TN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/2/19 through 1/3/19. The facility was not in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 90 certified bed facility was 83 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/02/10 through 01/03/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		1/31/19

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

Electronically Signed | 01/26/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 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 staff interview and clinical record review the facility staff failed to develop a comprehensive care plan for 2 of 21 Residents, #60 and #65. The findings included: 1. For Resident #60, the facility staff failed to develop a care plan for the Residents wound vac.	F 656	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	

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F 656	Continued From page 2 The clinical record review revealed that Resident #60 had been admitted to the facility 12/21/18. Diagnoses included, but were not limited to, chronic pain syndrome, bipolar disorder, fibromyalgia, and diabetes. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/02/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The EHR (electronic health record) included a physician order dated 12/22/18 that read "Ensure wound vac functioning at 125 mmHG (millimeter of mercury) continuously Q (every) shift..." When reviewing the Residents current care plan the surveyor was unable to find any information related to the wound vac. On 01/02/19 at 1:03 p.m., the surveyor and MDS staff #1 and #2 reviewed the care plan with the surveyor and were unable to locate any information related to the wound vac. The administrative staff were notified of the above during a meeting with the survey team on 01/03/19 at 3:53 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #65, the facility staff failed to develop a care plan in regards to the Residents suprapubic catheter.	F 656	correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. For resident # 60 the care plan was updated on the evening of 1/2/19 to reflect the use of the wound vac to her surgical wound. For resident #65, the care plan was updated on the evening of 1/2/19 to reflect that he has a suprapubic catheter. 2. Current residents are at risk for care plan omissions. 3. SDC or designee will educate licensed nursing staff regarding ensuring care plans are comprehensive and individualized to meet the medical and nursing needs of each resident. 4. An audit of the care plans for all current residents was performed on 1/2/19 to ensure that each one was reflective of the most recent comprehensive assessment. Unit managers will compare new orders to the care plan to ensure timely updates are done. D.O.N. or designee will perform weekly audits for four weeks with the findings reviewed in the next quarterly QA committee meeting. 5. Completion date: 1/31/19	

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F 656	Continued From page 3 The record review revealed that Resident #65 had been admitted to the facility 11/24/18. Diagnoses included, but were not limited to, presence of urogenital implants, diabetes, depressive disorder, essential hypertension, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/01/18 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points. Section H (bladder and bowel) had been coded to indicate the Resident had a catheter. The EHR (electronic health record) included a physicians order to "Change Suprapubic Catheter q (every) 30 days and PRN (as needed)..." This order was dated 11/24/18. When reviewing the Residents care plan the surveyor was unable to find any information related to the suprapubic catheter. On 01/02/19 at 3:32 p.m., the surveyor and the unit manager reviewed the care plan. After reviewing the care plan, the unit manager verbalized to the surveyor that the suprapubic catheter had not been care planned. The administrative staff were notified of the above during a meeting with the survey team on 01/03/19 at 3:53 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 656		

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F 677	Continued From page 4	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for 1 of 21 Residents, Resident #241. The findings included: The facility staff failed to provide the Resident with nail care. The Resident was observed with long and jagged fingernails. The clinical record review revealed that Resident #241 had been admitted to the facility 12/19/18. Diagnoses included, but were not limited to, diabetes, schizophrenia, anoxic brain damage, and rhabdomyolysis. There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated to person and place. The Residents care plan included the focus area Resident has an ADL self-care performance deficit related to activity intolerance, fatigue, and shortness of breath. During initial tour of the facility on 01/02/18 beginning at approximately 11:15 a.m., Resident #241 was observed in his room. During this	F 677	1. For resident #241 nail care was provided 1/3/19. 2. Current residents who require ADL assistance are at risk. 3. SDC or designee will educate nursing staff on weekly nail care. 4. Fingernail audit for current residents performed 1/24/19. DON or designee will do random fingernail checks weekly for four weeks. Results of audits will be reviewed in the next quarterly QA meeting. 5. Completion date: 1/31/19	1/31/19

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F 677	Continued From page 5 observation, the Residents fingernails were observed to be long and jagged. On 01/03/19 at 8:50 a.m., Resident #241 was again noted to have long and jagged fingernails. When asked about his nails Resident #241 stated he could not have clippers here at the facility and that he generally cut his own nails at home. On 01/03/19 at 10:17 a.m., the surveyor spoke with the unit manager regarding the Resident's nails. On 01/03/19 at 1:34 p.m., the surveyor interviewed CNA (certified nursing assistant) #1 regarding the Residents nails. CNA #1 verbalized to the surveyor that she had already cut the Residents nails and that some were broken off and did not need cutting but some of the nails did. The administrative staff were notified of the above during a meeting with the survey team on 01/03/19 at 3:53 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 677		
F 756 SS=B	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		1/31/19

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F 756	Continued From page 6 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the medical director reviewed a pharmacy recommendation for 1 of 21 Residents, Resident #41. The findings included:	F 756	1. For resident #41, the medical director was notified of the pharmacy recommendation via telephone and reviewed it in person on 1/4/19, with no new orders. 2. Current residents are at risk. 3. D.O.N. will keep pharmacy consult summary forms in a separate binder and	

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F 756	Continued From page 7 The facility failed to provide evidence that the medical director had reviewed the pharmacy recommendation for Resident #41 for the month of October 2018. The clinical record review revealed that Resident #41 had been admitted to the facility 10/19/18. Diagnoses included, but were not limited to, chronic respiratory failure, anxiety disorder, chronic atrial fibrillation, chronic obstructive pulmonary disease, and anemia. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/26/18 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points. The clinical record included a pharmacy consultation report dated 10/22/18 with the recommendation to discontinue the Residents PRN (as needed) lorazepam. The surveyor was unable to locate any information indicating the facility medical director had been notified of this pharmacy recommendation. On 01/03/19 at 3:22 p.m., the DON (director of nursing) verbalized to the surveyor that she was unable to find any documentation that the medical director had reviewed the pharmacy review for October 2018. The administrative staff were notified of the above during a meeting with the survey team on 01/03/19 at 3:53 p.m.	F 756	meet with medical director weekly to ensure each recommendation is reviewed. 4. Nurse Consultant will review consultant pharmacy report on each visit for the next four months to ensure compliance and appropriate review with the Medical Director has occurred. 5. Completion date 1/31/19	

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F 756	Continued From page 8 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 756		