's name] and Supervisor [supervisor name]" The nurse's progress notes then stated on 8/24/2018 at 08:52 am the nurse wrote "Resident being transferred to [Name of Hospital] found on floor on 11-7 shift. Alert and verbal X1, have an abrasion to left lower arm and bruise to left upper arm. Called [Name of a Hospital] Emergency room report given to [nurse's name] RN" On 0/30/2018 facility presented the fall investigation which stated that the fall was "UNWITNESSED" on 8/24/2018 at 06:50 am with a "Revision Date" of 9/7/2018 at 09:14 am. Under the heading Incident Description it states " Nursing assistant was in room with resident providing ADL care and resident rolled out of bed onto floor. Patient unable to give" Under the heading Immediate Action Taken it	F 689	that those residents requiring two person assist will have a sign placed above the resident□s bed. The Licensed Nursing staff will also be educated on documenting accurate accounts of incidents on the appropriate forms. 4- The Unit Manager or designee will complete weekly audits of those residents requiring 2 person assist with ADL care to ensure that the sign is placed appropriately. The Staff Development Coordinator or designee will complete observations of staff providing care on a monthly basis to ensure that they are following the provisions needed to prevent residents from rolling out of the bed. The DON will review incidents on a weekly basis to ensure that there is a clear and accurate documentation of the incident. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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states "Description- per family request resident sent to ER for evaluation".
"Patient taken to Hospital? N"

Under the heading of Injuries observed at the time of incident it states "Abrasion - Left Forearm Bruise- Upper left arm."

On 10/30/2018 during interview with Unit Manager she presented statements from the CNA involved as well as the LPN involved.

The statement from the LPN stated that the CNA came and told the LPN the Resident had fallen off the bed while she was providing ADL care. The LPN Statement says that the Resident was in the bed when the nurse got to the room to assess her. It notes her injuries to her arm the bruise and the abrasion as well as the bump to the head. The statement goes on to say the Nurse obtained vital signs and notified NP and family and Supervisor. The LPN states the NP stated to keep an eye on Resident for any changes. She stated the family requested she be sent to the hospital and she was sent to [Name of Hospital].

The CNA statement read that on 8/24/2018 around 6:30 AM the CNA was doing rounds and was going to clean Resident #36 and give her a bed bath. She gathered supplies and began the bed bath by removing the Residents gown and untaping the brief she washed the front part of the Resident and then turned her to her side to wash the back of her and remove the soiled brief. She states "I turned around to put soap on the wash cloth and when I turned around she was rolling out the bed". The statement further states that the CNA didn't want to leave the Resident on the "Cold Floor" so she assisted the resident back to

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F 689	Continued From page 20 bed before she went to get the nurse. On 10/30/2018 an interview with the DON was conducted and she stated that the CNA who worked the night of the incident was no longer employed with the facility. The CNA had been suspended for not following policy by not having a second person in the room with her and for picking the resident up off the floor alone, prior to the nurse assessing her. Once the investigation was over the employee did not wish to return to work. The DON further stated that it did look like there were some inconsistencies in the progress notes and the fall investigation. The Administrator was made aware on 10/31/2018 and no further information was provided.	F 689		
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.	F 761		12/12/18

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F 761	Continued From page 21 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff Interview, and clinical Record Review, the facility staff failed to ensure expired medications were not available for use, for one resident (Resident #32) out of 26 residents in the survey sample. The medication cart had two opened vials of Lantus that were past the expiration date. In addition, a vial of Pneumovax was not dated upon opening. The findings include: On 10/31/18 at 3:11 PM, The medication carts were checked for expired medication. Lantus for Resident #32 was opened on 10-1-18 and another was opened on 9-29-18, however, both vials were still in use. The stickers on bottles read to discard 28 days after opening. Review of the medication refrigerator revealed one vial of Pneumovax had been opened and was not dated. On 10/31/18 at 4:08 PM, the staff development nurse brought in a form from the pharmacy in which showed a vial of Pneumovax was sent to	F 761	F761 1-The expired vials of Lantus and the opened, undated Pneumovax vial was discarded on 10/31/18. 2-The Staff Development Coordinator checked the medication refrigerator and medication carts for any expired or opened medications not dated. Any identified issues were addressed appropriately. 3-The Staff Development Coordinator will educate all Licensed Nursing staff on dating opened medications and following the parameters for expirations of opened medications. 4-The Staff Development Coordinator or designee will check the medication refrigerator and medication carts on a weekly basis for any expired medications	

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F 761	Continued From page 22 the facility on 1-30-18. The staff development was asked about what the standard of nursing when opening a new vial was: "They are supposed to date it upon opening." When asked about the vials of Lantus, she stated, "I couldn't find anything about that." Review of the pharmacy policy and procedure for expired medication reads as followed: "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. On 11-1-18 at 2:30 PM, the facility Administrator and DON (director of nursing) were notified of above findings.	F 761	or opened vials that have not been dated.. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		12/12/18

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F 812	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility documentation review, the facility staff failed to store and distribute food in accordance with professional standards for food service safety for the following: 1) There was expired milk in the refrigerator 2) The food in the 'walk-in' fridge and 'walk-in' freezer was not shelved to allow air circulation 3) The internal temperatures for the 'reach-in' fridge, the 'walk-in' fridge, and the 'walk-in' freezer were not being monitored 4) Coffee and milk temperatures were not being monitored 5) There was half-melted ice cream and popsicles in the pantry freezer 6) Handwashing by kitchen staff was not performed according to guidelines The findings include: On 10/30/2018 at 11:30 AM, it was observed the outside temperature reading for the "reach-in" refrigerator was 39 degrees Fahrenheit. When asked about the internal temperature reading, Employee E looked at the thermometer, tapped it, and stated it was not working. On 10/30/2018 at 11:35 AM, Employee E and surveyor entered the "walk-in" refrigerator. The outside temperature reading was 40.3 degrees Fahrenheit. When asked about the internal temperature, Employee E could not locate the internal thermometer. There was an unopened container of milk observed in the "walk-in" refrigerator with an expiration date of 10/24/2018. Boxes were packed together tightly on the	F 812	F812 1- The expired milk was discarded on 10/30/18. The food in the walk-in refrigerator and walk-in freezer was arranged and stacked to allow adequate air circulation on 11/2/18. Internal thermometers for the reach-in fridge and the walk-in fridge are now in place and being monitored for proper temperatures. There is a log in place to record the coffee and milk temperatures. The half-melted cream and popsicles in the pantry freezers were discarded on 10/31/18. The Corporate Dietician confirmed that the pantry freezer is functioning properly as evidenced by appropriate temperatures on 11/15/18. The Dining Services staff will be educated on proper handwashing. 2- The Corporate Dietician completed a Sanitation Inspection Audit to check for expired food items, appropriate air circulation of stored food, internal temperature monitoring, coffee and milk temperatures, pantry freezer temperatures and proper Dining services staff handwashing. 3- The Corporate Dietician or designee will educate Dining Services staff on labeling and dating of food item, proper storage of refrigerated and frozen food items, proper temperature monitoring of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 24 shelves impeding air circulation and some items were stacked less than 6 inches from the ceiling. On 10/30/2018 at approximately 11:40 AM, the "walk-in" freezer outside temperature reading was (-12) degrees Fahrenheit. Employee E was unable to locate the internal thermometer and stated the thermometers were "on order." Boxes were packed together tightly on the shelves impeding air circulation and some items were stacked less than 6 inches from the ceiling. When asked which temperatures were recorded in the logs for the reach-in fridge, walk-in fridge, and walk-in freezer, Employee E pointed to the outside temperature reading of the fridge and stated the "outside" readings. The facility policy for food storage of refrigerated and frozen food was reviewed. Shelving spacing and internal refrigerator temperature monitoring were not addressed. On 10/30/18 at approximately 11:45, Employee E was asked about the milk and coffee temperature logs and he stated he does not keep a log of coffee temps or milk temps. He went on to say he checks the temperature of the coffee and expects a target temp of 125 degrees F. He also stated a temperature below 125 would be too cool and over 125 would be too hot. When asked about checking the milk temperatures, Employee E stated the milk was in sealed containers so the temperature was not checked. 10/30/18 12:15 PM, the temperature log on the pantry freezer was observed. On the form: "Alert the Dietary Manager immediately if temperatures are not in the following safe ranges: Freezer: 10 degrees F or less. Refrigerator: 41 degrees F or	F 812	food items, proper temperature monitoring of refrigerator and freezer units, and proper handwashing. 4-The Dietary Manager or designee will complete weekly audits to check for expired foods, proper air circulation of stored food items, internal temperature monitoring of reach-in refrigerator, walk-in refrigerator and walk-in freezer, food temperature log, pantry freezer temperatures and conduct weekly observations of Dining Services staff for proper handwashing. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 11/01/2018

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F 812	Continued From page 25	F 812		

less." For October 2018 the freezer log documentation had temperatures ranging from -15 to 18 degrees F. There was no corrective action documented for temperatures logged above 10 degrees Fahrenheit.

On 10/30/18 at approximately 3:00 PM, a Resident in the Resident Council meeting stated his popsicles, which are kept in the freezer in the pantry, have been "half-melted' at times.

On 10/31/18 at 12:15 PM, the ice cream in the pantry freezer was soft; the popsicles were soft and squishy, not fully frozen. When LPN B asked about if 18 degrees an appropriate temperature for the freezer, she stated 'I don't know.'

The following observations were made of kitchen staff washing their hands on initial kitchen tour and just prior to tray line:

On 10/30/18 at approximately 11:25 AM, Employee G turned on the water, applied soap to hands from wall dispenser, washed hands while under the water less than 10 seconds, dried hands, turned sink off with paper towel.
Then Employee E turned on water, applied soap to hands from wall dispenser, lathered and rinsed less than five seconds, dried hands, threw paper towel away and turned off water with bare hand.

On 10/31/18 at 11:45 AM, Employee F turned on water, applied soap from wall dispenser, lathered and rinsed hands for approximately 5 seconds, dried hands, and turned off water with a paper towel. Employee G turned on water, applied soap from wall dispenser, lathered and rinsed hands for approximately 10 seconds, dried hands, and turned off water with paper towel. Employee E

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F 812	Continued From page 26	F 812		

turned on water, lathered and rinsed hands for approximately 5 seconds, dried hands, and turned off water with paper towel.

A sign posted above the sinks in the kitchen listed steps to wash hands: 1) wet (hands) 2) (apply) soap 3) wash hands for 20 seconds 4) rinse (hands) 5) dry (hands) 6) turn off water with paper towel.

The Centers for Disease Control and Prevention (CDC) recommend the following step to effective handwashing:
Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
o Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.
o Scrub your hands for at least 20 seconds.
o Rinse your hands well under clean, running water.
o Dry your hands using a clean towel or air dry them

On 10/31/2018, Employee E stated the 'reach-in' fridge, the 'walk-in' fridge, and the 'walk-in' freezer now had internal thermometers.

On 11/01/2018 at 8:45 AM, the outside temperature reading for the walk-in freezer was (-15) degrees Fahrenheit and the internal reading was 0 degrees Fahrenheit. The internal temperature reading was 15 degrees warmer than the outside temperature reading.

On 11/01/2018 prior to the end of the survey, the Administrator and DON were notified of the findings.

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