STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/27/18 through 11/29/18. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/27/2018 through 11/29/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 22 current resident reviews and three (3) closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		1/11/19

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

Electronically Signed | 12/07/2018

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to honor the right to refuse medications for one of 25 residents in the survey sample. A nurse forced Resident #56 to take medications against her wishes by holding down her arms, pinching her nose closed until her mouth opened and pushing her lips against her teeth. The findings include: Resident #56 was admitted to the facility on	F 578	ISSUE/CONCERN: F578-483.10: Request/Refuse/Discontinue treatment; formulate Advance Directives. Facility staff failed to honor the right to refuse medications for one of 25 residents. GOALS/OBJECTIVES/EXPECTED OUTCOME: The facility's policy for Resident Abused and Neglect will be followed as evidenced by: Every resident has the right to be free from abuse, corporal punishment,	

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F 578	Continued From page 2 1/12/18 with diagnoses that included Alzheimer's dementia, seizure disorder, anxiety, depression and high blood pressure. The minimum data set (MDS) dated 10/16/18 assessed Resident #56 with short and long-term memory problems and severely impaired cognitive skills. A facility reported incident form dated 7/12/18 documented certified nurses' aides (CNAs) reported they observed registered nurse (RN) #1 being "rough and forceful" with Resident #56 when giving oral medications on 7/12/18. This report documented, "... [CNA #3] reported to [administrator] on July 12, 2018, that she witnessed [RN #1] holding [Resident #56's] hands down. [CNA #3] reported that [RN#1] pushed the plastic spoon into [Resident #56's] mouth with medicine on it. [RN #1] then held [Resident #56's] lip into her teeth and pulled down to get her to open her mouth, wanting her to take a drink. [Resident #56] told her to get away but [RN #1] didn't stop. [RN #1] then squeezed [Resident #56's] nose to get her to open her mouth. The reporting staff intervened and attempted to assist [RN #1] to administer the drink to [Resident #56]" The facility's investigation of this incident dated 7/17/18 documented that four CNAs witnessed RN #1 force Resident #56 to take oral medications on 7/12/18 using physical force/restraint and against the resident's wishes. Written statements from the CNAs that witnessed the incident of 7/12/18 documented RN #1 held down Resident #56's arms, "shoved" the spoon with medicine into the resident's mouth, pushed the resident's lips on the side in attempt to open her mouth and then held the resident's nose shut until she opened her mouth to breath. Statements documented RN #1 refused to stop	F 578	involuntary seclusion and suspected crime. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, friends or other individuals. Care will be provided in a manner that is professional, compassionate and respectful of the resident's rights. It will be recognized and respected that each resident has the right to be free from abuse, neglect, misappropriation of resident's property and exploitation. This includes being fee from any physical or chemical restraint not required to treat the resident's medical symptom. CORRECTION: Resident #56 plan of care was reviewed to assure approaches/interventions for refusal of medication were current and resident specific. Education to the resident and/or resident representative regarding the risk associated with refusal medication. OTHER POTENTIAL: 100% Audit of residents to identify those who may be at risk due to a history of refusing medications. SYSTEM CHANGES: -RN#1 received immediate education on Resident Abuse & Neglect, to include the resident's right to refuse medication, Customer Service: Dementia Care, Ethical Decision Making and Medication Administration. Medication Observation completed within Probationary Period. RN#1 has been terminated and no longer	

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F 578	Continued From page 3 holding down the resident's arm after CNA #3 intervened and told RN #1 to stop. Written witness statements of RN #1 administering medication to Resident #56 dated 7/12/18 were as follows. CNA #1 - "...Noticed nurse [RN #1] pressing down on residents arms. At first I thought she was moving her arms down out of the way to give medicine but she was forcing her arms down. She then forced the medicine in her mouth. Resident stated no and said to stop leave me alone go away!. Nurse then was trying to force residents mouth open to give water...then immediately pinched her nose to get her to open up to push straw in. She held it till resident gasped + she put straw in. That is when [CNA #3] said 'you can not do that.' Nurse said 'She needs to take her medicine.' CNA # 3 said well you can't do that give me the water let me try. Nurse then was still pressing on her arm saying she has to take it. Then the phone rang that is when she finally gave [CNA 3] the water..." (Sic) CNA #2 - "...When I looked over the nurse [RN #1] was holding residents arms down and the resident was saying 'stop' 'stop' 'Get away'...she [RN #1] shoved the spoon of medicine and chocolate pudding into her mouth, held her arms more Forcefully pushed her lip in on side to try to Force her to swallow and get water in...[Resident #56] was jerking her head away, She then held [Resident #56's] nose shut and that forced her to open her mouth to breathe for the nurse to get the straw in...[CNA #3] said '[RN#1] no don't do that give me the water and let me try.' [RN #1] then said 'it's better than her spitting her medicine out.' Finally the nurse phone rang and she gave the water to [CNA #3]..." (Sic)	F 578	employed with facility effective 9/26/18. -Clinical Team re-educated on Resident Rights to Refuse Medications and Abuse using Resident Abuse and Neglect Policy CE-012. -Social Services to present Resident Rights to Resident Council. MONITORING/QA OVERSIGHT: -A sample of the resident's identified as having a history of refusal will be monitored during a medication administration. 20% Audit per house/ neighborhood of resident's weekly x6; every 2 weeks x6; then monthly. Results of audits will be trended for any patterns. Results will be presented to QAPI for recommendations or additional comments. Any variances as a result of audit will be immediate education and correction. Re-education and counseling as necessary. -Interview sample of residents to verify their right to refuse medications is honored. 20% Audit per house/neighborhood of resident's weekly x 6; every 2 weeks x6; then monthly. Results of audits will be trended for any patterns. Results will be presented to QAPI for recommendations or additional comments. Any variances as a result of audit will be immediate education and correction. Re-education and counseling as necessary.	

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F 578	Continued From page 4	F 578		

CNA #3 - "I was in the kitchen and heard [Resident #56] say get away get away...I witnessed [RN #1] squeezing and holding [Resident #56's] hands down. She shoved the plastic spoon into [Resident #56's] mouth with medicine on it. [RN #1] then pushed [Resident #56's] lip into her teeth to get her to open her mouth again to get a drink. [Resident #56] kept telling her to get away but she wouldn't stop. [RN #1] then held [Resident #56's] nose shut to get her to open her mouth...I told [RN #1] don't do that and she still kept pushing on [Resident #56's] arms. I went to [RN #1] and said here let me give it to her and she wouldn't give me the cup of water after I asked for it several times. She finally gave me the cup because the phone rang."

CNA #4 - "[Resident #56] was sitting beside the dining room table, near the counter when [RN #1] approached her. She started trying to give [Resident #56] the medicine and [Resident #56] was trying to refuse. I saw [RN #1] pull [Resident #56's] arms down to restrain her, [Resident #56] was trying to bite her to get [RN #1] to let go. She the [then] proceeded to plug [Resident #56's] nose and shove the medicine in her mouth. [Resident #56] was trying to spit the medicine out and get [RN #1] to let go. Then [RN #1] put her finger between her lips and pushed her lip down on her teeth to make her open her mouth to dump water in. That's when [CNA #3] stepped in and told [RN #3] to stop... [CNA #3] tried to help [Resident #56] sip her water, and I heard [Resident #56] say 'I told her to leave me alone'." (Sic)

The facility's investigation dated 7/17/18 documented Resident #56 was assessed by the

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F 578	Continued From page 5	F 578		

nursing supervisor on 7/12/18 and that "there was no evidence of any injury or indication of abuse." A social worker note in the investigation folder dated 7/12/18 documented the resident was distracted and wanted to go to bed at the time of the assessment. This social worker note stated, "She [Resident #56] voiced no concerns or anything that would cause me to think that she is troubled by the experience that she had."

On 11/28/18 at 9:22 a.m., CNA #4 that witnessed the incident of 7/12/18 was interviewed. CNA #4 stated she was the food coordinator that day and she saw RN #1 "battling" to give medications to Resident #56. CNA #4 stated Resident #56 does not always want her medications. CNA #4 stated RN #1 held the resident's nose shut and when the resident opened her mouth to gasp for breath, RN #1 shoved the medicines into her mouth. CNA #4 stated RN #1 pinched the resident's lips against her teeth trying to get her to open and drink water. CNA #4 stated CNA #3 came over and told RN #1 to stop. CNA #4 stated Resident #56 pulled her shirt up over her mouth to avoid the medication. CNA #4 stated she then reported the incident to the administrator. CNA #4 stated she had seen other nurses give medications to Resident #56 and they "sweet talk" her or leave her alone and try at another time.

On 11/28/18 at 3:47 p.m., the administrator and DON were interviewed about RN #1 physically forcing Resident #56 to take medications on 7/12/18. The DON stated they physically assessed the resident following the incident and did not find any evidence of physical abuse but they were concerned the resident's rights had been violated. The DON stated after reading the statements she determined that RN #1's intent

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F 578	Continued From page 6	F 578		

was to get her to take the medications. The DON stated RN #1 should not have made her take the medication. The administrator stated after talking with RN #1, she felt RN #1's "intention was not bad."

On 11/29/18 at 7:08 a.m., CNA #3 was interviewed about Resident #56 with RN #1 on 7/12/18. CNA #3 stated she was in the dining area and heard Resident #56 say, "No. Stop it." CNA #3 stated RN#1 was shoving the spoon of medicine in Resident #56's face. CNA #3 stated RN #1 was pulling the resident's arms down and digging her fingertips into the resident's forearm. CNA #3 stated RN #1 held the resident's nose shut until the resident opened her mouth to breath and then shoved the medicine into her mouth. CNA #3 stated Resident #56 was "swatting" at RN #1, turned her head away and spit out the pudding/medicines everywhere. CNA #3 stated she told RN #1 to stop several times and she did not stop until the telephone rang and she left to answer the phone. CNA #1 stated residents were afraid of RN #1. CNA #3 stated she had seen RN #1 force other residents to take medications but "not this bad" or with this amount of physical force. CNA #3 stated, "This was to me major abuse, when she held her [Resident #56] nose closed and was pinching her arms." CNA #3 stated she tried to calm the resident and then reported the incident to the supervisor and administrator.

Resident #56's plan of care (revised 10/24/18) documented the resident had a history of refusing care, physical aggression and non-compliance with taking medications. Interventions to minimize refusals and aggression included, "...Be gentle and patient...Light and simple humor may

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F 578	Continued From page 7 be a distraction for her...Compliment for cooperative behavior...Explain what you are doing at all times...If possible, leave and return later to finish care...Talk while providing care...Offer simple choices for her to maintain some control...Use calm non-threatening tones when talking..." The facility's policy titled Resident Abuse and Neglect (revised 6/6/18) documented, "...Every [facility] resident has the right to be free from abuse, corporal punishment, involuntary seclusion, and suspected crime. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals...It is the policy of [facility] to provide care in a manner that is professional, compassionate, and respectful of the residents' rights...Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...This organization recognizes and respects that each resident has the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation...This includes, but is not limited freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptom..." These findings were reviewed with the administrator and director of nursing during a meeting on 11/28/18 at 5:00 p.m.	F 578		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		1/11/19

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F 600	Continued From page 8 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; 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 one of 25 residents was free from physical abuse that included restraint. A nurse forced Resident #56 to take medications by holding down her arms, pinching her nose closed until her mouth opened and pushing her lips against her teeth in an attempt to get her to swallow and/or take medications. The findings include: Resident #56 was admitted to the facility on 1/12/18 with diagnoses that included Alzheimer's dementia, seizure disorder, anxiety, depression and high blood pressure. The minimum data set (MDS) dated 10/16/18 assessed Resident #56 with short and long-term memory problems and severely impaired cognitive skills. A facility reported incident form dated 7/12/18	F 600	ISSUE/CONCERN: F600-483.12: Free from Abuse Neglect and Exploitation Facility staff failed to ensure one of 25 residents was free from physical abuse that included restraint. GOALS/OBJECTIVES/EXPECTED OUTCOME: The facility's policy for Resident Abuse and Neglect will be followed as evidenced by: Every resident has the right to be free from abuse, corporal punishment, involuntary seclusion and suspected crime. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, friends or other individuals. Care will be provided in a manner that is professional,	

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F 600	Continued From page 9 documented certified nurses' aides (CNAs) reported they observed registered nurse (RN) #1 being "rough and forceful" with Resident #56 when giving oral medications on 7/12/18. This report documented, "... [CNA #3] reported to [administrator] on July 12, 2018, that she witnessed [RN #1] holding [Resident #56's] hands down. [CNA #3] reported that [RN#1] pushed the plastic spoon into [Resident #56's] mouth with medicine on it. [RN #1] then held [Resident #56's] lip into her teeth and pulled down to get her to open her mouth, wanting her to take a drink. [Resident #56] told her to get away but [RN #1] didn't stop. [RN #1] then squeezed [Resident #56's] nose to get her to open her mouth. The reporting staff intervened and attempted to assist [RN #1] to administer the drink to [Resident #56]" The facility's investigation of this incident dated 7/17/18 documented that four CNAs witnessed RN #1 force Resident #56 to take oral medications on 7/12/18 using physical force/restraint and against the resident's wishes. Written statements from the CNAs that witnessed the incident of 7/12/18 documented RN #1 held down Resident #56's arms, "shoved" the spoon with medicine into the resident's mouth, pushed the resident's lips on the side in attempt to open her mouth and then held the resident's nose shut until she opened her mouth to breath. Statements documented RN #1 refused to stop holding down the resident's arm after CNA #3 intervened and told RN #1 to stop. Written witness statements of RN #1 administering medication to Resident #56 dated 7/12/18 were as follows. CNA #1 - "...Noticed nurse [RN #1] pressing down on residents arms. At first I thought she was	F 600	compassionate and respectful of the residents' rights. It will be recognized and respected that each resident has the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation. This includes being free from any physical or chemical restraint not required to treat the resident's medical symptom. CORRECTION: Resident #56's plan of care was reviewed to assure approaches for refusing medications were current and resident specific. The resident and/or resident representative were educated on the risk associated with refusal of medications. OTHER POTENTIAL: 100% Audit of residents to identify those who may be at risk due to a history of refusing medications. SYSTEM CHANGES: -Clinical Team re-educated on Resident Rights to Refuse Medications and Abuse using Resident Abuse and Neglect Policy CE-012. -RN#1 received immediate education on Resident Abuse and Neglect, Customer Service: Dementia Care, Ethical Decision Making and Medication Administration, Medication Observation completed within Probationary Period. RN#1 has been terminated and no longer employed with facility effective 9/26/18. -Social Services to present Resident Rights to Resident Council MONITORING/QA OVERSIGHT: A sample of residents will be interviewed to assure they are free from abuse, neglect and/or misappropriation. 20%	

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F 600	Continued From page 10 moving her arms down out of the way to give medicine but she was forcing her arms down. She then forced the medicine in her mouth. Resident stated no and said to stop leave me alone go away!. Nurse then was trying to force residents mouth open to give water...then immediately pinched her nose to get her to open up to push straw in. She held it till resident gasped + she put straw in. That is when [CNA #3] said 'you can not do that.' Nurse said 'She needs to take her medicine.' CNA # 3 said well you can't do that give me the water let me try. Nurse then was still pressing on her arm saying she has to take it. Then the phone rang that is when she finally gave [CNA 3] the water..." (Sic) CNA #2 - "...When I looked over the nurse [RN #1] was holding residents arms down and the resident was saying 'stop' 'stop' 'Get away'...she [RN #1] shoved the spoon of medicine and chocolate pudding into her mouth, held her arms more Forcefully pushed her lip in on side to try to Force her to swallow and get water in...[Resident #56] was jerking her head away, She then held [Resident #56's] nose shut and that forced her to open her mouth to breathe for the nurse to get the straw in...[CNA #3] said '[RN#1] no don't do that give me the water and let me try.' [RN #1] then said 'it's better than her spitting her medicine out.' Finally the nurse phone rang and she gave the water to [CNA #3]..." (Sic) CNA #3 - "I was in the kitchen and heard [Resident #56] say get away get away...I witnessed [RN #1] squeezing and holding [Resident #56's] hands down. She shoved the plastic spoon into [Resident #56's] mouth with medicine on it. [RN #1] then pushed [Resident #56's] lip into her teeth to get her to open her	F 600	Audit per house/neighborhood of resident's will occur weekly x6; every 2 weeks x6; then monthly. Results of Audit will be trended for any patterns. Results will be presented to QAPI for recommendations or additional comments. Any variances as a result of audit will be immediate education and correction. Re-education and counseling as necessary.	

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mouth again to get a drink. [Resident #56] kept telling her to get away but she wouldn't stop. [RN #1] then held [Resident #56's] nose shut to get her to open her mouth...I told [RN #1] don't do that and she still kept pushing on [Resident #56's] arms. I went to [RN #1] and said here let me give it to her and she wouldn't give me the cup of water after I asked for it several times. She finally gave me the cup because the phone rang."

CNA #4 - "[Resident #56] was sitting beside the dining room table, near the counter when [RN #1] approached her. She started trying to give [Resident #56] the medicine and [Resident #56] was trying to refuse. I saw [RN #1] pull [Resident #56's] arms down to restrain her, [Resident #56] was trying to bite her to get [RN #1] to let go. She the [then] proceeded to plug [Resident #56's] nose and shove the medicine in her mouth. [Resident #56] was trying to spit the medicine out and get [RN #1] to let go. Then [RN #1] put her finger between her lips and pushed her lip down on her teeth to make her open her mouth to dump water in. That's when [CNA #3] stepped in and told [RN #3] to stop... [CNA #3] tried to help [Resident #56] sip her water, and I heard [Resident #56] say 'I told her to leave me alone'." (Sic)

The facility's investigation dated 7/17/18 documented Resident #56 was assessed by the nursing supervisor on 7/12/18 and that "there was no evidence of any injury or indication of abuse." A social worker note in the investigation folder dated 7/12/18 documented the resident was distracted and wanted to go to bed at the time of the assessment. This social worker note stated, "She [Resident #56] voiced no concerns or anything that would cause me to think that she is

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troubled by the experience that she had."

On 11/28/18 at 9:22 a.m., CNA #4 that witnessed the incident of 7/12/18 was interviewed. CNA #4 stated she was the food coordinator that day and she saw RN #1 "battling" to give medications to Resident #56. CNA #4 stated Resident #56 does not always want her medications. CNA #4 stated RN #1 held the resident's nose shut and when the resident opened her mouth to gasp for breath, RN #1 shoved the medicines into her mouth. CNA #4 stated RN #1 pinched the resident's lips against her teeth trying to get her to open and drink water. CNA #4 stated CNA #3 came over and told RN #1 to stop. CNA #4 stated Resident #56 pulled her shirt up over her mouth to avoid the medication. CNA #4 stated she then reported the incident to the administrator. CNA #4 stated she had seen other nurses give medications to Resident #56 and they "sweet talk" her or leave her alone and try at another time.

On 11/28/18 at 3:47 p.m., the administrator and DON were interviewed about RN #1 physically forcing Resident #56 to take medications on 7/12/18. The DON stated they physically assessed the resident following the incident and did not find any evidence of physical abuse but they were concerned the resident's rights had been violated. The DON stated after reading the statements she determined that RN #1's intent was to get her to take the medications. The DON stated RN #1 should not have made her take the medication. The administrator stated after talking with RN #1, she felt RN #1's "intention was not bad."

On 11/29/18 at 7:08 a.m., CNA #3 was interviewed about Resident #56 with RN #1 on

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7/12/18. CNA #3 stated she was in the dining area and heard Resident #56 say, "No. Stop it." CNA #3 stated RN#1 was shoving the spoon of medicine in Resident #56's face. CNA #3 stated RN #1 was pulling the resident's arms down and digging her fingertips into the resident's forearm. CNA #3 stated RN #1 held the resident's nose shut until the resident opened her mouth to breath and then shoved the medicine into her mouth. CNA #3 stated Resident #56 was "swatting" at RN #1, turned her head away and spit out the pudding/medicines everywhere. CNA #3 stated she told RN #1 to stop several times and she did not stop until the telephone rang and she left to answer the phone. CNA #1 stated residents were afraid of RN #1. CNA #3 stated she had seen RN #1 force other residents to take medications but "not this bad" or with this amount of physical force. CNA #3 stated, "This was to me major abuse, when she held her [Resident #56] nose closed and was pinching her arms." CNA #3 stated she tried to calm the resident and then reported the incident to the supervisor and administrator.

Resident #56's plan of care (revised 10/24/18) documented the resident had a history of refusing care, physical aggression and non-compliance with taking medications. Interventions to minimize refusals and aggression included, "...Be gentle and patient...Light and simple humor may be a distraction for her...Compliment for cooperative behavior...Explain what you are doing at all times...If possible, leave and return later to finish care...Talk while providing care...Offer simple choices for her to maintain some control...Use calm non-threatening tones when talking..."

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F 600	Continued From page 14 The facility's policy titled Resident Abuse and Neglect (revised 6/6/18) documented, "...Every [facility] resident has the right to be free from abuse, corporal punishment, involuntary seclusion, and suspected crime. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals...It is the policy of [facility] to provide care in a manner that is professional, compassionate, and respectful of the residents' rights...Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...This organization recognizes and respects that each resident has the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation...This includes, but is not limited freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptom..." These findings were reviewed with the administrator and director of nursing during a meeting on 11/28/18 at 5:00 p.m.	F 600		
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		1/11/19

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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 medication pass and pour observation, staff interview and clinical record review, facility staff failed to administer a medication per manufacturer guidelines for one of 25 residents in the survey sample, Resident #52. Facility staff failed to administer Levothyroxine per manufacturer guidelines, (on an empty stomach) for Resident #52. Findings included: Resident #52 was originally admitted to the facility on 06/12/2015 and readmitted on 09/16/2016 with diagnoses including, but not limited to: Anal Cancer, Macular Degeneration, Depression, Parkinson's Disease, and Hypothyroidism. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 10/12/2018. Resident #52 was assessed as impaired in her short and long term memory and moderately impaired in her daily decision making skills. Resident #52 was observed eating breakfast with fellow residents on 11/28/18 at approximately 8:15 a.m. During the medication pass and pour observation conducted 11/28/2018 at 8:36 a.m., Resident #52 was administered Levothyroxine 75 mcg by mouth, by LPN #1 (licensed practical nurse). LPN #1 was interviewed regarding the administration time of this medication. LPN #1 stated, "It is actually scheduled for 8:00 a.m. I believe you should give one half hour before	F 684	ISSUE/CONCERN: F684-483.25: Quality of Care Medication Pass Facility staff failed to administer a medication per manufacturer guidelines for one of 25 residents. GOALS/OBJECTIVES/EXPECTED OUTCOME: Facility staff will administer Levothyroxine(Synthroid)per manufacturer guidelines. CORRECTION: Resident #52 will have time of Levothyroxine (Synthroid) changed to ensure administration occurs before meals. OTHER POTENTIAL: 100% Audit of all residents/patients receiving Levothyroxine (Synthroid) to determine scheduled time in Electronic Health Record (EHR. SYSTEM CHANGES: -All residents/patients receiving Levothyroxine (Synthroid) will be scheduled at 0600. If a resident refused to receive the medication at 0600, it will be documented on the resident/patient Care Plan. -Staff education regarding required scheduling and administration time of Levothyroxine (Synthroid). MONITORING/QA OVERSIGHT: Monitor Medication orders to ensure all Levothyroxine (Synthroid) are scheduled at required scheduled time. A 20% Audit	

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F 684	Continued From page 16 breakfast." Levothyroxine was reviewed in a nursing drug handbook with LPN #1. The nursing drug handbook included the following administration indication for Levothyroxine, "...Give drug at same time each day on an empty stomach, preferably 1/2 to 1 hour before breakfast..." (1) LPN #1 stated, "I need to change the time for this medication." Subsequent review of the POS (physician order sheet) dated 11/01/18 through 11/30/18 for Resident #52 included: "...Order Date: 12/26/2017, Start Date: 12/27/2017, Levothyroxine Sodium...tablet 75mcg [micrograms]: Administer 1 Tablet By Mouth Per Day..." The Administrator and DON (director of nursing) were informed of the above observation during an end of the day meeting with the survey team on 11/28/18. No further information was received by the survey team prior to the exit conference on 11/29/18. (1) Woods DNP, RN, Anne Dabrow. 39th Edition Nursing 2019 Drug Handbook. Philadelphia: Wolters Kluwer, 2019.	F 684	per house/neighborhood of resident's receiving Levothyroxine (Synthroid) to ensure correct time is scheduled will occur weekly x6; every 2 weeks x6; then monthly. Results of audits will be trended for any patterns. Results will be presented to QAPI for recommendations or additional comments. Any variances as a result of audit will be immediate education and correction. Re-education and counseling as necessary.	
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,	F 812		1/11/19

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F 812	Continued From page 17 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store, prepare and serve food in a sanitary manner in the main kitchen. Cole slaw, which temped at 53 degrees and was made with mayonnaise was served for the lunchtime meal in one of eight houses on the facility campus. Findings were: Initial tour of the facility was conducted on 11/27/2018 beginning at approximately 11:45 a.m. Upon arrival in one of the individual houses on campus, OS (other staff) #5 was observed in the kitchen, preparing to serve lunch. The menu for the day was stuffed pepper casserole, cole slaw and dessert. Lunchtime temperatures were obtained by OS #5. The temperature of the cole slaw was 53 degrees. OS #5 was observed plating the cole slaw and serving it to the the residents residing in the home.	F 812	ISSUE/CONCERN: F812-483.60: Food Procurement Store Prepare Serve-Sanitary Cole Slaw, which temped at 53 degrees and as made with mayonnaise was served for the lunchtime meal in one of eight houses on the facility campus. GOALS/OBJECTIVES/EXPECTED OUTCOMES: Foods will be stored, prepared, distributed and served in accordance with professional standards for food service safety. CORRECTION: Monitor (OS#5) for at least 1 meal/week for 90 days, then monthly as stated in System Changes, to ensure that proper food temperatures are being met. OTHER POTENTIAL: All Food Coordinators will receive re-education surrounding ServSafe food temp guidelines. SYSTEM CHANGES:	

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F 812	Continued From page 18 OS #5 was questioned about the cole slaw. She was asked if the cole slaw dressing was mayonnaise based. She stated "Yes, I fixed it last evening (Monday 11/26/2018) and it has been in the refrigerator all night." She stated the refrigerator temperature was 40 that morning and she had just checked it again and it was 42 degrees. OS #5 was asked about the parameters for serving cold foods. OS #5 stated, "They should be 40 degrees." She was asked about the cole slaw temperature. She stated, "53 degrees..I wouldn't serve it much higher than that...to be honest the foods don't usually temp at 40, they are usually higher...I just serve them anyway because I know they have been in the refrigerator...sometimes I need to adjust the temperature on the fridge if the temperatures aren't reading right." OS #5 was asked if maintenance had looked at the refrigerator regarding temperatures. She stated, "No." On 11/28/18 at approximately 3:45 p.m., OS #5 was interviewed about the food temperature of the cole slaw the previous day. She stated, "I did a lot of tossing over that last night, I talked to my supervisor about it this morning...He told me to calibrate my thermometer." OS #5 was asked if she had calibrated it. She stated, "Not yet." OS #5 was asked how often thermometers were calibrated. She stated, "We have this log." She opened a notebook and said, "Here it is." She presented a form titled "Thermometer Calibration Log-One Form Per Month." OS #5 was asked what the log was for. She stated, "This thermometer." She was asked when the log was filled out. She stated, "When we calibrate it." Instructions listed on the thermometer on the log	F 812	All Staff that handle food in Woodland Park will receive re-education surrounding appropriate food temperatures and what to do if proper food temperatures are not met. Monitoring/QA OVERSIGHT: Monitoring of meal service for food temperatures will occur monthly in each home. Results of audit will be trended for any patterns. Results will be presented to QAPI for recommendations or additional comments. Any variances as a result of audit will be immediate education and correction. Re-education and counseling as necessary.	

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were: "Check calibration of thermometers daily and when accidentally dropped. Thermometers must be accurate to at least +/- 2 [symbol for degrees] F [Fahrenheit] from 32 [symbol for degrees] F (or +/- 5 [symbol for degrees] C [Celsius] from 0 [symbol for degrees] C). Procedure: Fill Container with 50 % crushed ice and 50 % water (Use 60 %/40 % ratio for cubed ice and water); Place thermometer stern into ice water solution (sensor must be completely submerged); Read thermometer after 2 minutes; If thermometer does not read 32 [symbol for degrees] F (+/- 2 (symbol for degrees) or 0 [symbol for degrees] C (+/- 0.5 [symbol for degrees] C), adjust it accordingly; Complete appropriate columns below." Columns listed included the date, number of thermometers checked, number of thermometers correct; number of thermometers adjusted, comments, and employee initials.

OS #5's initials were written on the log for 11/26/2018, 11/27/2018, and 11/28/2018. OS #5 was asked if the initials on the log were hers and was that her handwriting. She confirmed that the initials were hers and that it was her handwriting. She was asked if she had calibrated the thermometer earlier in the day. She stated, "No." She was asked when the last time was that she calibrated it. She stated, "Probably last week sometime." The top of the log was reviewed and OS #5 was asked if the calibration was suppose to be done daily and were her initials in the blanks as having completed the calibration. She stated, "Yes." OS #5 was asked if she had done the calibration as she had previously stated she had not. She stated, "No, I didn't do it." OS #5 was asked why her initials were on the log. She did not answer.

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OS #5 was asked to calibrate the thermometer at that time. She obtained two cups. She filled one with ice and water and the other with warm water. She placed the thermometer in the ice water cup first. The water temped at 32.5 degrees. She then placed the thermometer in the cup of warm water and the water temped at 73 degrees. She removed the thermometer from the warm water and put it back into the ice water, which temped at 32.3 degrees. She was asked why she used the warm water with the ice water. She stated, "That's what they said to do in 'Food Safe'." OS #5 was asked if she had taken the 'Food Safe' class. She stated, "Yes." OS #5 was asked what 'Food Safe" had said about the serving temperature of cold foods. She stated, "40 degrees."

On 11/28/2018 at 4:30 p.m., OS #4, the lead guide over food and safety in the houses was interviewed. The above information was explained to him. He stated, "That should not have happened...I look at that thermometer log every day as part of my rounds...her initials on there tell me that she did what she was suppose to do...that's apparently not accurate." He was asked if there was a policy regarding at what temperatures food should be served. He stated, "We follow the 'serve safe' guidelines...all of our food coordinators and the [name used a the facility for certified nursing assistants] go through the 'serve safe' training because they all work with and serve the food...the guidelines are very clear. Cold foods should be at 40 degrees or less...she [OS #5] talked to me today about what happened...I went over there and temped the refrigerators with a laser thermometer a little bit ago and the temperatures were correct in both

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F 812	Continued From page 21 the pantry and kitchen refrigerators...when the cole slaw didn't temp at 40 or below, it should have been tossed and not served...she should have made another side...that's the expectation." The above information was reviewed with the administrator and the DON (director of nursing) during an end of the day meeting on 11/28/2018 at approximately 5:00 p.m. No further information was obtained prior to the exit conference on 11/29/2018.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		1/11/19

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	495385	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802

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F 880	Continued From page 22 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 23 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to implement a program for prevention of Legionella and other waterborne pathogens and failed to ensure infection control policies were reviewed annually. The facility failed to perform a risk assessment to identify where Legionella and other waterborne pathogens could grow and/or spread; failed to implement a water management program based upon industry standards and/or the CDC (centers for disease control) toolkit and; failed to perform and document specified testing for prevention of Legionella. In addition, the facility had performed no annual review of infection control policies. The findings include: 1. On 11/28/18 at 1:15 p.m., the maintenance director was interviewed about evidence of a water management program to prevent the growth and spread of Legionella and other waterborne pathogens. The maintenance director stated the facility had not set up a program yet to check for Legionella. The maintenance director stated they performed standard testing and maintenance on the boilers and water towers but had not implemented any testing regarding Legionella. The maintenance director stated, "We have more questions than answers." The maintenance director stated the current water management vendor did not know what was required regarding Legionella. The maintenance director stated he had not reviewed or utilized the CDC toolkit regarding Legionella prevention. The maintenance director stated they	F 880	ISSUE/CONCERN: F880-483.80: Infection Prevention & Control Facility staff failed to ensure infection control policies were reviewed annually. GOALS/OBJECTIVES/EXPECTED OUTCOME: -There will be a process regarding annual review of the facility's infection control policies implemented according to Licensure Requirements. -There will be a process regarding annual review of all Supportive Living policies by a facility committee(s) and Medical Director implemented according to Licensure Requirements CORRECTION: -Infection control policies will be reviewed -A plan for annual review of infection control policies will be developed OTHER POTENTIAL: A plan for annual review of all policies will be developed SYSTEM CHANGES: Checklist will be created with each infection control policy to track date and signature of Director of Nursing or designee, Medical Director and Administrator. MONITORING/QA OVERSIGHT: -100% audit of infection control policies will be reviewed every quarter and to ensure they remain current. Updates and revisions to occur as needed. Results of audit will be trended for any patterns.	

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F 880	Continued From page 24 were working with a new water management vendor but had not set up or implemented any protocols or testing regarding Legionella. The facility's policy titled Water Management Program (dated 11/28/18) documented, "The purpose of this policy is to monitor and test water to prevent Legionnaire's Disease...This water management program will utilize the services of a third party company to monitor, test, and treat the heating, ventilation, and air conditioning (HVAC) water systems and domestic water systems." The procedures listed in the policy included, water treatment chemicals, maintenance and repair of water treatment equipment, water analysis with record keeping, identification of areas where Legionella could grow/spread, control measures and monitoring for compliance. There was no evidence any interventions were implemented in the facility for the prevention of Legionella or other waterborne pathogens. 2. On 11/29/18 at 8:08 a.m., the director of nursing (DON) was interviewed regarding annual review of the facility's infection control policies. The DON stated the policies were maintained on a computer database. Accompanied by the DON, the policies were reviewed on the computer. The policies listed had no indication of an annual review. The DON printed a copy of the policy titled Multi Drug Resistant Organism (MDRO) Management. This policy was originated on 3/1/12 and was most recently reviewed and/or revised on 8/15/16. This and other policies had no indication of an annual review by the medical director or any facility committee. The DON stated at this time there was no system set up to review the policies annually. The DON stated	F 880	Results will be presented to QAPI for recommendations or additional comments. Any variances as a result of audit will be immediate correction. -100% audit of all policies requiring review will be completed every quarter until current. Updates and revisions to occur as needed. Results of audit will be trended for any patterns. Results will be presented to QAPI for recommendation or additional comments. Any variances as a result of audit will be immediate correction. ISSUE/CONCERN: F880-483.80: Infection Prevention & Control -Facility staff failed to implement a program for prevention of Legionella and other waterborne pathogens. -Facility staff failed to perform a risk assessment to identify where Legionella and other waterborne pathogens could grow and/or spread. -Facility staff failed to implement a water management program based upon industry standards and/or the CDC (Centers for Disease Control) toolkit. -Facility staff failed to perform and document specified testing for prevention of Legionella. -Facility staff failed to ensure infection control policies were reviewed annually. GOALS/OBJECTIVES/EXPECTED OUTCOMES: Establish and implement a Water Management Program to prevent Legionella Disease.	

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F 880	Continued From page 25 policies were updated as needed. These findings were reviewed with the administrator and director of nursing during a meeting on 11/28/18 at 5:00 p.m.	F 880	CORRECTION: Implement a program for prevention of Legionella and other waterborne pathogens. OTHER POTENTIAL: Perform a risk assessment to identify where Legionella and other waterborne pathogens could grow and/or spread SYSTEM CHANGES: -Implement a water management program based upon for industry standards and/or the CDC (Center for Disease Control) toolkit. -Perform and document specified testing for prevention of Legionella -Develop a plan for annual review of infection control policies associated with Legionella and other waterborne pathogens. -Contract with a third party Water Treatment vendor for the annual testing and reporting of identified areas. MONITORING/QA OVERSIGHT: Monitor that routine maintenance checks are conducted, documented and responded to per facility protocol. Results of audits will be trended for any patterns. Results will be presented to QAPI for recommendations or additional comments. Any variances as a results of audit will be immediate correction.	