STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 01/15/19 through 01/17/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/15/19 through 1/17/19. Complaints were investigated during the survey. 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 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of 39 current record reviews and three closed record 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	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights. RECEIVED FEB 06 2019 VDH/OLC	

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

Christopher Lynn LNHA | Executive Director | 2-5-19

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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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, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure dignity was provided during dinning for one of 42 residents in the survey sample, Resident #4. The facility failed to serve Resident #4 lunch on 1/15/19 at the same time his roommate received lunch. Resident #4 did not receive lunch until at least 12 minutes after his roommate was served. The findings include:	F 550	1. Resident #4 did not receive lunch at the same time as his roommate. Direct care staff and Dietary staff reeducated on Residents Rights and serving lunch at the same time at one table or room to leave no one waiting and watching someone else eat. 2. The facility has determined that the residents that reside here have the ability to be affected by this deficient practice. 3. Current employees will be re-educated by DON/ Designee on the importance of serving residents sitting at a table or in their room at the same time. New employees receive education on Resident Rights and re-education will be provided upon discovery of non-compliance. 4. The DON/Dietary Manager/Designee will conduct a random audit on 5 residents per week for 4 weeks to ensure the facility is practicing correctly. Results of audits will be discussed at morning meetings with Care Keepers, monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction to be complete by 2/15/19	

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F 550	Continued From page 2 Resident #4 was admitted to the facility on 11/21/12. Resident #4's diagnoses included but were not limited to major depressive disorder, stroke and high blood pressure. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/22/18, coded the resident's cognition as moderately impaired. Section G coded Resident #4 as requiring supervision with setup help only with eating. Resident #4's care plan dated 1/22/13, failed to document information regarding a dignified dining experience. On 1/15/19 at 12:14 p.m., Resident #4 was observed sitting up in bed with no lunch tray. The resident's roommate was observed sitting up in bed and eating lunch. Resident #4 confirmed he had not received his lunch tray. On 1/15/19 at 12:19 p.m., CNA (certified nursing assistant) #1 was observed entering Resident #4's room and speaking to the resident's roommate. CNA #1 exited the room, walked down the hall and returned to the room with artificial sweetener for Resident #4's roommate. On 1/15/19 at 12:26 p.m., CNA #2 provided Resident #4 his lunch tray. On 1/16/19 at 2:08 p.m., an interview as conducted with Resident #4. Resident #4 was made aware of the above observation and asked how he felt about receiving his lunch tray several minutes after his roommate. Resident #4 stated this made him feel, "Lousy." On 1/16/19 at 2:23 p.m., an interview was conducted with CNA #1. CNA #1 was asked if both residents in a room are supposed to be served their meal trays at the same time. CNA #1 stated, "Yes." When asked why, CNA #1 stated,	F 550		

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F 550	Continued From page 3 "Because you don't want one resident looking at the other resident while they eat and wondering why they don't get to eat right away." When asked how she would feel if she had to wait, at least 12 minutes to be served a meal after her roommate had been served, CNA #1 stated, "I would be pretty upset. That would be like if I was sitting down with my family at a restaurant and I'm the only one not eating." On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Order of Tray Service" documented, "POLICIES: Meals will be efficiently distributed to residents. PURPOSE: To assure efficient meal distribution to residents. PROCEDURES: 1. The Dining Services Director will coordinate with the nursing staff on the sequence of meal trays and dining room service. 2. The order of trays will be arranged so they are delivered to the same location in the facility for immediate service. For residents eating in their rooms, trays should be placed on the carts in room order..." No further information was presented prior to exit.	F 550		
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.	F 578	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 578	Continued From page 4 §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). (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 and clinical record review, it was determined that the facility staff failed to ensure accurate physician's orders for	F 578		

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F 578	Continued From page 5 code status (whether or not to resuscitate in the event of cardiac arrest) for one of 42 residents in the survey sample, Resident #49. Resident #49's active physician's order sheet contained a physician's order for dnr (do not resuscitate) and a physicians' order for full code status (to resuscitate). The facility staff failed to discontinue the physician's order for dnr for Resident #49 when the resident elected to change his code status to full code. The findings include: Resident #49 was admitted to the facility on 3/30/18. Resident #49's diagnoses included but were not limited to colon cancer, anxiety disorder and difficulty swallowing. Resident #49's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/18, coded the resident as being cognitively intact. Review of Resident #49's clinical record revealed an active physician's order sheet that documented a physician's order dated 3/31/18, for: "DNR Comfort Care" and a physician's order dated 1/3/19 for, "Full Code." Further review of Resident #49's clinical record revealed a "DNR/CPR (Cardiopulmonary Resuscitation) Order Form" signed by the physician on 1/3/19 that documented a check mark beside, "In the event of a cardiac and/or respiratory arrest, initiate CPR." Resident #49's comprehensive care plan dated 4/2/18 documented, "Patient has an advance Directive as evidenced by: FULL CODE." On 1/16/19 at 2:50 p.m., an interview was	F 578	1. Resident #49 facility failed to ensure accurate physician orders for code status (whether or not to resuscitate in the event of cardiac arrest) Facility staff failed to discontinue the physician's order for dnr when the resident elected to change code status to full code. 2. The facility has determined that residents that reside in this facility with Advance Directive have the ability to be affected by the deficient practice. 3. Admission/Social Services will be re-educated by DON/Designee on Advance Directive and auditing the chart as well as talking with the resident/POA for accuracy of Advance Directives. 4. The Admission/Social Services will conduct a random audit of charts on 5 residents per week for 4 weeks to ensure the facility is practicing correctly. Results of audits will be discussed at morning meetings with Care Keepers, monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction will be complete by 2/15/19	

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F 578	Continued From page 6	F 578		

conducted with LPN (licensed practical nurse) #1. LPN #1 was asked where a resident's code status is documented. LPN #1 stated, "In the doctor's orders. We also have a dnr sheet that they fill out, if they are a dnr, and we have the golden rod dnr form." When asked how nurses identify a resident's code status, LPN #1 stated, "Look at the doctor's orders. That is my only true identification." When asked if a resident should have a physician's order for full code and a physician's order for dnr, LPN #1 stated, "No and I was just sitting here thinking he (Resident #49) just recently changed his status." LPN #1 was asked what should be done when a resident changes his code status. LPN #1 stated, "The old order should be removed and the new order be put in (the computer system), printed out and placed in the chart." LPN #1 was shown Resident #49's conflicting code status orders and asked if the orders should have been updated to reflect the resident's current decision for full code. LPN #1 stated, "I did discontinue that and it didn't go out but I very well may have been called away and thought I had done that." On 1/16/19 at 4:39 p.m., LPN #1 stated, "I looked in the discontinued section of the orders and I did discontinue it (a dnr order) but he had two orders for dnr. There was another order, which was not discontinued. I should have scrolled down to check to make sure all dnr orders were discontinued."

On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

On 1/17/19 at 1:29 p.m., a facility policy regarding advance directives and code status was

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F 578	Continued From page 7 requested via a list given to ASM #1. On 1/17/19 at 3:15 p.m., ASM #1 provided a blank copy of the "DNR/CPR [cardiopulmonary resuscitation] Status Order Form." No further information was provided prior to exit.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 580	Continued From page 8 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a possible need to alter treatment for one of 42 residents in the survey sample, Resident #48. The facility staff failed to notify the physician when Vitamin B-12 (1) and Vitamin D3 (2) were not available for administration to Resident #42 on 9/17/18. The findings include: Resident #48 was admitted to the facility on 9/10/18. Resident #48's diagnoses included but were not limited to intellectual disabilities, seizures and high blood pressure. Resident #48's most recent MDS (minimum data set), a	F 580	Nurse failed to notify the physician when vitamin B-12 and vitamin D3 were not available for administration to resident #42 I. Nurse notified central supply of the vitamins that were not available and the vitamins were restocked in the medication carts. II. Residents that reside in this facility that take vitamin B-12 or vitamin D3 have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/ designee regarding notifying the physician promptly on the medications/vitamins that are not available to administer. Unit manager to audit medication carts weekly to assure medication/vitamins are available for administration. IV. Meeting/education minutes/signatures will be turned in to HR to assure Nursing staff is Re-educated on notification of changes. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 580	Continued From page 9 quarterly assessment with an ARD (assessment reference date) of 12/6/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #48 as requiring extensive assistance of two or more staff with bed mobility/transfers and as being totally dependent on one staff with eating. Review of Resident #48's clinical record revealed physician's orders dated 9/10/18 for Vitamin B-12- 100 mcg (micrograms), one tablet once a day for supplement and Vitamin D3- 1,000 units, one tablet once a day for supplement. Review of Resident #48's September 2018 MAR (medication administration record) revealed the above Vitamin B-12 and Vitamin D3 orders. On 9/17/18, LPN (licensed practical nurse) #2 documented the code "7= Other/ See Nurse Notes" instead of documenting a check mark to indicate the Vitamin B-12 and Vitamin D3 was administered to Resident #48. Nurses' notes signed by LPN #2 on 9/17/18 documented Vitamin B-12 and Vitamin D3 was unavailable. Resident #48's comprehensive care plan dated 9/11/18 failed to document specific information regarding physician notification of unavailable medications. On 1/16/19 at 3:26 p.m., a telephone interview with LPN #2 was attempted. LPN #2 was unavailable. On 1/16/19 at 4:31 p.m., an interview was conducted with LPN #3. LPN #3 was asked the process for ensuring Vitamin B-12 and Vitamin D3 are administered to residents per physician's orders. LPN #3 stated Vitamin B-12 and Vitamin	F 580		

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F 580	Continued From page 10 D3 are not provided by the pharmacy because they are kept onsite in bulk quantities. LPN #3 stated he would check other medication carts and the medication rooms if he did not have Vitamin B-12 and Vitamin D3 in his medication cart. LPN #3 stated he would contact the physician and ask permission to hold the medications if they were not available. When asked if the physician should be notified if the medications are not available, LPN #3 stated, "The doctor should be notified." When asked why, LPN #3 stated, "Because it's medication that the doctor has ordered and the doctor needs to be notified if it wasn't given and why it wasn't given." On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Medication Administration- General Guidelines" documented, "2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified." No further information was provided prior to exit. (1) "Vitamin B12 is a nutrient that helps keep the	F 580		

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F 580	Continued From page 11 body's nerve and blood cells healthy and helps make DNA, the genetic material in all cells." This information was obtained from the website: https://ods.od.nih.gov/factsheets/VitaminB12-Consumer/ (2) "Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d3&_ga=2.199577710.1336833414.1548171654-139120270.1477942321	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 583	Continued From page 12 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide privacy during wound care for one of 42 residents in the survey sample, Resident #84. The facility staff failed to close the window blinds/curtains while providing Resident #84's wound care on 1/17/19. The findings include: Resident #84 was admitted to the facility on 3/2/11. Resident #84's diagnoses included but were not limited to heart failure, chronic kidney disease and diabetes. Resident #84's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/2/19, coded the resident's cognitive skills for daily decision-making as severely	F 583	Nursing staff failed to close the window/blinds/curtains while providing Resident #84 wound care I. Unable to correct incident that occurred due to completion of resident's care had been completed. II. Residents that reside in this facility have the potential to be affected by the deficient practice. III. Nursing staff to be re-educated by DON/designee regarding resident's rights. Residents have the right to a dignified existence, and the right to personal privacy. An audit will be conducted on residents receiving wound care or general care for privacy provided. Daily rounds to be completed by the unit managers/designee to ensure resident's privacy is being provided. The care keepers will follow up once per shift to ensure that privacy is provided and discuss results during afternoon stand down meeting x 4 weeks. IV. Results of audit will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 583	Continued From page 13 impaired. Section G coded Resident #84 as requiring extensive assistance of two or more staff with bed mobility. Resident #84's comprehensive care plan dated 12/16/14 failed to document information regarding privacy during wound care. On 1/17/19 at 10:15 a.m., LPN (licensed practical nurse) #4 was observed providing wound care on Resident #84's bottom. The window blinds/curtains were not pulled and the outside area (including a side road to the facility back entrance) could be seen. An individual driving a tractor-trailer for a food company drove by the window during wound care. On 1/17/19 at 10:24 a.m., an interview was conducted with LPN #4. LPN #4 was asked what should be done during wound care, in regards to privacy. LPN #4 stated, "I should have closed the blind." When asked why, LPN #4 stated, "In case anyone would walk by or ride by. I usually do close. I was really nervous." On 1/17/19 at 10:42 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "RESIDENT RIGHTS" documented, "The Resident has a right to a dignified existence...The resident has the right to personal privacy..." No further information was provided prior to exit.	F 583		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		

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F 622	Continued From page 14 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the	F 622	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 622	Continued From page 15 facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.	F 622	1. Resident #99, #23, #93, #66, #52, #91 and #80 the facility staff failed to provide required information (including physician contact information, resident representative contact information, special instructions, adv directives, etc when the resident was discharged to the hospital. 2. The facility has determined that residents that reside in this facility have the ability to be affected by the deficient practice when discharging from facility. 3. Admission/Social Services/Designee will be re-educated by DON on required information that facility will provide upon discharge from facility. New employees will be educated on the required information that is need to discharge resident to the community. 4. The Admission/Social Services will conduct a weekly audits of residents who are sent to the hospital to assure they have received the required materials upon discharge and will perform this type of audit for 4 weeks to ensure the facility is practicing correctly. Results of audits will be discussed at morning meetings with Care Keepers, monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction will be complete by 2/15/19	

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F 622	Continued From page 16 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide required documentation to the receiving hospital and required documentation in the clinical record for facility initiated-transfers for seven of 42 residents in the survey sample, Residents #99, #23, #66, #93, #52, #91 and #80. 1. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff for Resident #99's facility initiated transfer to the hospital on 12/23/18. 2. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff for Resident #23's facility initiated transfer to the hospital on 10/30/18. 3. The facility staff failed to evidence what if any documentation, including comprehensive care plan goals, was provided to the hospital when Resident #66 was transferred to the hospital on	F 622		

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F 622	Continued From page 17 12/6/18. 4. The facility staff failed to evidence that the facility physician documented information regarding the resident's hospitalizations and failed to evidence what if any documentation, including comprehensive care plan goals, was provided to the hospital, when Resident #93 was transferred to the hospital on 11/18/18 and 12/21/18. 5. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving provider for Resident #52's facility initiated hospital transfers dated 10/5/18 and 11/21/18. 6. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving provider for Resident #91's facility initiated hospital transfer dated 12/19/18. 7. The facility staff failed to provide the receiving hospital with the resident's comprehensive care plan goals for Resident #80's facility initiated transfer to the hospital on 10/8/18. The findings include: 1. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff for Resident #99's facility initiated transfer to the hospital on 12/23/18. Resident #99 was admitted to the facility on	F 622		

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F 622	Continued From page 18 9/1/18. Resident #99's diagnoses included but were not limited to difficulty breathing, muscle weakness and heart failure. Resident #99's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 1/8/19, coded the resident as being cognitively intact. Review of Resident #99's clinical record revealed a nurse's note dated 12/23/18 that documented Resident #99 was transferred to the hospital due to lying on the floor and a low blood sugar. Further review of Resident #99's clinical record (including nurses' notes) failed to reveal evidence that the facility staff provided the required information to hospital staff upon Resident #99's transfer to the hospital. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what information is provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated, "We send the doctor's order, a physician order sheet, code status, a doctor's progress note, and the most current. I send current labs (laboratory tests) and a MAR (medication administration record) to show what medicines they have had so far today." When asked if she provides residents' comprehensive care plan goals, LPN #1 stated she did not. When asked how she evidences the information she provides to hospital staff, LPN #1 stated, "There is an interact form, where you check off everything you send. We make a copy of that and put it in the chart." Further review of Resident #99's clinical record failed to reveal an interact form for the resident's hospital transfer on 12/23/18.	F 622		

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F 622	Continued From page 19 On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility document regarding transfers and discharges failed to document information regarding the above transfer requirements. No further information was presented prior to exit. 2. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff for Resident #23's facility initiated transfer to the hospital on 10/30/18. Resident #23 was admitted to the facility on 3/29/18. Resident #23's diagnoses included but were not limited to difficulty breathing, heart failure and bacterial infection. Resident #23's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 11/16/18, coded the resident as being cognitively intact. Review of Resident #23's clinical record revealed a nurse's note dated 10/30/18 that documented Resident #23 was transferred to the hospital and admitted for dehydration. Further review of Resident #23's clinical record (including nurses' notes) failed to reveal evidence that the facility staff provided the required information to hospital staff.	F 622		

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F 622	Continued From page 20 On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what information is provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated, "We send the doctor's order, a physician order sheet, code status, a doctor's progress note, and the most current. I send current labs (laboratory tests) and a MAR (medication administration record) to show what medicines they have had so far today." When asked if she provides residents' comprehensive care plan goals, LPN #1 stated she did not. When asked how she evidences the information she provides to hospital staff, LPN #1 stated, "There is an interact form where you check off everything you send. We make a copy of that and put it in the chart." Further review of Resident #23's clinical record failed to reveal an interact form for the resident's hospital transfer on 12/23/18. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to evidence what if any documentation, including comprehensive care plan goals, was provided to the hospital when Resident #66 was transferred to the hospital on 12/6/18.	F 622		

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F 622	Continued From page 21 Resident #66 was admitted to the facility on 9/9/13 with the diagnoses of but not limited to dementia, diabetes, depression, paranoid schizophrenia, high blood pressure and convulsions. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a physician's note dated 12/6/18 which documented, "Called by RN (Registered Nurse) to address sugar level of High - provided with 10 units and her blood sugar was then to 342 2 hours later. Reviewed nursing notes and BS (blood sugar) levels - she has been fluctuating from HI-72 - with last 72 on 12/2 - she has a hx (history) of hypoglycemia. STA (stat) labs were ordered and are back for review....Assessment....Shallow breathing noted tachypnic [Abnormally fast or deep respiration]....Tachicardia [fast heart rate] {sic}....Metabolic Acidosis: due to diabetes....Pt needs higher level of care will be sent out - POA is her sister - will notify...." Further review of the clinical record failed to reveal any evidence of what, if any, documentation was provided to the receiving hospital. On 1/17/19 at 9:23 a.m., an interview was conducted with LPN #5 (Licensed Practical Nurse). Upon review of the clinical record for Resident #66, and when asked about what is sent to the hospital upon a residents transfer, she stated that "If they sent the transfer form to the	F 622		

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F 622	Continued From page 22 hospital and the hospital did not send it back, we would not have it." When asked if the facility keeps a copy of what was sent to the hospital, LPN #5 stated, "Well, we should. The only thing I can think of is that they put the transfer sheet with the documentation. I don't have it." LPN #5 was asked what information is sent with residents' to the hospital. LPN #5 stated, "We send the transfer form, copy of MAR (Medication Administration Record), the face sheet, the DNR (Do Not Resuscitate orders)." When asked about sending the comprehensive care plan goals, LPN #5 stated, "We do not send care plan. We send the MAR. Even if we don't send the form (transfer form) we still need to call the hospital and give report of why we are sending them over there. I usually put in my notes "report called" or something of that nature." When asked if the record reflects what documentation and information was sent to and provided to the hospital, LPN #5 stated the record does not reflect that. A review of the "Nursing Home to Hospital Transfer Form" documented the following as some of the data that should be provided to the hospital: Resident name, Contact Person, Primary Care Clinician, Code Status, Key Clinical Information, Usual Mental Status, Usual Functional Status, Additional Clinical Information, Devices and Treatments. Isolation Precautions, Allergies, Risk Alerts, Primary Goals of Care at Time of Transfer, Treatments and Frequency, Diet, Skin/Wound Care, Immunizations, Physical Rehabilitation Therapy, ADLs, Impairments - General, Impairments - Musculoskeletal, Continence, Additional Relevant Information...." The facility was unable to evidence that this form	F 622		

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F 622	Continued From page 23 or any of the information included within were provided to the hospital when Resident #66 was transferred to the hospital on 12/6/18. On 1/17/18 at 3:30 p.m., the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey. 4. The facility staff failed to evidence that the facility physician documented information regarding the resident's hospitalizations and failed to evidence what if any documentation, including comprehensive care plan goals, was provided to the hospital, when Resident #93 was transferred to the hospital on 11/18/18 and 12/21/18. Resident #93 was admitted to the facility on 10/3/18 with the diagnoses of but not limited to Parkinson's disease, dysphagia, high and low blood pressure episodes, paraplegia, stroke, aphasia, and effusion, of the right knee. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/31/18. The resident was coded as being severely impaired in ability to make daily life decisions. A review of the clinical record revealed a note dated 11/18/18, which documented, "CNA (Certified Nursing Assistant) changed resident and started out of room when she noticed resident unresponsive. CNA called for this nurse. Upon entering room resident was unresponsive, diaphoretic, O2 sats (oxygen saturation) were in	F 622		

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	495140	A. BUILDING _____ B. WING _____	C 01/17/2019

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F 622	Continued From page 24 the 50's. Pulse was faint. O2 put on resident and sats remained in the 50's. BS (blood sugar) - 266. Temp (temperature) 100.0. Resident aroused a little and then went unresponsive again. Non-rebreather put on resident. NP (nurse practitioner) called and order given to send to (hospital) for eval (evaluation). Unable to obtain BP (blood pressure). Son called and he stated he was out of town until Tuesday but to keep him updated." Another subsequent hospitalization occurred on 12/21/18. A nurse's note dated 12/21/18 documented, "resident unresponsive and diaphoretic and gray. Resident roused after being spoken to a few times. Temp 99.1 oral. Pulse 20. BP (blood pressure) unable to read. Notified NP and POA (power if attorney). POA requested send to (hospital). DON (Director of Nursing) notified." Further review of the clinical record failed to reveal any evidence of physician documentation regarding these hospitalizations, documenting what the facility did to attempt to improve the resident's condition, why the resident had to be sent to a higher level of care, and what the hospital was able to provide, that the facility could not, to treat the resident. Further review of the clinical record also failed to reveal any evidence of what, if any, documentation was provided to the receiving hospital for either hospitalization. On 1/17/19 at 9:23 a.m., an interview was conducted with LPN #5 (Licensed Practical Nurse). Upon review of the clinical record for Resident #66, and when asked about what is sent	F 622		

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F 622	Continued From page 25 to the hospital upon transfer, LPN #5 stated, "If they sent the transfer form to the hospital and the hospital did not send it back, we would not have it." When asked if the facility keeps a copy of what was sent to the hospital with residents', LPN #5 stated, "Well, we should. The only thing I can think of is that they put the transfer sheet with the documentation. I don't have it." LPN #5 was asked what information is sent with residents' to the hospital. LPN #5 stated, "We send the transfer form, copy of MAR (Medication Administration Record), the face sheet, the DNR (Do Not Resuscitate orders)." When asked about sending the comprehensive care plan goals, LPN #5 stated, "We do not send care plan. We send the MAR. Even if we don't send the form (transfer form) we still need to call the hospital and give report of why we are sending them over there. I usually put in my notes "report called" or something of that nature." When asked if the record reflects what documentation and information was sent to and provided to the hospital, LPN #5 stated the record does not reflect that. LPN #5 was asked if the physician should be documenting why a resident was sent out to the hospital, what the facility did to attempt to improve the resident's condition. Why the resident had to be sent to a higher level of care, and what was the hospital able to provide the facility could not, to treat the resident. LPN #5 stated that they should be. She stated there were no physician's notes regarding these hospitalizations. The facility was unable to evidence that this form or any of the information included within were provided to the hospital, or that the physician made any documentation regarding these	F 622		

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F 622	Continued From page 26 hospitalizations. On 1/17/18 at 3:30 p.m., the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey. 5. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving provider for Resident #52's facility initiated hospital transfers dated 10/5/18 and 11/21/18. Resident #52 was admitted to the facility on 9/14/2018 with a most recent readmission date of 1/7/2019. Diagnoses included but were not limited to: diabetes, heart failure (1), gastro-esophageal reflux (2), high blood pressure, chronic obstructive pulmonary disease (3), and anemia (4). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/11/18, coded the resident as having a score of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for daily decision making. Review of Resident #52's clinical record revealed that he was sent to the hospital on 10/5/18. A nursing note dated 10/8/18 at 12:44 p.m., documented "Late entry for 10/5/18. Resident yelling from room at 1830 (6:30 p.m.). Said he slipped on his fluids from his foot. Tried several times to get up but was not successful. Said he could not move. Notified NP (nurse practitioner) and DON (director of nursing). Requested to go	F 622		

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F 622	Continued From page 27 ED (emergency department). Received order. Called 911 (emergency services). Sent to ED for evaluation and treatment." Review of Resident #52's clinical record revealed that he was sent to the hospital on 11/21/18. A nursing note dated 11/21/18 at 17:15 (5:15 p.m.), documented, "Patient c/o (complain of) severe pain to bilateral (both) legs. Noted L (left) stump very redden and warm to touch this shift. Given liquid diet for dinner. VS (vital signs) Blood pressure 150/75, P (pulse) - 99, R (respirations) - 20 (breaths per minute), T (temperature) 100.6 (degrees Fahrenheit) There was no evidence in the clinical record that Resident #52's comprehensive care plan goals were sent to the receiving provider for the facility-initiated transfers dated 10/5/18 or 11/21/18. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what information is provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated, "We send the doctor's order, a physician order sheet, code status, a doctor's progress note, and the most current. I send current labs and a MAR (medication administration record) to show what medicines they have had so far today." When asked if she provides residents' comprehensive care plan goals, LPN #1 stated she did not. When asked how she evidences the information provided to hospital staff, LPN #1 stated, "There is an 'Interact' form where you check off everything you send. We make a copy of that and put it in the chart." On 1/17/19 at approximately 9:27 a.m., an	F 622		

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F 622	Continued From page 28 interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. ASM #2 was asked if the facility could evidence comprehensive care plan goals were sent to the receiving provider for Resident #52's facility initiated hospital transfer dated, 10/5/18 and subsequent hospital transfer on 11/21/18. ASM #2 replied, "We have not sent care plans and the nurses have not been doing the 'Interact' forms." On 1/17/18 at approximately 3:51 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 1. A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 2. Stomach contents leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 3. A disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution,	F 622		

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F 622	Continued From page 29 chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=anemia&_ga=2.71282640.1704263304.1542638661-1154288035.1542638661 6. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving provider for Resident #91's facility initiated hospital transfer dated 12/19/18. Resident #91 was admitted to the facility on 12/20/2016 with a most recent readmission date of 1/15/2019. Diagnoses included but were not limited to: diabetes, heart failure (1), hyponatremia (2), high blood pressure, chronic obstructive pulmonary disease (3), and peripheral vascular disease (4). The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 1/4/19 coded the resident as having a score of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for daily decision making.	F 622		

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F 622	Continued From page 30 Review of Resident #91's clinical record revealed that he was sent to the hospital on 12/19/18. A nursing note dated 12/19/18 at 23:25 (11:25 p.m.), documented "NP (nurse practitioner) called facility requesting resident be sent to ER (emergency room) via 911 d/t (due to) severe pain in right lower extremity. Resident left facility via (name of emergency medical service) EMS at 2130 (9:30 p.m.). DON (director of nursing) aware. Resident shows understanding. Will follow up." There was no evidence in the clinical record that Resident #91's comprehensive care plan goals were sent to the receiving provider for this facility-initiated transfer dated 12/19/18. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what information is provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated, "We send the doctor's order, a physician order sheet, code status, a doctor's progress note, and the most current. I send current labs and a MAR (medication administration record) to show what medicines they have had so far today." When asked if she provides residents' comprehensive care plan goals, LPN #1 stated she did not. When asked how she evidences the information provided to hospital staff, LPN #1 stated, "There is an 'Interact' form where you check off everything you send. We make a copy of that and put it in the chart." On 1/17/19 at approximately 9:27 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. ASM #2 was asked if the facility could evidence	F 622		

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F 622	Continued From page 31 comprehensive care plan goals were sent to the receiving provider for Resident #91's facility initiated hospital transfer dated, 12/19/18. ASM #2 replied, "We have not sent care plans and the nurses have not been doing the 'Interact' forms." On 1/17/18 at approximately 3:51 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 1. A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 2. Low sodium (salt) level. This information was obtained from the website: https://medlineplus.gov/ency/article/000394.htm. 3. A disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4. The vascular system is the body's network of	F 622		

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F 622	Continued From page 32 blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 7. The facility staff failed to provide the receiving hospital with the resident's comprehensive care plan goals for Resident #80's facility initiated transfer to the hospital on 10/8/18. Resident #80 was admitted to the facility on 3/10/17 with a most recent readmission on 10/30/18 with diagnoses that included but were not limited to: diabetes, dementia, breast cancer, diverticulitis [inflammation of an abnormal sac at a weakened point in the digestive tract, especially the colon (1)], urinary tract infection, macular degeneration [A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. (2)], high blood pressure and atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 12/27/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily	F 622		

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F 622	Continued From page 33 cognitive decisions. The nurse's note dated, 10/8/19 at 11:24 p.m. documented in part, "This nurse entered the residents (sic) room. The resident is very confused. Noted a non productive (sic) cough. Wheezing in upper lobes. Afebrile (without fever). Stated. 'I feel horrible.' This nurse advised the resident of the importance of going to the ER (emergency room) to be evaluated. The resident agreed. Order received from NP (nurse practitioner) on call to send to the ER to be evaluated and treated. Son and daughter notified. 911 (emergency medical services) called and resident transferred to (initials of hospital) via stretcher." Review of the clinical record failed to evidence documentation that the comprehensive care plan goals were sent with the resident to the hospital. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what information is provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated, "We send the doctor's order, a physician order sheet, code status, a doctor's progress note, and the most current. I send current labs and a MAR (medication administration record) to show what medicines they have had so far today." When asked if she provides residents' comprehensive care plan goals, LPN #1 stated she did not. When asked how she evidences the information she provides to hospital staff, LPN #1 stated, "There is an interact form where you check off everything you send. We make a copy of that and put it in the chart."	F 622		

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F 622	Continued From page 34 On 1/17/19 at 1:12 p.m., an interview was conducted with LPN (licensed practical nurse) #10, the nurse who sent Resident #80 out to the hospital on 10/8/18. When asked what forms she sent with the resident to the hospital on 10/8/18, LPN #10 stated I send the nurse's notes, a copy of the MD (medical doctor) orders, the MAR (medication administration record) and their code status." When asked if she sends an "Interact Form", LPN #10 stated, "No, I've never heard of that form." When asked if she sends a copy of the comprehensive care plan goals, LPN #10 stated she didn't send that. She stated she had not been instructed to send that. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 1/17/19 at 4:09 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 173. (2) This information was obtained from the following website: https://medlineplus.gov/maculardegeneration.html. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		

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F 623	Continued From page 35 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 623	Continued From page 36 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623		

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F 623	Continued From page 37 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide written notification to the resident and/or resident representative for a facility-initiated transfer for seven of 42 residents in the survey sample, Residents #99, #23, #66, #93, #52, #91 and #80. 1. Resident #99 was transferred to the hospital on 12/23/18. The facility staff failed to provide written notification of the facility-initiated transfer to the resident and/or the resident's representative. 2. Resident #23 was transferred to the hospital on 10/30/18. The facility staff failed to provide written notification of the facility-initiated transfer to the resident and/or the resident's representative. 3. The facility staff failed to evidence that written notification was provided to Resident #66 or the resident's representative and to the Ombudsman,	F 623	1. Resident #99, #23, #93, #66, #52, #91 and #80 the facility staff failed to provide written notification to the resident, resident representative, or the Ombudsman when the resident was discharged to the hospital. 2. The facility has determined that residents that reside in this facility have the ability to be affected by the deficient practice when discharging from facility 3. Admission/Social Services/Designee will be re-educated by DON on required information that facility will provide upon discharge from facility. New employees will be educated on the required information that is need to discharge resident to the community. 4. The Admission/Social Services will conduct a weekly audits of residents who are sent to the hospital to assure they have received the required materials upon discharge and will perform this type of audit for 4 weeks to ensure the facility is practicing correctly. Results of audits will be discussed at morning meetings with Care Keepers, monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction will be complete by 2/15/19	

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F 623	Continued From page 38 when Resident #66 was transferred to the hospital on 12/6/18. 4. The facility staff failed to evidence that written notification of hospital transfers were provided to the Resident #93 or the resident representative when Resident #93 was transferred to the hospital on 11/18/18 and 12/21/18. 5. The facility staff failed to provide Resident #52 or the resident's representative (RP) with written documentation of a facility initiated transfer dated 10/5/18 or for a facility initiated hospital transfer dated 11/21/18. 6. The facility staff failed to provide Resident #91 or the resident's representative (RP) with written documentation of a facility initiated transfer dated 12/19/18. 7. The facility staff failed to provide written documentation to the resident and/or resident representative regarding the reason for the facility initiated transfer to the hospital on 10/8/18 for Resident #80. The findings include: 1. Resident #99 was transferred to the hospital on 12/23/18. The facility staff failed to provide written notification of the facility-initiated transfer to the resident and/or the resident's representative. Resident #99 was admitted to the facility on 9/1/18. Resident #99's diagnoses included but were not limited to difficulty breathing, muscle weakness and heart failure. Resident #99's most recent MDS (minimum data set), a 14 day	F 623		

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F 623	Continued From page 39 Medicare assessment with an ARD (assessment reference date) of 1/8/19, coded the resident as being cognitively intact. Review of Resident #99's clinical record revealed a nurse's note dated 12/23/18 that documented Resident #99 was transferred to the hospital due to lying on the floor and a low blood sugar. Further review of Resident #99's clinical record failed to reveal written notification of the transfer was provided to the resident and/or the resident's representative. On 1/16/19 at 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 confirmed she does notify the ombudsman regarding resident transfers to the hospital but does not provide written notice of transfer and the reason for the transfer to residents and/or their representatives. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides residents and/or their representatives' written notice of transfer and the reason for the transfer when residents are transferred to the hospital, LPN #1 stated she calls residents' representatives but does not provide any written notice. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 1/17/19 at 1:00 p.m., an interview was conducted with Resident #99. The resident stated she did not receive any written notice when	F 623		

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F 623	Continued From page 40 she was transferred to the hospital on 12/23/18. The facility document regarding transfer and discharges documented, "We will not discharge you from Facility against your wishes without prior written notice, as required by law. Our written notice of transfer or discharge against your wishes will be provided 30 days in advance. However, we may provide less than 30 days notice: (a) if the reason for the transfer or discharge is to protect your health and safety or the health and safety of other individuals..." The document did not include specific information regarding facility initiated hospital transfers. No further information was presented prior to exit. 2. Resident #23 was transferred to the hospital on 10/30/18. The facility staff failed to provide written notification of the facility-initiated transfer to the resident and/or the resident's representative. Resident #23 was admitted to the facility on 3/29/18. Resident #23's diagnoses included but were not limited to difficulty breathing, heart failure and bacterial infection. Resident #23's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 11/16/18, coded the resident as being cognitively intact. Review of Resident #23's clinical record revealed a nurse's note dated 10/30/18 that documented Resident #23 was transferred to the hospital and admitted for dehydration. Further review of Resident #23's clinical record failed to reveal written notification of the transfer was provided to the resident and/or the resident's representative.	F 623		

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F 623	Continued From page 41 On 1/16/19 at 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 confirmed she does notify the ombudsman regarding resident transfers to the hospital but does not provide written notice of transfer and the reason for the transfer to residents and/or their representatives. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides residents and/or their representatives' written notice of transfer and the reason for the transfer when residents are transferred to the hospital, LPN #1 stated she calls residents' representatives but does not provide any written notice. On 1/16/19 at 4:56 p.m., an interview was conducted with Resident #23. The resident stated she did not receive any written notice when she was transferred to the hospital on 10/30/18. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to evidence that written notification was provided to Resident #66 or the resident's representative and to the Ombudsman, when Resident #66 was transferred to the hospital on 12/6/18. Resident #66 was admitted to the facility on	F 623		

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F 623	Continued From page 42 9/9/13 with the diagnoses of but not limited to dementia, diabetes, depression, paranoid schizophrenia, high blood pressure and convulsions. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a physician's note dated 12/6/18 which documented, "Called by RN (Registered Nurse) to address sugar level of High - provided with 10 units and her blood sugar was then to 342 2 hours later. Reviewed nursing notes and BS (blood sugar) levels - she has been fluctuating from HI-72 - with last 72 on 12/2 - she has a hx (history) of hypoglycemia. STA (stat) labs were ordered and are back for review....Assessment....Shallow breathing noted tachypnic [Abnormally fast or deep respiration]....Tachicardia [fast heart rate] {sic}....Metabolic Acidosis: due to diabetes....Pt needs higher level of care will be sent out - POA is her sister - will notify...." Further review of the clinical record failed to reveal any evidence that written notification was provided to the resident or resident representative and the Ombudsman for this facility initiated transfer to the hospital. On 1/17/18 at 10:00 a.m., in an interview with OSM #1 (Other Staff Member, the Director of Social Services) and OSM #3 (the Business Office Manager), OSM #1 and OSM #3 were asked about Ombudsman notification and written family notification for hospital transfers. OSM #1	F 623		

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F 623	Continued From page 43 and OSM #3 stated that in researching why the Ombudsman was not notified of the hospitalization, they determined that the report that was sent to the Ombudsman on 12/7/18, which should have captured Resident #66, was generated before their 3rd-party billing company had updated the system with census information. They stated this is the report that was provided to the Ombudsman's office. OSM #3 stated that when a nurse puts into the system that a resident was transferred, the next morning she uploads a daily census sheet to the billing company and they update the incomplete census information, finish admitting a resident or if discharged they are the ones that update it with the correct action code. OSM #3 stated that this report had already been run and faxed to the Ombudsman, prior to the system being updated on the morning after the resident was sent to the hospital. OSM #1 stated that she runs the report every Friday. OSM #1 stated the resident was sent to the hospital on 12/6/18. The report that was sent to the Ombudsman was run on 12/7/18 at 10:06 a.m., but the report through the 7th was not updated by the 3rd-party billing company until after this time (time not provided), and therefore failed to capture Resident #66 being discharged to the hospital. OSM #1 stated the next report provided to the Ombudsman would have been dated from the 8th through December 14 and would not have captured the resident on that one because her transfer was the 6th. Regarding providing written notification to the resident representative, OSM #1 stated that she does not provide a written notice to the family. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides residents and/or their	F 623		

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F 623	Continued From page 44 representatives' written notice of transfer and the reason for the transfer when residents are transferred to the hospital, LPN #1 stated she calls residents' representatives but does not provide any written notice. On 1/17/19 at 1:29 p.m., the Executive Director was provided a list of policies, including policies regarding Admission, Transfer, and Discharge requirements. None of the policies provided addressed the requirement of Ombudsman and resident representative written notifications. On 1/17/18 at 3:30 p.m., the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey. 4. The facility staff failed to evidence that written notification of hospital transfers were provided to the Resident #93 or the resident representative when Resident #93 was transferred to the hospital on 11/18/18 and 12/21/18. Resident #93 was admitted to the facility on 10/3/18 with the diagnoses of but not limited to Parkinson's disease, dysphagia, high and low blood pressure episodes, paraplegia, stroke, aphasia, and effusion of the right knee. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/31/18. The resident was coded as being severely impaired in ability to make daily life decisions. A review of the clinical record revealed a note	F 623		

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F 623	Continued From page 45 dated 11/18/18, which documented, "CNA (Certified Nursing Assistant) changed resident and started out of room when she noticed resident unresponsive. CNA called for this nurse. Upon entering room resident was unresponsive, diaphoretic, O2 sats (oxygen saturation) were in the 50's. Pulse was faint. O2 put on resident and sats remained in the 50's. BS (blood sugar) - 266. Temp (temperature) 100.0. Resident aroused a little and then went unresponsive again. Non-rebreather put on resident. NP (nurse practitioner) called and order given to send to (hospital) for eval (evaluation). Unable to obtain BP (blood pressure). Son called and he stated he was out of town until Tuesday but to keep him updated." Another subsequent hospitalization occurred on 12/21/18. A nurse's note dated 12/21/18 documented, "resident unresponsive and diaphoretic and gray. Resident roused after being spoken to a few times. Temp 99.1 oral. Pulse 20. BP (blood pressure) unable to read. Notified NP and POA (power if attorney). POA requested send to (hospital). DON (Director of Nursing) notified." Further review of the clinical record failed to reveal any evidence written notification was provided to the resident or resident representative for either hospitalization. On 1/17/18 at 10:00 a.m., in an interview with OSM #1 (Other Staff Member, the Director of Social Services, when asked about providing written notification of a hospitalization to the resident or resident representative, OSM #1 stated that she does not provide a written notice to the family.	F 623		

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F 623	Continued From page 46 On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides residents and/or their representatives' written notice of transfer and the reason for the transfer when residents are transferred to the hospital, LPN #1 stated she calls residents' representatives but does not provide any written notice. On 1/17/19 at 1:29 p.m., the Executive Director was provided a list of policies, including policies regarding Admission, Transfer, and Discharge requirements. None of the policies provided addressed the requirement of Ombudsman and resident representative written notifications and physician documentation requirements for emergent transfers. On 1/17/18 at 3:30 p.m., the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey. 5. The facility staff failed to provide Resident #52 or the resident's representative (RR) with written documentation of a facility initiated transfer dated 10/5/18 or for a facility initiated hospital transfer dated 11/21/18. Resident #52 was admitted to the facility on 9/14/2018 with a most recent readmission date of 1/7/2019. Diagnoses included but were not limited to: diabetes, heart failure (1), gastro-esophageal reflux (2), high blood pressure, chronic obstructive pulmonary disease (3), and anemia (4).	F 623		

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F 623	Continued From page 47 The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/11/18 coded the resident as having a score of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for daily decision making. Review of Resident #52's clinical record revealed that he was sent to the hospital on 10/5/18. A nursing note dated 10/8/18 at 12:44 p.m., documented "Late entry for 10/5/18. Resident yelling from room at 1830 (6:30 p.m.). Said he slipped on his fluids from his foot. Tried several times to get up but was not successful. Said he could not move. Notified NP (nurse practitioner) and DON (director of nursing). Requested to go ED (emergency department). Received order. Called 911 (emergency services). Sent to ED for evaluation and treatment." Review of Resident #52's clinical record revealed that he was sent to the hospital on 11/21/18. A nursing note dated 11/21/18 at 17:15 (5:15 p.m.), documented "Patient c/o (complain of) severe pain to bilateral (both) legs. Noted L (left) stump very redden and warm to touch this shift. Given liquid diet for dinner. VS (vital signs) Blood pressure 150/75, P (pulse) - 99, R (respirations) - 20 (breaths per minute), T (temperature) 100.6 (degrees Fahrenheit) The clinical record failed to evidence documentation that Resident #52, the RR were given written notification regarding the facility initiated transfer dated 10/5/18 or for the facility initiated hospital transfer dated 11/21/18. On 1/16/19 at approximately 2:35 p.m., an interview was conducted with OSM (other staff	F 623		

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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 623	Continued From page 48 member) #1 (the social services director). OSM #1 was asked if she provide the resident and/ or the RR with written notice of a facility initiated hospital transfer. OSM #1 replied, "I do notify the ombudsman regarding resident transfers to the hospital but I have not provided written notice of transfer and the reason for the transfer to residents and/or their representatives. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides residents and/or their representative's written notice of transfer and the reason for the transfer when residents are transferred to the hospital, LPN #1 stated she calls residents' representatives but does not provide any written notice. On 1/17/18 at approximately 3:51 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 1. A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 2. Stomach contents leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.	F 623		

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F 623	Continued From page 49 3. A disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=anemia&_ga=2.71282640.1704263304.1542638661-1154288035.1542638661 6. The facility staff failed to provide Resident #91 or the resident's representative (RR) with written documentation of a facility initiated transfer dated 12/19/18. Resident #91 was admitted to the facility on 12/20/2016 with a most recent readmission date of 1/15/2019. Diagnoses included but were not limited to: diabetes, heart failure (1), hyponatremia (2), high blood pressure, chronic obstructive pulmonary disease (3), and peripheral vascular disease (4).	F 623		

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F 623	Continued From page 50 The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 1/4/19 coded the resident as having a score of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for daily decision making. Review of Resident #91's clinical record revealed that he was sent to the hospital on 12/19/18. A nursing note dated 12/19/18 at 23:25 (11:25 p.m.), documented "NP (nurse practitioner) called facility requesting resident be sent to ER (emergency room) via 911 d/t (due to) severe pain in right lower extremity. Resident left facility via (name of emergency medical service) EMS at 2130 (9:30 p.m.). DON (director of nursing) aware. Resident shows understanding. Will follow up." The clinical record failed to evidence documentation that Resident #91, or the RR were given written notification regarding the facility initiated transfer dated 12/19/18. On 1/16/19 at approximately 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she provided the resident and/ or the RR with written notice of a facility initiated hospital transfer. OSM #1 replied, "I do notify the ombudsman regarding resident transfers to the hospital but I have not provided written notice of transfer and the reason for the transfer to residents and/or their representatives. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides residents and/or their	F 623		

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F 623	Continued From page 51	F 623		

representative's written notice of transfer and the reason for the transfer when residents are transferred to the hospital, LPN #1 stated she calls residents' representatives but does not provide any written notice.

On 1/17/18 at approximately 3:51 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings.

No further information was provided prior to exit.

1. A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

2. Low sodium (salt) level. This information was obtained from the website: https://medlineplus.gov/ency/article/000394.htm.

3. A disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

4. The vascular system is the body's network of blood vessels. It includes the arteries, veins and

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F 623	Continued From page 52 capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 7. The facility staff failed to provide written documentation to the resident and/or resident representative regarding the reason for the facility initiated transfer to the hospital on 10/8/18 for Resident #80. Resident #80 was admitted to the facility on 3/10/17 with a most recent readmission on 10/30/18 with diagnoses that included but were not limited to: diabetes, dementia, breast cancer, diverticulitis [inflammation of an abnormal sac at a weakened point in the digestive tract, especially the colon (1)], urinary tract infection, macular degeneration [A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. (2)], high blood pressure and atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 12/27/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions.	F 623		

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F 623	Continued From page 53 The nurse's note dated, 10/8/19 at 11:24 p.m. documented in part, "This nurse entered the residents (sic) room. The resident is very confused. Noted a non productive (sic) cough. Wheezing in upper lobes. Afebrile (without fever). Stated. 'I feel horrible.' This nurse advised the resident of the importance of going to the ER (emergency room) to be evaluated. The resident agreed. Order received from NP (nurse practitioner) on call to send to the ER to be evaluated and treated. Son and daughter notified. 911 (emergency medical services) called and resident transferred to (initials of hospital) via stretcher." Review of the clinical record failed to evidence documentation of written notification to the resident and/or resident representative for the reasons for the transfer to the hospital on 10/8/18. On 1/16/19 at 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 confirmed she does notify the ombudsman regarding resident transfers to the hospital but does not provide written notice of transfer and the reason for the transfer to residents and/or their representatives. On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides residents and/or their representatives' written notice of transfer and the reason for the transfer when residents are transferred to the hospital, LPN #1 stated she calls residents' representatives but does not provide any written notice.	F 623		

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F 623	Continued From page 54 ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 1/17/19 at 4:09 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 173. (2) This information was obtained from the following website: https://medlineplus.gov/maculardegeneration.html. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 625	Continued From page 55 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide evidence that a written bed hold policy was provided within 24 hours of a facility-initiated transfer for five of 42 residents in the survey sample, Residents #99, #66, #93, #91 and #80. 1. The facility staff failed to provide Resident #99 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 12/23/18. 2. The facility staff failed to evidence that a written bed hold notice was provided to Resident #66 and/or resident representative when the resident was transferred to the hospital on 12/6/18. 3. The facility staff failed to evidence that written bed hold notification was provided to the resident or resident representative when Resident #93 was transferred to the hospital on 11/18/18 and 12/21/18. 4. The facility staff failed to provide Resident #91	F 625	1. Resident #99, #66, #93, #91, and #80 the facility staff failed to provide written notification to resident or the resident's representative of the bed hold policy when the resident was discharged to the hospital. 2. The facility has determined that residents that reside in this facility have the ability to be affected by the deficient practice when discharging from facility. 3. Admission/Social Services will be re-educated by DON/Designee on the Bed Hold policy and have evidence that written Bed Hold Policy was given within 24 hours of facility transfer and maintain compliance. 4. The Admission/Social Services will conduct a weekly audits of residents who are sent to the hospital to assure they have received the BH Policy and will perform this type of audit for 4 weeks to ensure the facility is practicing correctly. Results of audits will be discussed at morning meetings with Care Keepers, monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction will be complete by 2/15/19	

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F 625	Continued From page 56 with a written notice of bed-hold policy for a facility initiated hospital transfer dated 12/19/18. 5. The facility staff failed to evidence documentation of a bed hold policy being sent with the resident upon a facility initiated transfer to the hospital on 10/8/18 for Resident #80. The findings include: 1. The facility staff failed to provide Resident #99 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 12/23/18. Resident #99 was admitted to the facility on 9/1/18. Resident #99's diagnoses included but were not limited to difficulty breathing, muscle weakness and heart failure. Resident #99's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 1/8/19, coded the resident as being cognitively intact. Review of Resident #99's clinical record revealed a nurse's note dated 12/23/18 that documented Resident #99 was transferred to the hospital due to lying on the floor and a low blood sugar. Further review of Resident #99's clinical record (including interdisciplinary notes) failed to reveal the resident or the resident's representative was provided written information regarding the facility, bed hold policy within 24 hours of the resident's discharge. On 1/16/19 at 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she provides the bed hold policy to residents	F 625		

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F 625	Continued From page 57 and/or their representatives when residents are discharged to the hospital. OSM #1 stated, "When someone goes out to the hospital, there is a packet that goes with them and the bed hold policy is in that and if someone has a responsible party I send one in the mail. When asked if she could provide evidence of the bed hold policies that she sends through the mail, OSM #1 stated, "Yeah. I make copies of who I will mail it out to." On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides the bed hold policy to residents and/or their representative when residents are transferred to the hospital, LPN #1 stated, "I have packets made up on the unit that has the interact form in it and the bed hold policy in it. The bed hold policy goes in the envelope with the stuff that I send to the hospital." When asked if she could provide evidence that the bed hold policy is provided when residents are transferred to the hospital, LPN #1 stated she was not sure. On 1/16/19 at 3:17 p.m., OSM #1 stated she could not provide evidence that a bed hold policy was sent to Resident #99's representative when the resident was transferred to the hospital on 12/23/18. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 1/17/19 at 1:00 p.m., an interview was conducted with Resident #99. The resident stated she did not receive any written information	F 625		

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F 625	Continued From page 58 regarding the bed hold policy when she was transferred to the hospital on 12/23/18. The facility document regarding bed holds documented "If you will be temporarily absent from Facility for hospitalization or therapeutic leave, you may request the center to hold your bed during this time (called a 'bed hold'). The Medicare program and most private insurance companies do not cover costs related to holding your bed in these situations. We will notify you and/or your Legal Representative of the option to pay the applicable daily rate for each day we hold your bed open. You and your representative have 24 hours after receiving this notice to let us know whether you want us to hold your bed for you." No further information was presented prior to exit. 2. The facility staff failed to evidence that a written bed hold notice was provided to Resident #66 and/or resident representative when the resident was transferred to the hospital on 12/6/18. Resident #66 was admitted to the facility on 9/9/13 with the diagnoses of but not limited to dementia, diabetes, depression, paranoid schizophrenia, high blood pressure and convulsions. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a physician's note dated 12/6/18 which	F 625		

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documented, "Called by RN (Registered Nurse) to address sugar level of High - provided with 10 units and her blood sugar was then to 342 2 hours later. Reviewed nursing notes and BS (blood sugar) levels - she has been fluctuating from HI-72 - with last 72 on 12/2 - she has a hx (history) of hypoglycemia. STA (stat) labs were ordered and are back for review....Assessment....Shallow breathing noted tachypnic [Abnormally fast or deep respiration]....Tachicardia [fast heart rate] {sic}....Metabolic Acidosis: due to diabetes....Pt needs higher level of care will be sent out - POA is her sister - will notify...."

Further review of the clinical record failed to reveal any evidence of a written bed hold notice being provided to the resident and/or resident representative.

On 1/16/19 at 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she provides the bed hold policy to residents and/or their representatives when residents are discharged to the hospital. OSM #1 stated, "When someone goes out to the hospital, there is a packet that goes with them and the bed hold policy is in that and if someone has a responsible party I send one in the mail. When asked if she could provide evidence of the bed hold policies that she sends through the mail, OSM #1 stated, "Yeah. I make copies of who I will mail it out to."

On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides the bed hold policy to residents and/or their representative when residents are transferred to the hospital, LPN #1

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F 625	Continued From page 60 stated, " I have packets made up on the unit that has the interact form in it and the bed hold policy in it. The bed hold policy goes in the envelope with the stuff that I send to the hospital." When asked if she could provide evidence that the bed hold policy is provided when residents are transferred to the hospital, LPN #1 stated she was not sure. On 1/17/19 at 9:55 a.m., in an interview with OSM #1, the Director of Social Services (Other Staff Member) she stated she did not have any evidence of bed holds being sent for Resident #66. A review of a copy of a bed hold notice documented, "_____ ("the Resident") has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever the resident's payment source, unless the nursing home is paid to reserve the bed while the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home (and, if the resident is on Medicaid, he or she is eligible for Medicaid nursing home services. If the nursing home does not readmit the resident to the first available bed in a semi-private room when the resident is ready to leave the hospital, the resident has a right to: *Appeal the nursing home's decision to the Department of Medical Assistance Services, Appeals Division (address documented), *File a complain with the Office of Licensure and	F 625		

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F 625	Continued From page 61 Certification (address documented). For help in filing an appeal or a complaint, contact the Office of the State Long Term Care Ombudsman at (phone numbers documented)." There was no evidence this information was provided to the resident representative for Resident #66. On 1/17/18 at 3:30 p.m., the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey. 3. The facility staff failed to evidence that written bed hold notification was provided to the resident or resident representative when Resident #93 was transferred to the hospital on 11/18/18 and 12/21/18. Resident #93 was admitted to the facility on 10/3/18 with the diagnoses of but not limited to Parkinson's disease, dysphagia, high and low blood pressure episodes, paraplegia, stroke, aphasia, and effusion of the right knee. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 12/31/18. The resident was coded as being severely impaired in ability to make daily life decisions. A review of the clinical record revealed a note dated 11/18/18, which documented, "CNA (Certified Nursing Assistant) changed resident and started out of room when she noticed resident unresponsive. CNA called for this nurse.	F 625		

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F 625	Continued From page 62 Upon entering room resident was unresponsive, diaphoretic, O2 sats (oxygen saturation) were in the 50's. Pulse was faint. O2 put on resident and sats remained in the 50's. BS (blood sugar) - 266. Temp (temperature) 100.0. Resident aroused a little and then went unresponsive again. Non-rebreather put on resident. NP (nurse practitioner) called and order given to send to (hospital) for eval (evaluation). Unable to obtain BP (blood pressure). Son called and he stated he was out of town until Tuesday but to keep him updated." Another subsequent hospitalization occurred on 12/21/18. A nurse's note dated 12/21/18 documented, "resident unresponsive and diaphoretic and gray. Resident roused after being spoken to a few times. Temp 99.1 oral. Pulse 20. BP (blood pressure) unable to read. Notified NP and POA (power if attorney). POA requested send to (hospital). DON (Director of Nursing) notified." Further review of the clinical record failed to reveal any evidence of a written bed hold notice being provided to the resident and/or resident representative. On 1/16/19 at 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she provides the bed hold policy to residents and/or their representatives when residents are discharged to the hospital. OSM #1 stated, "When someone goes out to the hospital, there is a packet that goes with them and the bed hold policy is in that and if someone has a responsible party I send one in the mail. When asked if she could provide evidence of the bed hold policies	F 625		

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F 625	Continued From page 63	F 625		

that she sends through the mail, OSM #1 stated, "Yeah. I make copies of who I will mail it out to."

On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides the bed hold policy to residents and/or their representative when residents are transferred to the hospital, LPN #1 stated, " I have packets made up on the unit that has the interact form in it and the bed hold policy in it. The bed hold policy goes in the envelope with the stuff that I send to the hospital." When asked if she could provide evidence that the bed hold policy is provided when residents are transferred to the hospital, LPN #1 stated she was not sure.

On 1/17/19 at 9:55 a.m., in an interview with OSM #1, the Director of Social Services (Other Staff Member) she stated she did not have any evidence of bed holds being sent for Resident #93.

On 1/17/18 at 3:30 p.m., the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey.

4. The facility staff failed to provide Resident #91 with a written notice of bed-hold policy for a facility initiated hospital transfer dated 12/19/18.

Resident #91 was admitted to the facility on 12/20/2016 with a most recent readmission date of 1/15/2019. Diagnoses included but were not limited to: diabetes, heart failure (1), hyponatremia (2), high blood pressure, chronic

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F 625	Continued From page 64 obstructive pulmonary disease (3), and peripheral vascular disease (4). The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 1/4/19 coded the resident as having a score of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for daily decision making. A review of Resident #91's clinical record revealed that he was sent to the hospital on 12/19/18. A nursing note dated 12/19/18 at 23:25 (11:25 p.m.), documented, "NP (nurse practitioner) called facility requesting resident be sent to ER (emergency room) via 911 d/t (due to) severe pain in right lower extremity. Resident left facility via (name of emergency medical service) EMS at 2130 (9:30 p.m.). DON (director of nursing) aware. Resident shows understanding. Will follow up." The clinical record failed to evidence that written notification of the bed-hold policy was provided to Resident #91 or the resident's representative; regarding the facility initiated hospital transfer dated 12/19/18. On 1/16/19 at approximately 2:39 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she provides the bed hold policy to residents and/or their representatives when residents are transferred to the hospital. OSM #1 stated, "When someone goes out to the hospital, there is a packet that goes with them and the bed hold policy is in that and if someone has a responsible party I send one in the mail. When asked if she could provide evidence of the bed	F 625		

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F 625	Continued From page 65	F 625		

hold policies that she sends through the mail, OSM #1 stated, "Yeah. I make copies of who I will mail it out to." OSM #1 was asked if she had evidence that Resident #91 was provided a bed hold policy for the facility initiated hospital transfer dated 12/19/18, OSM #1 replied, "I will check and get back to you."

On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides the bed hold policy to residents and/or their representative when residents are transferred to the hospital, LPN #1 stated, " I have packets made up on the unit that has the interact form in it and the bed hold policy in it. The bed hold policy goes in the envelope with the stuff that I send to the hospital." When asked if she could provide evidence that the bed hold policy is provided when residents are transferred to the hospital, LPN #1 stated she was not sure.

On 1/17/18 at approximately 8:58 a.m., a follow up interview was conducted with OSM #1. OSM #1 was asked if she could evidence that Resident #91 was provided a bed hold policy for the facility initiated hospital transfer dated 12/19/18, OSM #1 replied, "I can't find any evidence they were given a bed hold policy."

On 1/17/18 at approximately 3:51 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings.

No further information was provided prior to exit.

1. A condition in which the heart can't pump

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F 625	Continued From page 66 enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 2. Low sodium (salt) level. This information was obtained from the website: https://medlineplus.gov/ency/article/000394.htm. 3. A disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 5. The facility staff failed to evidence documentation of a bed hold policy being sent with the resident upon a facility initiated transfer to the hospital on 10/8/18 for Resident #80. Resident #80 was admitted to the facility on	F 625		

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F 625	Continued From page 67 3/10/17 with a most recent readmission on 10/30/18 with diagnoses that included but were not limited to: diabetes, dementia, breast cancer, diverticulitis [inflammation of an abnormal sac at a weakened point in the digestive tract, especially the colon (1)], urinary tract infection, macular degeneration [A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. (2)], high blood pressure and atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 12/27/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The nurse's note dated, 10/8/19 at 11:24 p.m. documented in part, "This nurse entered the residents (sic) room. The resident is very confused. Noted a non productive (sic) cough. Wheezing in upper lobes. Afebrile (without fever). Stated. 'I feel horrible.' This nurse advised the resident of the importance of going to the ER (emergency room) to be evaluated. The resident agreed. Order received from NP (nurse practitioner) on call to send to the ER to be evaluated and treated. Son and daughter notified. 911 (emergency medical services) called and resident transferred to (initials of hospital) via stretcher."	F 625		

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F 625	Continued From page 68 The review of the clinical record failed to evidence documentation of the bed hold policy being sent with Resident #80 upon transfer to the hospital on 10/8/18. A request was made on 1/17/19 at 11:25 a.m. to ASM (administrative staff member) #1, the executive director, for a copy of the bed hold provided to Resident #80 upon her transfer to the hospital on 10/8/18. On 1/16/19 at 2:35 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she provides the bed hold policy to residents and/or their representatives' when residents are discharged to the hospital. OSM #1 stated, "When someone goes out to the hospital, there is a packet that goes with them and the bed hold policy is in that and if someone has a responsible party I send one in the mail. When asked if she could provide evidence of the bed hold policies that she sends through the mail, OSM #1 stated, "Yeah. I make copies of who I will mail it out to." On 1/16/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she provides the bed hold policy to residents and/or their representative when residents are transferred to the hospital, LPN #1 stated, " I have packets made up on the unit that has the interact form in it and the bed hold policy in it. The bed hold policy goes in the envelope with the stuff that I send to the hospital." When asked if she could provide evidence that the bed hold policy was provided when residents are transferred to the hospital, LPN #1 stated she was not sure.	F 625		

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F 625	Continued From page 69 ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concern on 1/17/19 at 4:09 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 173. (2) This information was obtained from the following website: https://medlineplus.gov/maculardegeneration.html. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 625		
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 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	F 656	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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

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F 656	Continued From page 70 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, facility document review, and clinical record review, it was determined that the facility staff failed to ensure a comprehensive care plan was developed and/or followed for three of 42 residents in the survey sample; Residents #60, #80, and #103 1. The facility staff failed to follow Resident #60's care plan for the administration of a medication for respiratory conditions. 2. The facility staff failed to implement Resident #80's comprehensive care plan for the	F 656	Facility staff failed to ensure a comprehensive care plan was developed and/or followed for residents #60, #80 and #103 I. Comprehensive care plans for #60, #80 and #103 have been updated reflecting the administration of a medication for respiratory condition for #60. Administration of antibiotics for #80 and the use of oxygen for #103 II. Residents that reside in this facility that have medication for respiratory condition, use antibiotics or use oxygen have the potential to be affected by the deficient practice. III. Nursing staff/MDS to be re-educated by DON/designee regarding care plan preparation, which directs the patient's nursing care from admission to discharge. The care plan consists of three parts which are goals or expected outcomes, interventions and evaluations of the established goals. The care plans are updated and revised throughout the resident's stay based on response of resident. IV. Education minutes/signatures will be turned in to HR to assure staff were re-educated on care plan preparation and updating. V. Correction to be completed by 2/15/19	

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F 656	Continued From page 71 administration of antibiotics. 3. The facility staff failed to develop a comprehensive care plan to address the use of oxygen by Resident #103. The findings include: 1. The facility staff failed to follow Resident #60's care plan for the administration of a medication for respiratory conditions. Resident #60 was admitted to the facility on 6/25/18 with the diagnoses of but not limited to acute and chronic respiratory failure, high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD), and cognitive communication deficit. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for transfers, ambulation, dressing, toileting, and hygiene; and as requiring supervision for eating. A review of the clinical record revealed an order dated 6/26/18 for "Tiotropium Bromide Monohydrate (Spiriva) {1} Capsule 18 MCG (micrograms) ....1 puff inhale orally one time a day for COPD." On 01/16/19 08:09 a.m., LPN #6 was observed preparing the following medications for administration to Resident #60: 1. Spiriva 18mcg {1} not given. 2. Breo 200/25 {2} mcg, 1 puff	F 656		

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F 656	Continued From page 72 3. Norvasc {3} 10 mg (milligrams), 1 tab (tablet) 4. Janumet {4} 50-1000 mg, 1 tab 5. Lasix {5} 40 mg, 2 tabs for 80mg 6. Meloxicam {6} 7.5 mg, 1 tab 7. Potassium {7} 20 meq (milliequivalents) 1 tab 8. Prednisone {8} 10 mg 1 tab 9. Lisinopril {9} 2.5 mg, 3 tabs for 7.5 mg 10. Oxycontin {10} ER (extended release) 20 mg, 2 tabs for 40 mg 11. Ventolin {11} 90 mcg inhaler. 12. Metamucil {12} 17 grams. A review of the nurses' notes revealed one dated 1/16/18, which documented, "Tiotropium Bromide Monohydrate Capsule 18 MCG 1 puff inhale orally one time a day for COPD on back order at pharmacy, pharm (pharmacy) notified. NP (nurse practitioner) notified, requested albuterol instead." On 1/16/19 at 9:18 a.m., in an interview with LPN #6, she stated that the medication (Tiotropium Bromide Monohydrate Capsule [Spiriva] 18 MCG) was reordered days ago but that the pharmacy was on back order. LPN #6 stated she was not aware of the backup pharmacy being utilized to ensure the medication was available. On 1/16/19 at 9:37 a.m., ASM (administrative staff member) #2, the Director of Nursing stated that the backup pharmacy should have been used. A review of the care plan revealed one dated 6/29/18 for "Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease...rt (related to) will turn O2 (oxygen) up a liter, is non-compliant with setting at times...." The interventions included one dated 6/29/18, which documented, "Administer medications as	F 656		

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F 656	Continued From page 73 ordered. Observe Labs (laboratory tests), response to medication and treatments." On 1/17/19 at 7:34 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of the care plan. LPN #1 stated, "It's specific to that resident. Their daily needs how they prefer things." When asked how nurses ensure residents' care plans are implemented, LPN #1 stated, "I would go to the care plan and look." On 1/17/19 at 3:18 p.m., in an interview with LPN #3, when asked if a resident was to receive a medication for respiratory conditions and the medication was not given, and the care plan stated to administer medications as ordered, then was the care plan followed? He stated the care plan was not followed. A review of the facility policy, "Care Plan Preparation" documented, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process....The care plan consists of three parts: goals or expected outcomes, which describe behaviors or results to be achieved within a specified time; appropriate nursing actions or interventions needed to achieve these goals; and evaluations of the established goals.....A nursing care plan should be written for each patient, preferably within 24 hours of admission. It is usually started by the patient's primary nurse or other nurse who admits the patient. If the care plan contains more than one nursing diagnosis, assign priority to each diagnosis and implement	F 656		

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F 656	Continued From page 74 those with the highest priority first. Update and revise the plan throughout the patient's stay, based on the patient's response. The document becomes part of the permanent patient record...." On 1/17/18 at 3:30 PM, the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey. References: {1} Spiriva - Used to control wheezing, shortness of breath, coughing, and chest tightness in patients with (COPD). Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html {2} Breo - Used "to control wheezing, shortness of breath, coughing, and chest tightness caused by asthma and (COPD)....To use the inhaler follow these steps....9. Rinse your mouth with water, but do not swallow." Information obtained from https://medlineplus.gov/druginfo/meds/a613037.html {3} Norvasc - Used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.html {4} Janumet - Used in the treatment of diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a606023.html	F 656		

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F 656	Continued From page 75 {5} Lasix - Used to treat high blood pressure and edema Infomration obtained from https://medlineplus.gov/druginfo/meds/a682858.html {6} Meloxicam - Used to treat pain, tenderness, swelling and stiffness caused by osteoarthritis and rheumatoid arthritis. Infomration obtained from https://medlineplus.gov/druginfo/meds/a601242.html {7} Potassium Chloride - Is an electrolyte replacement needed for nerves to function and muscles to contract.....Some diuretics (i.e. Lasix) causes low levels of potassium in the body. Information obtained from https://medlineplus.gov/potassium.html and from https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/blood-pressure/FAQ-20058432?p=1 {8} Prednisone - Used to treat arthritis; severe allergic reactions; multiple sclerosis; lupus; and certain conditions that affect the lungs, skin, eyes, kidneys, blood, thyroid, stomach, and intestines, and symptoms of certain types of cancer. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html {9} Lisinopril - Used to treat high blood pressure Information obtained from https://medlineplus.gov/druginfo/meds/a692051.html	F 656		

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F 656	Continued From page 76 (10) OxyContin - Used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html (11) Ventolin - Used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease. Information obtained from https://medlineplus.gov/druginfo/meds/a682145.html 2. The facility staff failed to implement Resident #80's comprehensive care plan for the administration of antibiotics. Resident #80 was admitted to the facility on 3/10/17 with a most recent readmission on 10/30/18 with diagnoses that included but were not limited to: diabetes, dementia, breast cancer, diverticulitis [inflammation of an abnormal sac at a weakened point in the digestive tract, especially the colon (1)], urinary tract infection, macular degeneration [A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. (2)], high blood pressure and atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 12/27/18,	F 656		

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F 656	Continued From page 77 coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as having highly impaired vision. Resident #80 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. The resident was coded as being frequently incontinent of both bowel and bladder. The comprehensive care plan dated, 9/13/18, documented in part, Focus: Infection actual or at risk for related to: UTI (urinary tract infection), ESBL [Extended spectrum beta-lactamase - a drug resistant organism (5)]." The "Interventions" documented in part, "Administer antibiotics and treatment as ordered." The nurse's note dated, 10/12/18 at 8:24 p.m. documented in part, "This Caucasian Female was admitted to (room number), to the services of (doctor's name). Her meds (medications) were faxed to the pharmacy. The first does of the ABT (antibiotic) is to be gotten from the IV (intravenous) box." The physician orders dated 10/12/18 documented, "Meropenem Solution Reconstituted [Meropenem is used to treat complicated infections. (4)] 500 MG (milligrams); Use 500 mg intravenously every 8 hours related to urinary tract infection for 7 days." The MAR (medication administration record) for October 2018, documented the above physician orders for medication. The scheduled times of administration were documented as 6:00 a.m., 2:00 p.m. and 10:00 p.m. On 10/12/18, the 10:00	F 656		

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F 656	Continued From page 78 p.m. dose was not documented as administered. The IV (intravenous) medication back up box contents from documented, "Merrem 1 g (gram) vial (Meropenem)." The form documented there were four vials in the box. An interview was conducted with LPN (licensed practical nurse) #1 on 1/17/19 at 11:15 a.m. When asked the purpose of the comprehensive care plan, LPN #1 stated it's the guide to the care we provide. When asked if it should be followed, LPN #1 stated, "Yes, of course, because it's patient specific." On 1/17/19 at 1:33 p.m., an interview was conducted with LPN # 9, the nurse who wrote the nurse's note on 10/12/18, LPN #9 was asked about the process staff follows for obtaining medications if the medication is not available in the medication cart. LPN #9 stated, "You check the backup box first. If it's not there, you contact the pharmacy and ask that they get it here as soon as possible. If it doesn't arrive in time for the dose, the nurse has to contact the MD (medical doctor) or NP (Nurse Practitioner) and tell them it's not available and follow their instructions." LPN #9 was shown the nurse's note of 10/12/18, and the MAR for October 2018, showing the Meropenem order and the blank spot for the dose of medication on 10/12/18 at 10:00 p.m. When asked if she had given the dose, LPN #9 stated, "I had just come back to work here on 10/8/18, I can't remember if I gave it or not. If I didn't sign it out, then I didn't give it." ASM (administrative staff member) #1, the executive director, ASM #2, and ASM #3, the regional director of clinical services, were made	F 656		

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F 656	Continued From page 79 aware of the above concern on 1/17/19 at 4:09 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 173. (2) This information was obtained from the following website: https://medlineplus.gov/maculardegeneration.html. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0d37e43b-ff8d-495d-b9af-4fd5fce53d56. (5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmed/12558458 3. The facility staff failed to develop a care plan to address the use of oxygen by Resident #103. Resident #103 was admitted to the facility on 11/14/18 with a most recent readmission date of 12/28/18 with diagnoses that included but were not limited to: obstructive sleep apnea (OSA) (1), high blood pressure, dyspnea (2) and diabetes. The most recent MDS (minimum data set), a fourteen day assessment, with an ARD (assessment reference date) of 1/9/19 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily	F 656		

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

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F 656	Continued From page 80 decisions. Section O0100 documented that Resident #103 receives oxygen therapy. Resident #103's most recent POS (physician order summary) dated January 2019 documented "O2 via Nasal cannula at 2L/min (Oxygen two liters per minute via nasal cannula) as needed for shortness of breath or hypoxia (3)." Review of Resident #103's care plan with a quarterly revision dated 11/28/18 failed to evidence any reference to oxygen use by Resident #103. On 1/17/19 at approximately 9:36 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #4. LPN #4 was asked when care plan need to be updated, LPN #4 replied, "When anything major changes with the resident like a new diagnosis or behavior." LPN #4 was asked who develops and implements care plans, LPN #4 replied "Nursing and MDS." LPN #4 was asked if a resident uses oxygen should that to be on a care plan, LPN #4 replied "Yes." On 1/17/19 at approximately 11:18 a.m., an interview was conducted with LPN #11, unit manager. LPN #11 was asked who develops and implements care plans, LPN #11 replied "The nurses, MDS and administration." LPN #11 was asked if a resident uses oxygen should that be included on their care plan, LPN #11 responded, "Yes."" The facility policy, "Care Plan Preparation" documented in part, "A care plan directs the patients nursing care from admission to discharge. This written action plan is based on the nursing diagnoses that have been formulated	F 656		

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F 656	Continued From page 81 after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation, and evaluation." On 1/17/18 at approximately 3:51 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 1. Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. 2. When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This information was obtained from the website: https://medlineplus.gov/breathingproblems.html. 3. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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F 658	Continued From page 82 §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 observation, staff interview, and clinical record review, facility staff failed to provide care and services that met professional standards of practice for two of 42 residents in the survey sample, Resident #70 and Resident #60.. 1. The facility staff applied an Allevyn dressing to Resident #70's wound without a provider's order. 2. The facility staff failed to follow professional standards of practice for medication administration to Resident #60, as evidenced by failure to follow the manufacturer's instructions of a medication and failure to educate the resident and/or document resident's refusal to follow the manufacturer's instructions of a medication. The findings included 1. The facility staff applied an Allevyn dressing to Resident #70's wound without a provider's order. Resident #70 was admitted to the facility on 12/13/2018. Her diagnoses included Hip Fracture, Hypertension (high blood pressure), and Asthma. Resident #70's most recent Minimum Data Set (MDS) Assessment was a 14-Day Assessment with an Assessment Reference Date (ARD) of 12/25/2018. Resident #70 was coded with a BIMS (Brief Interview for Mental Status) of 8, indicating	F 658	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights. Nurse applied an Allevyn dressing to resident #70's wound without a providers order. I. Nurse obtained order for Allevyn dressing to be applied to resident #70 wound. II. Residents that reside in this facility with treatment orders have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/designee regarding obtaining orders prior to applying a dressing. Monthly audit x 2 of residents who have treatment/ dressing orders to be completed by unit manager/ designee to ensure that residents with treatment/ dressings have physician orders that match the correct dressing/treatment that is applied. IV. Results of audit will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 658	Continued From page 83 moderate impairment. Resident #70 was coded as requiring extensive assistance of 2 or more persons for bed mobility, transfers, and toileting; extensive assistance of 1 person for ambulation and personal hygiene, and as requiring supervision and setup assistance for eating. When reviewing the documentation of Resident #70's wounds, it was revealed that RN #5 made the initial discovery of Resident #70's wounds. A progress note documented on 01/01/19 at 11:46 p.m. documents: "Resident remains skilled for therapy. A&O (alert and oriented) x3 (to person, place, and time). C/o (complains of) pain to R hip earlier around dinner-time. Given PRN (as-needed) Percocet (a narcotic based pain medication) PO (by mouth) x (times)1. No further complaints noted. Resting with eyes open. Requires assist x1 w/ ADLs (with/activities of daily living). Allevyn (1) drsgs (dressings) applied below coccyx (tailbone) area to open sores. Call bell in reach. Will cont. (continue) to monitor for chgs (changes)." A review of Resident #70s Physician Orders for the duration of her stay revealed no order for an Allevyn dressing in place on 01/01/19. The dressing was documented as first ordered on 01/02/19, and timed to take effect on 01/03/19 at 7:00a.m. Administrative Staff Member (ASM) #2, the Director of Nursing, was informed of the findings on 01/16/19, at the end of day meeting. ASM #2 was asked to look for and provide any documentation of an order for the Allevyn dressing being in place at the time of RN #5's note.	F 658	Nurse failed to follow professional standards of practice for medication administration to resident #60 I. Nurse could not correct at this time d/t medication already administered II. Residents that reside in this facility with the medication Breo have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/designee regarding the importance of following orders with additional directions attached (rinse mouth with water and spit back into cup after use) Weekly audit x 4 of residents who use Breo is to be completed by unit manager/designee to ensure all residents who uses Breo have the additional directions attached to order and is followed through by the nurses. IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 658	Continued From page 84 ASM #2 stated that they were unable to locate any further documentation related to an order for the Allevyn dressing, at the end of day meeting on 01/17/19. 1. Allevyn Dressings are hydocellular dressings for wound care that remove fluid faster than regular dressings. This information was obtained from the website: (https://www.vitalitymedical.com/allevyn.html) 2. The facility staff failed to follow professional standards of practice for medication administration to Resident #60, as evidenced by failure to follow the manufacturer's instructions of a medication; and failure to educate the resident and/or document resident's refusal to follow the manufacturer's instructions of a medication. Resident #60 was admitted to the facility on 6/25/18 with the diagnoses of but not limited to acute and chronic respiratory failure, high blood pressure, diabetes, chronic obstructive pulmonary disease, and cognitive communication deficit. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for transfers, ambulation, dressing, toileting, and hygiene; and as requiring supervision for eating; and as occasionally incontinent of bladder and bowel. A review of the clinical record revealed an order dated 11/8/18 for "Breo {1} ...200-25 mcg/inh (micrograms/inhalation) 1 puff inhale orally one	F 658		

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

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F 658	Continued From page 85 time a day for COPD ...Rinse mouth with water and spit back into cup after use." On 01/16/19 08:09 a.m., LPN #6 was observed to preparing the following medications for administration to Resident #60: 1. Breo 200/25 {1} mcg, 1 puff 2. Spiriva 18mcg {2} not given. 3. Norvasc {3} 10 mg (milligrams), 1 tab (tablet) 4. Janumet {4} 50-1000 mg, 1 tab 5. Lasix {5} 40 mg, 2 tabs for 80mg 6. Meloxicam {6} 7.5 mg, 1 tab 7. Potassium {7} 20 meq (milliequivalents) 1 tab 8. Prednisone {8} 10 mg 1 tab 9. Lisinopril {9} 2.5 mg, 3 tabs for 7.5 mg 10. Oxycontin {10} ER 20 mg, 2 tabs for 40 mg 11. Ventolin {11} 90 mcg inhaler. 12. Metamucil {12} 17 grams. After administering the Breo, LPN #6 did not instruct Resident #60 to rinse his mouth with water and spit back into the cup afterwards. LPN #6 provided Resident #60 with a cup of water containing Metamucil powder mixed in and instructed him to drink that, which he did, and swallowed it. On 1/16/19 at 9:18 a.m., in an interview with LPN #6, when asked about the observation of not having the resident rinse and spit after administering the Breo, LPN #6 stated, "Normally he doesn't do the spit and rinse. I could have offered it to him but in working with him every day he doesn't do that." When asked if she has documented his refusal to follow manufacturer instructions for this medication, LPN #6 stated, "I have not documented that he was educated on this and that he refused to do it."	F 658		

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F 658	Continued From page 86 A review of the care plan revealed one dated 6/29/18 for "Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease...rt (related to) will turn O2 (oxygen) up a liter, is non-compliant with setting at times...." The interventions included one dated 6/29/18, which documented, "Administer medications as ordered. Observe Labs (laboratory tests), response to medication and treatments." This care plan did not document that the resident was educated and non-compliant with following manufacturer's instructions for the use of the Breo inhaler medication. It only documented non-compliance with oxygen settings. A review of the manufacturer's information on Breo as provided by the facility, documented, "Instructions for Use....Step 6. Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water." A review of the facility policy, "Medication Administration" documented, "1. Medications are administered in accordance with written orders of the prescriber.....13. Explain to resident the type of medication being administered and the procedure." The policy, which was only partially provided (pages 3-6 of 6 pages was provided) did not provide direction for ensuring manufacturer's instructions are followed. On 1/17/18 at 3:30 p.m., the Executive Director and Director of Nursing (ASM (Administrative Staff Member) #1 and #2 respectively) were notified of the concern. No further information was provided by the end of the survey. According to "Fundamentals of Nursing" 7th	F 658		

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F 658	Continued From page 87 edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Chapter 23 "Legal Implications in Nursing Practice" Page 337, "Nurses are responsible for performing all procedures correctly and exercising professional judgment as they carry out physicians' or health care provider's orders." References: {1} Breo - Used "to control wheezing, shortness of breath, coughing, and chest tightness caused by asthma and (COPD)....To use the inhaler follow these steps....9. Rinse your mouth with water, but do not swallow." Information obtained from https://medlineplus.gov/druginfo/meds/a613037.html {2} Spiriva - Used to control wheezing, shortness of breath, coughing, and chest tightness in patients with (COPD). Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html {3} Norvasc - Used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.html {4} Janumet - Used in the treatment of diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a606023.html {5} Lasix - Used to treat high blood pressure and edema Information obtained from	F 658		

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F 658	Continued From page 88 https://medlineplus.gov/druginfo/meds/a682858.html {6} Meloxicam - Used to treat pain, tenderness, swelling and stiffness caused by osteoarthritis and rheumatoid arthritis. Information obtained from https://medlineplus.gov/druginfo/meds/a601242.html {7} Potassium Chloride - Is an electrolyte replacement needed for nerves to function and muscles to contract.....Some diuretics (i.e. Lasix) causes low levels of potassium in the body. Information obtained from https://medlineplus.gov/potassium.html and from https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/blood-pressure/FAQ-20058432?p=1 {8} Prednisone - Used to treat arthritis; severe allergic reactions; multiple sclerosis; lupus; and certain conditions that affect the lungs, skin, eyes, kidneys, blood, thyroid, stomach, and intestines, and symptoms of certain types of cancer. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html {9} Lisinopril - Used to treat high blood pressure Information obtained from https://medlineplus.gov/druginfo/meds/a692051.html {10} OxyContin - Used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.h	F 658		

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F 658	Continued From page 89 tml {11} Ventolin - Used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease. Information obtained from https://medlineplus.gov/druginfo/meds/a682145.html {12} Metamucil - Used to treat constipation Information obtained from https://medlineplus.gov/druginfo/meds/a601104.html	F 658		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, facility document review, and clinical record review it was determined the facility staff failed to ensure care was provided by qualified staff for one of 42 residents in the survey sample, Resident #103. The facility staff failed to ensure a trained staff member administered oxygen to resident #103	F 659	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 659	Continued From page 90 The findings include: Resident #103 was admitted to the facility on 11/14/18 with a most recent readmission date of 12/28/18 with diagnoses that included but were not limited to: obstructive sleep apnea (OSA) (1), high blood pressure, dyspnea (2) and diabetes. The most recent MDS (minimum data set), a fourteen day assessment, with an ARD (assessment reference date) of 1/9/19 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Section O0100 documented that Resident #103 receives oxygen therapy. Resident #103's most recent POS (physician order summary) dated January 2019 documented "O2 via Nasal cannula at 2L/min (Oxygen two liters per minute via nasal cannula) as needed for shortness of breath or hypoxia (3)." On 1/15/18 2:45 p.m. Resident #103 was observed in his room sitting in his wheelchair wearing a nasal cannula (NC) connected to an oxygen concentrator with the oxygen flow rate set to 2.0 L/min. At this time, an interview with Resident #103 was conducted. During this interview, three CNA's (certified nursing assistant staff) knocked on the door, entered the resident's room, and asked if he was ready to get back in bed. Resident #103 indicated to the staff he was ready to get back in bed. The three CNA's were observed using a mechanical lift to move the resident from his wheelchair to his bed, including CNA #25. The staff then washed their hands and left the room. After resuming the interview it was observed that Resident #103's nasal cannula had	F 659	Nursing staff failed to ensure a trained staff member administered oxygen to resident #103 I. Staff member retrieved the nurse whom was responsible for the care of resident #103 and admitted placing oxygen on resident #103. Nurse then verified oxygen flow rate and saturation level was obtained. II. Residents that reside in this facility that use oxygen have the potential to be affected by the deficient practice. III. Nursing staff to be Re-educated by DON/designee regarding scope of practice of RN, LPN, CNA's and who can administer/place cannula on resident's that are to receive oxygen. IV. Meeting/education minutes/signatures will be turned in to HR to assure staff is in compliance with the rules and regulations of oxygen administration. V. Correction to be completed by 2/15/19	

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F 659	Continued From page 91	F 659		

been removed prior to him being placed back in bed and had not been returned to him. The resident was asked who had removed his nasal cannula; Resident #103 replied "One of the young ladies that put me back in bed." On 1/15/18 at approximately 3:00 p.m., Resident #103' call button was pressed and at approximately 3:05 p.m., the call light was answered by CNA #24. CNA #24 was informed that the resident had been on oxygen prior to him being placed back in bed and it had not been put back on. CNA #24 proceeded to come into the room and placed Resident #103 oxygen nasal cannula back on the resident. CNA #24 was asked if a pulse oximetry (4) could be taken prior to placing Resident #103's nasal cannula back on. CNA #24 placed a pulse oximetry monitor on the Resident #103's finger and his pulse ox was noted to be 85 - 86% on room air. CNA #24, then proceeded to place Resident #103's oxygen on. With the pulse oximeter monitor on his finger, his oxygen saturation was noted to be 94% on 2 L/min of oxygen.

Review of Resident #103's care plan with a quarterly revision dated 11/28/18 failed to evidence any reference to oxygen use by Resident #103.

On 1/15/18 at approximately 3:15 p.m., and interview was conducted with CNA #24. CNA #24 was asked was asked who can put on, take off or adjust oxygen; CNA #24 replied, "I don't know."

On 1/16/19 at approximately 2:41 p.m., an interview was conducted with CNA #25. CNA #25 was asked if all staff who assisted moving Resident #103 from his wheelchair to his bed were CNA's, CNA #25 replied "Yes." CNA #25

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F 659	Continued From page 92 was asked if she recalled which staff took Resident #103's nasal cannula off the resident. CNA #25 stated she did not. CNA #25 was asked who could put on, take off or adjust oxygen, CNA #25 replied "An LPN (licensed practical nurse) or RN (registered nurse). When CNA #25 was asked if a CNA could take off or put on oxygen, CNA #25 replied "No." On 1/16/19 at approximately 2:44 p.m., an interview was conducted with LPN #12. When asked who can put on, take off, or adjust oxygen, LPN #12 replied "LPN's and RN's." LPN #12 was asked if a CNA can adjust oxygen, LPN #12 replied "No." LPN #12 was asked why is it important to maintain not take of a residents oxygen, LPN #12 replied, "They could go into respiratory failure."(5) The facilities oxygen administration policy documented in part, "Oxygen administration increases blood oxygen content so that the heart doesn't have to pump as much blood per minute to meet tissue demands. Verify the practitioners order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed." On 1/17/18 at approximately 3:51 p.m., ASM)administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 1. Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This	F 659		

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F 659	Continued From page 93 occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. 2. When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This information was obtained from the website: https://medlineplus.gov/breathingproblems.html. 3. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia. 4. Most people need an oxygen saturation level of at least 89% to keep their cells healthy. Having an oxygen level lower than this for a short time is not believed to cause damage. However, your cells can be strained or damaged if low oxygen levels happen many times. If your oxygen level is low on room air, you may be asked to use supplemental (extra) oxygen. The oximeter can be used to help see how much oxygen you need and when you may need it. This information was obtained from the website: file:///C:/Users/mth39879/Downloads/pulse-oximetry.pdf 5. When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 659		

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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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to ensure two of 42 sampled residents, (Residents #80 and #48), received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan. 1. The facility staff failed to administer an intravenous antibiotic per physician orders to Resident #80. 2. The facility staff failed to administer Vitamin D3 (a medication kept in bulk quantities onsite) per physician's order to Resident #48 on 9/17/18. The findings include: 1. The facility staff failed to administer an intravenous antibiotic per physician orders to Resident #80. Resident #80 was admitted to the facility on 3/10/17 with a most recent readmission on 10/30/18 with diagnoses that included but were	F 684	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights. Nurse failed to administer an intravenous antibiotic per physician orders to resident #80 I. Nurse checked the backup box in the medication room to verify the antibiotic that was prescribed was available. II. Residents that reside in this facility that get intravenous antibiotics have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/ designee regarding the proper process when a medication is unavailable and pulling medication out of backup box before the first dose is due, calling pharmacy and being aware of the facility's backup pharmacy's availability. Unit manager to audit the backup boxes in the medication room weekly to assure medication that are listed on the box are available for administration. IV. Results of audit will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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not limited to: diabetes, dementia, breast cancer, diverticulitis [inflammation of an abnormal sac at a weakened point in the digestive tract, especially the colon (1)], urinary tract infection, macular degeneration [A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. (2)], high blood pressure and atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)].

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 12/27/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as having highly impaired vision. Resident #80 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. The resident was coded as being frequently incontinent of both bowel and bladder.

The nurse's note dated, 10/12/18 at 8:24 p.m. documented in part, "This Caucasian Female was admitted to (room number), to the services of (doctor's name). Her meds (medications) were faxed to the pharmacy. The first does of the ABT (antibiotic) is to be gotten from the IV (intravenous) box."

The physician orders dated 10/12/18 documented, "Meropenem Solution Reconstituted [Meropenem is used to treat complicated

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F 684	Continued From page 96 infections. (4)] 500 MG (milligrams); Use 500 mg intravenously every 8 hours related to urinary tract infection for 7 days." The MAR (medication administration record) for October 2018, documented the above physician orders for medication. The scheduled times of administration were documented as 6:00 a.m., 2:00 p.m. and 10:00 p.m. On 10/12/18, the 10:00 p.m. dose was not documented as administered. The IV (intravenous) medication back up box contents from documented, "Merrem 1 g (gram) vial (Meropenem)." The form documented there were four vials in the box. The comprehensive care plan dated, 9/13/18, documented in part, Focus: Infection actual or at risk for related to: UTI (urinary tract infection), ESBL [Extended spectrum beta-lactamase - a drug resistant organism (5)]." The "Interventions" documented in part, "Administer antibiotics and treatment as ordered." An interview was conducted with LPN (licensed practical nurse) #8 on 1/17/19 at 8:42 a.m. LPN #8 was asked about the process staff follows if a drug is not available for the scheduled time of administration. LPN #8 stated, "First you check the "E kit" (emergency kit of medications). If it's not there you contact the pharmacy to get it sent over immediately from the backup pharmacy." When asked if a resident should miss a dose of IV (intravenous) antibiotics, LPN #8 stated, "We should not be missing doses. If the dose cannot be given for some reason, you must contact the doctor or nurse practitioner and explain to them and follow any instructions they may give."	F 684		

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F 684	Continued From page 97 An interview was conducted with LPN #6 on 1/17/19 at 9:00 a.m. When asked about the process staff follows if a drug is not available for the scheduled time of administration, LPN #6 stated, "First you check the STAT box, if it's not there you call the pharmacy and have them STAT (immediately) it over. If there is any hold up on getting the medication, the nurse has to call the MD (medical doctor) or NP (nurse practitioner) and follow their orders." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/17/19 at 9:50 a.m. When asked about the process staff follows if a medication is not available at the scheduled time, ASM #2 stated the nurse should check the backup first. If it's not available in the back up box, they need to contact the pharmacy. If it's not on the first run from the pharmacy, then they need to have it sent from the backup pharmacy." The above order and MAR were shown to ASM #2. ASM #2 stated she would check with the pharmacy to determine if it was taken from the STAT box." On 1/17/19 at 1:33 p.m., an interview was conducted with LPN # 9, the nurse who wrote the nurse's note on 10/12/18, LPN #9 was asked about the process staff follows for obtaining medications if the medication is not available in the medication cart. LPN #9 stated, "You check the backup box first. If it's not there, you contact the pharmacy and ask that they get it here as soon as possible. If it doesn't arrive in time for the dose, the nurse has to contact the MD (medical doctor) or NP (Nurse Practitioner) and tell them it's not available and follow their instructions." LPN #9 was shown the nurse's note of 10/12/18, and the MAR for October 2018, showing the	F 684		

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F 684	Continued From page 98	F 684		

Meropenem order and the blank spot for the dose of medication on 10/12/18 at 10:00 p.m. When asked if she had given the dose, LPN #9 stated, "I had just come back to work here on 10/8/18, I can't remember if I gave it or not. If I didn't sign it out, then I didn't give it."

The facility policy, "Medication Administration" documented in part, "1. Medications are administered in accordance with written orders of the prescriber."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were made aware of the above concern on 1/17/19 at 4:09 p.m. ASM #3 stated they had no further information to provide for the above mentioned concerns.

No further information was provided prior to exit.

COMPLAINT DEFICIENCY

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 173.
(2) This information was obtained from the following website:
https://medlineplus.gov/maculardegeneration.html.
(3) Barron's Dictionary of Medical Terms for the

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F 684	Continued From page 99 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0d37e43b-ff8d-495d-b9af-4fd5fce53d56 . (5) This information was obtained from the following website:https://www.ncbi.nlm.nih.gov/pubmed/12558458 2. The facility staff failed to administer Vitamin D3 (a medication kept in bulk quantities onsite) per physician's order to Resident #48 on 9/17/18. Resident #48 was admitted to the facility on 9/10/18. Resident #48's diagnoses included but were not limited to intellectual disabilities, seizures and high blood pressure. Resident #48's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/6/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #48 as requiring extensive assistance of two or more staff with bed mobility/transfers and as being totally dependent on one staff with eating. Review of Resident #48's clinical record revealed a physician's order dated 9/10/18 for Vitamin D3 (1)- 1,000 units, one tablet once a day for supplement. Review of Resident #48's September 2018 MAR (medication administration record) revealed the above Vitamin D3 order. On 9/17/18, LPN (licensed practical nurse) #2 documented the code "7= Other/ See Nurse Notes" instead of documenting a check mark to indicate Vitamin D3	F 684		

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F 684	Continued From page 100 was administered to Resident #48. A nurse's note signed by LPN #2 on 9/17/18 documented Vitamin D3 was unavailable. Resident #48's care plan dated 9/11/18 failed to document specific information regarding Vitamin D3 administration. Review of a list of bulk medications that are kept onsite at the facility revealed Vitamin D3 1,000 unit tablets were available. On 1/16/19 at 3:26 p.m., a telephone interview with LPN #2 was attempted. LPN #2 was unavailable. On 1/16/19 at 4:31 p.m., an interview was conducted with LPN #3. LPN #3 was asked the process for ensuring Vitamin D3 is administered to residents per physician's orders. LPN #3 stated Vitamin D3 is not provided by the pharmacy because it is kept onsite in bulk quantities. LPN #3 stated he would check other medication carts and the medication rooms if he did not have Vitamin D3 in his medication cart. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Medication Administration- General Guidelines" documented, "1. Medications are administered in accordance with written orders of the prescriber..." No further information was provided prior to exit.	F 684		

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F 684	Continued From page 101 (1) "Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d3&_ga=2.199577710.1336833414.1548171654-139120270.1477942321	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, facility document review, and clinical record review it was determined the facility staff failed to provide respiratory services per the plan of care for two of 42 residents in the survey sample, Resident #22 and Resident #103. 1. The facility staff failed to store Resident #22's nebulizer mask in a sanitary manner. 2. The facility staff failed to administer oxygen,	F 695	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 695	Continued From page 102 per the physician order, for Resident #103. The findings include: 1. Resident #22 was admitted to the facility on 10/19/2018. Diagnoses included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), diabetes, chronic respiratory failure (2), shortness of breath, gastroesophageal reflux disease (GERD) (3) and cellulitis (4). The most recent MDS (minimum data set), a thirty day assessment, with an ARD (assessment reference date) of 11/14/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The physician order dated January 2019, documented "DuoNeb Solution 0.5-2.5 mg/3 ml (milligrams per milliliter) 1 inhalation inhale orally three times a day for wheezing." (5) Review of the MAR (medication administration record) dated January 2019, documented "DuoNeb Solution 0.5-2.5 mg/3 ml (milligrams per milliliter) 1 inhalation inhale orally three times a day for wheezing" was documented as having been administered. On 1/15/19 at approximately 12:34 p.m., an observation was made of Resident #22. Resident #22's nebulizer mask was on his bedside table without any cover and not in use by the resident. On 1/15/19 at approximately 4:39 p.m., a second observation was made of Resident #22. Resident #22's nebulizer mask remained on his bedside table without any cover and not in use by the	F 695	Facility staff failed to store resident #22 nebulizer mask in a sanitary manner I. Nebulizer mask and tubing removed from use for resident #22 and new tubing and nebulizer mask obtained and placed in clear bag on 1/16/19 II. Residents that reside in this facility who use a nebulizer have the potential to be affected by his deficient practice. III. Nurses to be Re-educated by DON/designee regarding appropriate storage of nebulizer/tubing equipment. Daily rounds to be completed by unit manager/designee to ensure proper storage of nebulizer equipment when not in use and will be reported during stand up meeting. The care keepers/ Manager on dutiy will follow up once per day to ensure that the nebulizer equipment is properly stored and discuss results during afternoon stand down meeting x 4 weeks IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 695	Continued From page 103 resident. On 1/16/18 at approximately 3:40 p.m., an interview was conducted with Resident #22, regarding the nebulizer not being stored in a bag when not in use. Resident #22 stated, "I use to have one (a bag) but someone threw it away." On 1/16/18 at approximately 3:45 p.m., an interview was conducted with CNA (certified nursing assistant) #24. When asked how Resident #22's nebulizer mask should be stored when not in use, CNA #24 replied, "They are supposed to be covered with a towel or placed in a bag." When asked why a resident's nebulizer mask is supposed to covered while not is use, CNA #24 replied, "If the mask does not get put in bag it can get contaminated." On 1/16/18 at approximately 3:52 p.m., a third observation was made of Resident #22's room with LPN (licensed practical nurse) #6. Resident #22's nebulizer mask was observed on his TV stand, without any cover and not in use by the resident. LPN #6 was asked how a nebulizer mask is supposed to be stored when not in use; LPN #6 replied, "We store them in a bag." When asked why are nebulizer mask supposed to be covered, LPN #6 "To keep it clean." The facility supplied policy on the storage of respiratory equipment "Equipment Management" documented in part, "Equipment will be cleaned, disinfected or sterilized following guidelines and manufacturers' recommendations." On 1/17/18 at approximately 3:51 p.m., ASM #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of	F 695	Nursing staff failed to administer oxygen per the physician order, for resident #103 I. The nurse caring for resident #103 was brought back to resident room to verify placement of oxygen tubing, flow rate of 2 liters and the saturation level was obtained-1/15/19 II. Residents who in this facility who use oxygen have the potential to be affected by this deficient practice. III. Nurses to be educated by DON/designee regarding proper oxygen administration and what nursing staff is able to apply the oxygen according to facility's policy and state regulations. An audit of all resident's receiving oxygen will be completed weekly by unit manager or designee for 4 weeks to ensure proper administration of oxygen is delivered per physician's order. Re-education will be provided if compliance not followed. IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 695	Continued From page 104 Clinical Services were made aware of the findings. No further information was provided prior to exit. References 1. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 3. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 4. A common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was obtained from the website: https://medlineplus.gov/ency/article/000855.htm. 5. Duo Neb Ipratropium/albuterol oral inhalation is used to prevent wheezing, shortness of breath, coughing, and chest tightness in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and	F 695		

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airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Ipratropium is in a class of medications called bronchodilators. It works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695021.html.

2. The facility staff failed to administer oxygen, per the physician order, for Resident #103.

Resident #103 was admitted to the facility on 11/14/18 with a most recent readmission date of 12/28/18 with diagnoses that included but were not limited to: obstructive sleep apnea (OSA) (1), high blood pressure, dyspnea (2) and diabetes.

The most recent MDS (minimum data set), a fourteen day assessment, with an ARD (assessment reference date) of 1/9/19 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Section O0100 documented that Resident #103 receives oxygen therapy.

Resident #103's most recent POS (physician order summary) dated January 2019 documented "O2 via Nasal cannula at 2L/min (Oxygen two liters per minute via nasal cannula) as needed for shortness of breath or hypoxia (3)."

On 1/15/18 2:45 p.m. Resident #103 was observed in his room sitting in his wheelchair wearing a nasal cannula (NC) connected to an

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oxygen concentrator with the oxygen flow rate set to 2.0 L/min. At this time, an interview with Resident #103 was conducted. During this interview, three CNA's (certified nursing assistant staff) knocked on the door, entered the resident's room, and asked if he was ready to get back in bed. Resident #103 indicated to the staff he was ready to get back in bed. The three CNA's were observed using a mechanical lift to move the resident from his wheelchair to his bed, including CNA #25. The staff then washed their hands and left the room. After resuming the interview it was observed that Resident #103's nasal cannula had been removed prior to him being placed back in bed and had not been returned to him. The resident was asked who had removed his nasal cannula; Resident #103 replied "One of the young ladies that put me back in bed." On 1/15/18 at approximately 3:00 p.m., Resident #103' call button was pressed and at approximately 3:05 p.m., the call light was answered by CNA #24. CNA #24 was informed that the resident had been on oxygen prior to him being placed back in bed and it had not been put back on. CNA #24 proceeded to come into the room and placed Resident #103 oxygen nasal cannula back on the resident. CNA #24 was asked if a pulse oximetry (4) could be taken prior to placing Resident #103's nasal cannula back on. CNA #24 placed a pulse oximetry monitor on the Resident #103's finger and his pulse ox was noted to be 85 - 86% on room air. CNA #24 then proceeded to place Resident #103's oxygen on. With the pulse oximeter monitor on his finger, his oxygen saturation was noted to be 94% on 2 L/min of oxygen.

Review of Resident #103's care plan with a quarterly revision dated 11/28/18 failed to

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evidence any reference to oxygen use by Resident #103.

On 1/15/18 at approximately 3:15 p.m., and interview was conducted with CNA #24. CNA #24 was asked who can put on, take off or adjust oxygen; CNA #24 replied, "I don't know."

On 1/16/19 at approximately 2:41 p.m., an interview was conducted with CNA #25. CNA #25 was asked if all staff who assisted moving Resident #103 from his wheelchair to his bed were CNA's, CNA #25 replied "Yes." CNA #25 was asked if she recalled which staff took Resident #103's nasal cannula off the resident. CNA #25 stated she did not. CNA #25 was asked who could put on, take off or adjust oxygen, CNA #25 replied "An LPN (licensed practical nurse) or RN (registered nurse). When CNA #25 was asked if a CNA could take off or put on oxygen, CNA #25 replied "No."

On 1/16/19 at approximately 2:44 p.m., an interview was conducted with LPN #12. When asked who can put on, take off, or adjust oxygen, LPN #12 replied "LPN's and RN's." LPN #12 was asked if a CNA can adjust oxygen, LPN #12 replied "No." LPN #12 was asked why is it important to maintain not take of a residents oxygen, LPN #12 replied, "They could go into respiratory failure."(5)

The facilities oxygen administration policy documented in part, "Oxygen administration increases blood oxygen content so that the heart doesn't have to pump as much blood per minute to meet tissue demands. Verify the practitioners order for the oxygen therapy, because oxygen is considered a medication or therapy and should

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 695	Continued From page 108 be prescribed." On 1/17/18 at approximately 3:51 p.m., ASM)administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 1.Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. 2. When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This information was obtained from the website: https://medlineplus.gov/breathingproblems.html. 3. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia. 4. Most people need an oxygen saturation level of at least 89% to keep their cells healthy. Having an oxygen level lower than this for a short time is not believed to cause damage. However, your cells can be strained or damaged if low oxygen levels happen many times. If your oxygen level is low on	F 695		

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F 695	Continued From page 109 room air, you may be asked to use supplemental (extra) oxygen. The oximeter can be used to help see how much oxygen you need and when you may need it. This information was obtained from the website: file:///C:/Users/mth39879/Downloads/pulse-oximetry.pdf 5. When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 726	Continued From page 110 to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, facility document review, and clinical record review it was determined the facility staff failed to ensure care was provided by a competent qualified staff as part of their license and certification requirements defined under State law or regulations for one of 42 residents in the survey sample, Resident #70. The facility staff failed to ensure a registered nurse participated/ supervised the assessment and treatment of Resident #70's pressure injury. A Licensed Practical Nurse (LPN), who did not have any specific wound training or certifications, performed initial assessment and staging of Resident #70's pressure injury. The findings include: Resident #70 was admitted to the facility on 12/13/2018. Her diagnoses included Hip Fracture, Hypertension (high blood pressure), and Asthma. Resident #70's most recent Minimum Data Set (MDS) Assessment was a 14-Day Assessment with an Assessment Reference Date (ARD) of 12/25/2018. Resident #70 was coded with a BIMS (Brief Interview for Mental Status) of 8, indicating moderate impairment. Resident #70 was coded as requiring extensive assistance of 2 or more	F 726	The facility staff failed to ensure a registered nurse participated/supervised the assessment and treatment of resident #70 pressure injury I. Unable to correct resident #70's wound documentation at this time d/t documentation completed prior. II. Residents that reside in this facility who have pressure injuries have the potential to be affected by this deficient practice III. Nurses will be Re-educated by DON/ Designee on the regulations of staging of wounds by a Registered nurse and the proper documentation to follow. IV. An audit of resident's with pressure injuries will be completed upon admission and weekly by the unit manager or designee for 4 weeks to ensure the proper staging and documentation is completed correctly. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for analysis and review. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 726	Continued From page 111 persons for bed mobility, transfers, and toileting; extensive assistance of 1 person for ambulation and personal hygiene, and as requiring supervision and setup assistance for eating. A document entitled "Initial Pressure Injury Record" was found in the Electronic Health Record for Resident #70. This document describes the various stages of pressure injuries, as well as providing space for documenting the wound stage and measurements. The pressure injury record in Resident #70's record documented, "stg 2 and 3" following the size measurements. This document was electronically signed as completed by the facility wound nurse, LPN #4. An interview was conducted with LPN #4 on 01/16/19 at 10:06 a.m. LPN #4 was asked to describe how she became aware of Resident #70's pressure injuries. LPN #4 stated that she had been on vacation, so she was made aware of the wounds when she returned to work on 01/02/19. When asked to describe the wounds at the time she saw them, LPN #4 stated "There were two wounds, the one on top looked like a stage 3 to me, the one just below looked like a stage 2." When asked if this was how she documented the wounds in the pressure injury record, LPN #4 stated "yes". On the morning of 01/17/19, a brief interview was conducted with Other Staff Member (OSM) #2, the Human Resources manager. OSM #2 was asked if LPN #4 had any wound-related training's or certifications. OSM #2 stated that other than facility orientation to the role, LPN #4 did not have any specific wound training or certifications.	F 726		

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F 726	Continued From page 112 On the morning of 01/17/19, an interview was conducted with Administrative Staff Member (ASM) #2, the Director of Nursing. ASM #2 was asked if LPN #4 was the facility's wound nurse. She replied yes. When asked if an RN (Registered Nurse) assessed wounds, ASM #2 stated that she, as Director of Nursing, often accompanied LPN #4 on her wound rounds. When asked if she, as Director of Nursing, documented the findings, she said no. When asked if there was any documentation of her accompanying LPN #4 in assessing this wound, ASM#2 stated there would not be, as LPN #4 charted all wound documentation. When asked if she was aware that initial staging of wounds is outside the scope of practice of an LPN, ASM #2 stated she was not aware of that. 18VAC90-19-70. Supervision of licensed practical nurses. Licensed practical nursing shall be performed under the direction or supervision of a licensed medical practitioner, a registered nurse, or a licensed dentist. 18VAC90-19-250. Criteria for delegation. 3. Establishment of organizational standards to provide for sufficient supervision that assures safe nursing care to meet the needs of the clients in their specific settings. 2. The delegating nurse retains responsibility and accountability for nursing care of the client, including nursing assessment, planning, evaluation, documentation, and supervision.(6) The Administrator, ASM #1 and Director of Nursing, ASM #2 were informed of the findings at the end of day meeting on 01/17/19. No further	F 726		

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F 726	Continued From page 113 documentation was provided.	F 726		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to conduct annual performance reviews for 14 out of 14 CNAs (certified nursing assistants) who were employed at the facility for at least one year. The facility staff failed to complete annual performance reviews for CNA #1, CNA #2, CNA #4, CNA #11, CNA #12, CNA #13, CNA #14, CNA #15, CNA #16, CNA #17, CNA #18, CNA #19, CNA #20 and CNA #21. The findings include: On 1/16/19 at 10:48 a.m., a request for annual performance reviews and associated trainings for a sample of six CNAs was made to OSM (other staff member) #2, (the human resource generalist). On 1/16/19 at 10:52 p.m., OSM #2 stated she did not have the requested performance reviews or associated trainings. OSM #2 stated the facility had employed four different directors of nursing	F 730	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights. 1. The facility staff failed to complete annual performance reviews for 14 CNA's Nurse that have worked over the past 12 months. 2. The facility has determined that residents that reside in this facility have the ability to be affected by the deficient practice. 3. Human Resource Director/DON/Designee will be re-educated by Administrator on completing Performance evaluation timely. Administrator will re-educate in the event that the deficient practice occurs and maintain compliance. 4. The HR/DON/Designee will provide each of the 14 CNA's with Performance evals by correction date. HR and DON will conduct audits of CNA's weekly for 4 weeks to ensure the facility is practicing correctly and timely performance. Results of audits will be discussed at monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction will be complete by 2/15/19	

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F 730	Continued From page 114 since March 2018 and the performance reviews and associated trainings were currently in the QAPI (quality assurance and performance improvement) program. OSM #2 confirmed the QAPI plan for this was not complete and stated the plan was a work in progress that the facility staff will using to move forward. On 1/16/19 at 12:31 p.m., OSM #2 was asked to provide a list of all CNAs who had been employed at the facility for at least one year. The list contained the following CNAs: CNA #1, hired on 8/8/17 CNA #2, hired on 3/7/17 CNA #4, hired on 11/10/17 CNA #11, hired on 6/27/17 CNA #12, hired on 4/17/80 CNA #13, hired on 5/10/01 CNA #14, hired on 6/5/03 CNA #15, hired on 10/9/11 CNA #16, hired on 7/30/86 CNA #17, hired on 12/20/17 CNA #18, hired on 5/27/14 CNA #19, hired on 6/30/08 CNA #20, hired on 12/2/82 CNA #21, hired on 9/30/14 OSM #2 confirmed performance reviews and associated trainings had not been completed for any of the above 14 CNAs. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Performance	F 730		

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F 730	Continued From page 115 Evaluations" documented, "POLICY: The Performance evaluation provides a formal vehicle for the supervisor and the employee to discuss the employee's overall work performance and developmental areas as it relates to the employee's job description. Communication between employees and supervisors or managers is very important. PROCEDURES: 1. Performance evaluations are conducted in privacy and will be used as a tool in determining employee promotions, shift/position transfers, demotions, terminations, wage increases, etc., and to improve the quality of the employee's work performance and development. 2. A Performance evaluation must be completed on each employee within 30 days of their original service date utilizing the Annual Performance Review Forms...3. Performance evaluations may be given at any time there is a significant change in job expectations or performance at management discretion..." No further information was presented prior to exit.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 755	Continued From page 116 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure a medication was available for administration as ordered by the physician for two of 42 residents in the survey sample; Residents #60 and #48. 1. The facility staff failed to ensure a medication (Spiriva) prescribed by the physician was available for administration to Resident #60 on 1/16/18. 2. The facility staff failed to ensure Vitamin B-12, prescribed by the physician was available for administration to Resident #48 on 9/17/18.	F 755	Nursing staff failed to ensure a medication was available for administration to resident #60. Failed to ensure Vitamin B-12 was available for administration to resident #48 I. The order for B-12 100mcq for resident #48 was placed on hold and a Vitamin B-12 lab was drawn. Lab results revealed that the level was with in normal limits and resident no longer needs Vitamin B-12. Order obtained to discontinue vitamin B-12. Resident #60 Spiriva was not given d/t backorder from pharmacy. Nurse received order for albuterol until Spiriva was delivered. Nurse administered albuterol at this time. II. Residents that reside in this facility who use take Vitamin B-12 and Spiriva have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/designee regarding proper medication administration, checking labels, when to reorder from pharmacy and proper procedure when medication is unavailable for administration. Monthly audit x 2 of residents who are on vitamin B-12 and Spiriva to be completed by unit manager/designee to ensure proper dosage, and supply is available and physician orders are correct. IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 755	Continued From page 117 The findings include: 1. The facility staff failed to ensure a medication (Spiriva) prescribed by the physician was available for administration to Resident #60 on 1/16/18. Resident #60 was admitted to the facility on 6/25/18 with the diagnoses of but not limited to acute and chronic respiratory failure, high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD, and cognitive communication deficit. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a physician's order dated 6/26/18 for "Tiotropium Bromide Monohydrate (Spiriva) {1} Capsule 18 MCG (micrograms) ....1 puff inhale orally one time a day for COPD." On 01/16/19 08:09 a.m., LPN #6 was observed preparing the following medications for administration to Resident #60: 1. Spiriva 18mcg {1} not available and not given. 2. Breo 200/25 {2} mcg, 1 puff 3. Norvasc {3} 10 mg (milligrams), 1 tab (tablet) 4. Janumet {4} 50-1000 mg, 1 tab 5. Lasix {5} 40 mg, 2 tabs for 80mg 6. Meloxicam {6} 7.5 mg, 1 tab 7. Potassium {7} 20 meq (milliequivalents) 1 tab 8. Prednisone {8} 10 mg 1 tab 9. Lisinopril {9} 2.5 mg, 3 tabs for 7.5 mg 10. Oxycontin {10} ER (extended release) 20 mg, 2 tabs for 40 mg 11. Ventolin {11} 90 mcg inhaler.	F 755		

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F 755	Continued From page 118 12. Metamucil {12} 17 grams. Upon review of the physician's orders, it was noted that the Spiriva had not been administered, resulting in a medication error. A review of the nurses' notes revealed one dated 1/16/18, which documented, "Tiotropium Bromide Monohydrate Capsule 18 MCG 1 puff inhale orally one time a day for COPD on back order at pharmacy, pharm (pharmacy) notified. NP (nurse practitioner) notified, requested albuterol instead." On 1/16/19 at 9:18 a.m., in an interview with LPN #6, she stated that the medication (Tiotropium Bromide Monohydrate Capsule [Spiriva] 18 MCG) was reordered days ago but that the pharmacy was on back order. LPN #6 stated she was not aware of the backup pharmacy being utilized to ensure the medication was available. On 1/16/19 at 9:37 a.m., ASM (administrative staff member) #2, the Director of Nursing stated that the backup pharmacy should have been used. A review of the care plan revealed one dated 6/29/18 for "Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease...rt (related to) will turn O2 (oxygen) up a liter, is non-compliant with setting at times...." The interventions included one dated 6/29/18, which documented, "Administer medications as ordered. Observe Labs (laboratory tests), response to medication and treatments." A review of the facility policy, "Medication Ordering and Receiving From Pharmacy Provider" documented, "Medications and related	F 755		

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F 755	Continued From page 119 products are received form the provider pharmacy on a timely basis....all medications shall be reordered in advanced by writing the medication name and prescription number, or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. Reorder routine medications by the re-order date on the label to assure an adequate supply is on hand....2. Receiving medications from the pharmacy: A licensed nurse or appropriate personnel as required by law: ....Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor...." On 1/17/18 at 3:30 p.m., ASM #1, the Executive Director and ASM #2, the Director of Nursing were notified of the concern. No further information was provided by the end of the survey. References: {1} Spiriva - Used to control wheezing, shortness of breath, coughing, and chest tightness in patients with (COPD). Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html {2} Breo - Used "to control wheezing, shortness of breath, coughing, and chest tightness caused by asthma and (COPD)....To use the inhaler follow these steps....9. Rinse your mouth with water, but do not swallow." Information obtained from https://medlineplus.gov/druginfo/meds/a613037.h	F 755		

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ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

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F 755	Continued From page 120 tml {3} Norvasc - Used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.html {4} Janumet - Used in the treatment of diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a606023.html {5} Lasix - Used to treat high blood pressure and edema Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html {6} Meloxicam - Used to treat pain, tenderness, swelling and stiffness caused by osteoarthritis and rheumatoid arthritis. Information obtained from https://medlineplus.gov/druginfo/meds/a601242.html {7} Potassium Chloride - Is an electrolyte replacement needed for nerves to function and muscles to contract.....Some diuretics (i.e. Lasix) causes low levels of potassium in the body. Information obtained from https://medlineplus.gov/potassium.html and from https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/blood-pressure/FAQ-20058432?p=1 {8} Prednisone - Used to treat arthritis; severe allergic reactions; multiple sclerosis; lupus; and certain conditions that affect the lungs, skin, eyes,	F 755		

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F 755	Continued From page 121 kidneys, blood, thyroid, stomach, and intestines, and symptoms of certain types of cancer. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html {9} Lisinopril - Used to treat high blood pressure Information obtained from https://medlineplus.gov/druginfo/meds/a692051.html {10} OxyContin - Used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html {11} Ventolin - Used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease. Information obtained from https://medlineplus.gov/druginfo/meds/a682145.html {12} Metamucil - Used to treat constipation Information obtained from https://medlineplus.gov/druginfo/meds/a601104.html 2. The facility staff failed to ensure Vitamin B-12 (1) was available for administration to Resident #48 on 9/17/18. Resident #48 was admitted to the facility on 9/10/18. Resident #48's diagnoses included but	F 755		

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F 755	Continued From page 122	F 755		

were not limited to intellectual disabilities, seizures and high blood pressure. Resident #48's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/6/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #48 as requiring extensive assistance of two or more staff with bed mobility/transfers and as being totally dependent on one staff with eating.

Review of Resident #48's clinical record revealed a physician's order dated 9/10/18, for Vitamin B-12- 100 mcg (micrograms), one tablet once a day for supplement.

Review of Resident #48's September 2018 MAR (medication administration record) revealed the above Vitamin B-12 order. On 9/17/18, LPN (licensed practical nurse) #2 documented the code "7= Other/ See Nurse Notes" instead of documenting a check mark to indicate the Vitamin B-12 was administered to Resident #48. A nurse's note signed by LPN #2 on 9/17/18, documented Vitamin B-12 was unavailable.

Resident #48's care plan dated 9/11/18 failed to document specific information regarding the administration of Vitamin B-12.

Review of a list of medications that are kept onsite at the facility revealed Vitamin B-12 100 mcg tablets were not available in the facility.

On 1/16/19 at 3:26 p.m., a telephone interview with LPN #2 was attempted. LPN #2 was unavailable.

On 1/17/19 at 8:29 a.m., an interview was

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F 755	Continued From page 123 conducted with LPN #1. LPN #1 was made aware of Resident #48's physician's order for 100 mcg of Vitamin B-12 and asked if that medication was available in the facility medication supply. LPN #1 stated she thought only 500 mcg tablets of Vitamin B-12 was available. LPN #1 was asked what nurses should do if a physician ordered medication is not available for administration. LPN #1 stated, "Go to central supply to see if she can get it and if not then call the pharmacy and if they don't have it then I go to the physician." On 1/17/19 at 10:42 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "ORDERING AND RECEIVING NON-CONTROLLED MEDICATIONS" documented, "PROCEDURES: 1. Ordering medications from provider pharmacy: a. All new medication orders are transmitted to the pharmacy. The prescriber medication order includes all required elements. (Refer to Section 2 Medication Orders). b. If utilizing a 'cycle fill' or 'anniversary fill' system, all routinely used dosage forms are provided by 'automatic' dispensing and no reorder is required of these medications. For remaining routine and PRN (as needed) orders, repeat medications (refills for a new supply) are ordered by writing the medication name and prescription number, or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. Reorder routine medications by the re-order date on the label to assure an adequate supply is on hand..."	F 755		

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F 755	Continued From page 124 No further information was provided prior to exit. (1) "Vitamin B12 is a nutrient that helps keep the body's nerve and blood cells healthy and helps make DNA, the genetic material in all cells." This information was obtained from the website: https://ods.od.nih.gov/factsheets/VitaminB12-Consumer/	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a resident was	F 757	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 757	Continued From page 125 free of unnecessary medication for one of 42 residents in the survey sample, Resident #48. The facility staff failed to administer the physician prescribed dose of Vitamin B-12 (1), 100 mcg (micrograms) to Resident #48. Instead, the facility staff administered 500 mcg of Vitamin B-12 to the resident. The findings include: Resident #48 was admitted to the facility on 9/10/18. Resident #48's diagnoses included but were not limited to intellectual disabilities, seizures and high blood pressure. Resident #48's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/6/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #48 as requiring extensive assistance of two or more staff with bed mobility/transfers and as being totally dependent on one staff with eating. Review of Resident #48's clinical record revealed a physician's order dated 9/10/18 for Vitamin B-12- 100 mcg (micrograms), one tablet once a day for supplement. Review of Resident #48's January 2019 MAR (medication administration record) revealed the above Vitamin B-12 order. Resident #48's care plan dated 9/11/18 failed to document specific information regarding the administration of Vitamin B-12. On 1/16/19 at 9:52 a.m., observation of facility medication carts and a medication storage room revealed the facility utilized a bulk supply of over-the-counter medications that were kept	F 757	Nursing staff failed to administer the physician prescribed dose of vitamin B-12 100mcq, to resident #48, instead, the facility staff administered 500mcq of B-12 to the resident I. The order for B-12 100mcq for resident #48 was placed on hold and a Vitamin B-12 lab was drawn. Lab results revealed that the level was with in normal limits and resident no longer needs Vitamin B-12. Order obtained to discontinue vitamin B-12 II. Residents that reside in this facility who use take Vitamin B-12 have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/designee regarding proper medication administration. Verifying medication is the correct dose three times before administering the medication. When pulling medication from the medication cart, when dose is prepared and before the dose is administered. Monthly audit x 2 of residents who are on vitamin B-12 to be completed by unit manager/designee to ensure proper dosage is available and physician orders are correct. IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 757	Continued From page 126 onsite. Review of a list of bulk medications that were kept onsite at the facility revealed Vitamin B-12 100 mcg tablets were not available in the facility. On 1/17/19 at 8:29 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was made aware of Resident #48's physician's order for 100 mcg of Vitamin B-12 and was asked if that medication was obtained from the facility bulk supply. LPN #1 stated, "I think all I have is Vitamin B-12, 500 micrograms." When asked what dose of Vitamin B-12 she had been administering to Resident #48, LPN #1 looked through the medication cart and confirmed there was no 100 mcg tablets of Vitamin B-12 provided from the bulk supply or the pharmacy. LPN #1 confirmed she had been administering 500 mcg of Vitamin B-12 to Resident #48. Review of Resident #48's January 2019 MAR revealed LPN #1 had administered Vitamin B-12 to Resident #48 on 1/12/19, 1/13/19 and 1/16/19. On 1/17/19 at 10:42 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Medication Administration- General Guidelines" documented, "1. Medications are administered in accordance with written orders of the prescriber..." No further information was provided prior to exit. (1) "Vitamin B12 is a nutrient that helps keep the body's nerve and blood cells healthy and helps make DNA, the genetic material in all cells." This	F 757		

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F 757	Continued From page 127 information was obtained from the website: https://ods.od.nih.gov/factsheets/VitaminB12-Consumer/	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 758	Continued From page 128 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a resident was free of unnecessary psychotropic medication for one of 42 residents in the survey sample, Resident #35. The facility staff failed to monitor Resident #35's behaviors for the use of the antipsychotic medication Seroquel (1). The findings include: Resident #35 was admitted to the facility on 1/10/18. Resident #35's diagnoses included dementia (2) with behavioral disturbance, chronic kidney disease and muscle weakness. Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/28/18, coded the resident's cognition as moderately impaired. Section G coded Resident #35 as requiring extensive assistance of one staff with locomotion, dressing,	F 758	Nursing staff failed to monitor Resident #35 behaviors for the use of the antipsychotic medication Seroquel I. A behavior sheet was obtained and filled out with medication and behaviors noted for use of Seroquel for resident #35 II. Residents that reside in this facility who use antipsychotic medications have the potential to be affected by this deficient practice. III. Nurses to be Re-educated by DON/designee regarding documentation of behaviors for residents t hat are on antipsychotic medications. Weekly audits to be completed by unit manager/designee to ensure proper documentation of behaviors x 4 weeks and then monthly IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 758	Continued From page 129 toilet use and personal hygiene. Section N coded the resident as receiving an antipsychotic medication seven out of the last seven days. Resident #35's comprehensive care plan dated 1/11/18 documented, "Potential for drug related complications associated with use of psychotropic medications related to: antianxiety meds (medications), antipsychotics...Provide Medications as ordered by physician and evaluate for effectiveness..." Review of Resident #35's clinical record revealed a physician's order dated 6/4/18 for Seroquel 25 mg (milligrams) twice daily for psychosis (3). Review of Resident #35's eMARs (electronic medication administration records) from June 2018 through January 2019 revealed the resident received Seroquel as prescribed. Further review of Resident #35's clinical record (including eMARs and nurses' notes from June 2018 through January 2019) failed to reveal behavior monitoring documentation (except for one nurse's note dated 9/13/18 that documented the resident was somewhat agitated). On 1/16/19 at 4:31 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (a nurse who occasionally cared for Resident #35). LPN #3 was asked the facility process for behavior monitoring for a resident who is receiving antipsychotic medication. LPN #3 stated, "We have behaviors that we sign off on the eMARs, whether they have had or have not had behaviors. If they have had behaviors, we note on it and address with psych (psychiatrist)." LPN #3 stated there should be a section on the eMAR for nurses to sign off on behaviors every shift.	F 758		

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F 758	Continued From page 130 As documented above, review of Resident #35's eMARs for June 2018 through January 2019 failed to reveal behavior-monitoring documentation. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Chemical Restraint" documented, "5. All residents receiving psycho-pharmacologic drugs will be monitored using the psycho-pharmacologic drug monitoring record..." No further information was presented prior to exit. (1) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression...Studies have shown that older adults with dementia (a brain	F 758		

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F 758	Continued From page 131 disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine have an increased risk of death during treatment. Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html (2) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.227373405.1336833414.1548171654-139120270.1477942321 (3) "Most people think of psychosis as a break with reality. In a way it is. Psychosis is characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't. These disruptions are often experienced as seeing, hearing and believing things that aren't real or having strange, persistent thoughts, behaviors and emotions. While everyone's	F 758		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

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F 758	Continued From page 132 experience is different, most people say psychosis is frightening and confusing." This information was obtained from the website: https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Psychosis	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure a medication error rate of less than five percent involving one of 6 residents (Resident #60) in the Medication Administration task, with 29 opportunities. The medication error rate was 6.9 percent. The findings include: Resident #60 was admitted to the facility on 6/25/18 with the diagnoses of but not limited to acute and chronic respiratory failure, high blood pressure, diabetes, chronic obstructive pulmonary disease, (COPD), and cognitive communication deficit. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/18/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for transfers, ambulation,	F 759	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 759	Continued From page 133 dressing, toileting, and hygiene; and required supervision for eating; and was occasionally incontinent of bladder and bowel. A review of the clinical record revealed an order dated 11/8/18 for "Breo {1} ....200-25 mcg/inh (micrograms/inhalation ....1 puff inhale orally one time a day for COPD ...Rinse mouth with water and spit back into cup after use." A review of the clinical record revealed an order dated 6/26/18 for "Tiotropium Bromide Monohydrate (Spiriva) {2} Capsule 18 MCG (micrograms) ....1 puff inhale orally one time a day for COPD." On 01/16/19 08:09 a.m., LPN #6 was observed preparing the following medications for administration to Resident #60: 1. Breo 200/25 mcg, 1 puff 2. Norvasc {3} 10 mg (milligrams), 1 tab (tablet) 3. Janumet {4} 50-1000 mg, 1 tab 4. Lasix {5} 40 mg, 2 tabs for 80mg 5. Meloxicam {6} 7.5 mg, 1 tab 6. Potassium {7} 20 meq (milliequivalents) 1 tab 7. Prednisone {8} 10 mg 1 tab 8. Lisinopril {9} 2.5 mg, 3 tabs for 7.5 mg 9. Oxycontin {10} ER (extended release) 20 mg, 2 tabs for 40 mg 10. Ventolin {11} 90 mcg inhaler. 11. Spiriva 18mcg not given. 12. Metamucil {12} 17 grams. After administering the Breo, LPN #6 did not instruct Resident #60 to rinse his mouth with water and spit back into the cup afterwards. LPN #6 provided Resident #60 with a cup of water containing Metamucil powder mixed in and instructed him to drink that, which he did, and	F 759	Facility staff failed to ensure a medication error rate of less than 5% involving resident #60. Spiriva had not been administered due to unavailable and not following order for Breo (rinsing mouth after use) I. The Spiriva was on backorder from pharmacy and a new order was given for albuterol until the Spiriva had arrived from pharmacy. Pharmacy was called and Spiriva order arrived that evening. The Breo medication error was unable to correct at this time due to resident already received medication. II. Residents that reside in this facility who have medication orders have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/designee regarding ordering medication from pharmacy and what steps to take if unavailable and the importance of reading medication orders with additional instructions of particular medications. Audit of completion of MARS will checked weekly by the unit managers/designee x 4 weeks and then monthly. IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 759	Continued From page 134 swallowed it. Failure to educate and instruct the resident to rinse and spit afterwards resulted in a medication error. On 1/16/19 at 9:18 a.m., in an interview with LPN #6, when asked about the observation of not having the resident rinse and spit after administering the Breo, LPN #6 stated, "Normally he doesn't do the spit and rinse. I could have offered it to him but in working with him every day he doesn't do that." When asked if she has documented his refusal to follow manufacturer instructions for this medication, LPN #6 stated, "I have not documented that he was educated on this and that he refused to do it." Upon review of the physician's orders, it was noted that the Spiriva had not been administered, resulting in a medication error. A review of the nurses' notes revealed one dated 1/16/18, which documented, "Tiotropium Bromide Monohydrate Capsule 18 MCG 1 puff inhale orally one time a day for COPD on back order at pharmacy, pharm (pharmacy) notified. NP (nurse practitioner) notified, requested albuterol instead." On 1/16/19 at 9:18 a.m., in an interview with LPN #6, she stated that the medication (Tiotropium Bromide Monohydrate Capsule [Spiriva] 18 MCG) was reordered days ago but that the pharmacy was on back order. LPN #6 stated she was not aware of the backup pharmacy being utilized to ensure the medication was available. On 1/16/19 at 9:37 a.m., ASM (administrative staff member) #2, the Director of Nursing stated that the backup pharmacy should have been used.	F 759		

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F 759	Continued From page 135 A review of the care plan revealed one dated 6/29/18, for "Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease...rt (related to) will turn O2 (oxygen) up a liter, is non-compliant with setting at times...." The interventions included one dated 6/29/18, which documented, "Administer medications as ordered. Observe Labs (laboratory tests), response to medication and treatments." A review of the facility policy, "Medication Administration" documented, "1. Medications are administered in accordance with written orders of the prescriber....13. Explain to resident the type of medication being administered and the procedure." The policy, which was only partially provided (pages 3-6 of 6 pages was provided) did not provide direction for ensuring manufacturer's instructions are followed. A review of the facility policy, "Medication Ordering and Receiving From Pharmacy Provider" documented, "Medications and related products are received form the provider pharmacy on a timely basis....all medications shall be reordered in advanced by writing the medication name and prescription number, or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. Reorder routine medications by the re-order date on the label to assure an adequate supply is on hand....2. Receiving medications from the pharmacy: A licensed nurse or appropriate personnel as required by law: ....Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor...."	F 759		

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F 759	Continued From page 136 On 1/17/18 at 3:30 p.m., ASM #1, the Executive Director and ASM #2, the Director of Nursing were notified of the concern. No further information was provided by the end of the survey. References: {1} Breo - Used "to control wheezing, shortness of breath, coughing, and chest tightness caused by asthma and (COPD)....To use the inhaler follow these steps....9. Rinse your mouth with water, but do not swallow." Information obtained from https://medlineplus.gov/druginfo/meds/a613037.html {2} Spiriva - Used to control wheezing, shortness of breath, coughing, and chest tightness in patients with (COPD). Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html {3} Norvasc - Used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.html {4} Janumet - Used in the treatment of diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a606023.html {5} Lasix - Used to treat high blood pressure and edema Information obtained from https://medlineplus.gov/druginfo/meds/a682858.h	F 759		

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F 759	Continued From page 137 tml {6} Meloxicam - Used to treat pain, tenderness, swelling and stiffness caused by osteoarthritis and rheumatoid arthritis. Information obtained from https://medlineplus.gov/druginfo/meds/a601242.html {7} Potassium Chloride - Is an electrolyte replacement needed for nerves to function and muscles to contract.....Some diuretics (i.e. Lasix) causes low levels of potassium in the body. Information obtained from https://medlineplus.gov/potassium.html and from https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/blood-pressure/FAQ-20058432?p=1 {8} Prednisone - Used to treat arthritis; severe allergic reactions; multiple sclerosis; lupus; and certain conditions that affect the lungs, skin, eyes, kidneys, blood, thyroid, stomach, and intestines, and symptoms of certain types of cancer. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html {9} Lisinopril - Used to treat high blood pressure Information obtained from https://medlineplus.gov/druginfo/meds/a692051.html {10} OxyContin - Used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html	F 759		

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F 759	Continued From page 138 (11) Ventolin - Used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease. Information obtained from https://medlineplus.gov/druginfo/meds/a682145.html (12) Metamucil - Used to treat constipation Information obtained from https://medlineplus.gov/druginfo/meds/a601104.html	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 761	Continued From page 139 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 facility document review, it was determined that the facility staff failed to label medications in accordance with professional standards for two of eight medication carts, carts #3 and #4 on the South unit. According to manufacturer's instructions for various insulin's, the insulin's should be discarded a certain amount of days after being opened. The facility staff failed to label multiple vials and pens of insulin's with either an open date or a modified expiration date to ensure the insulin's were discarded per manufacturer's instructions. The findings include: On 1/16/19 at 10:06 a.m., observations of carts #3 and #4 on the South unit were conducted. The following was observed: Cart #3- one open vial of novolog (1) with no labeled open or modified expiration date, one open vial of humulin n (2) with no labeled open or modified expiration date and one open novolog flexpen (3) with no labeled open or modified expiration date. Cart #4- one open humalog kwikpen (4) with no labeled open or modified expiration date. The novolog manufacturer's website documented, "Throw away open vials and pens 28 days after first use, even if there is insulin left inside." This information was obtained from the website:	F 761	Facility staff failed to label medications in accordance with professional standards for two medications in each medication carts #3 and #4 I. The insulin's were thrown out due to no l abeling of when opened or an expiration date of when to dispose. New insulin's was ordered from pharmacy STAT and facility received insulin's for next doses that were due. II. Residents that reside in this facility who have insulin orders have the potential to be affected by the deficient practice. III. Nurses to be Re-educated by DON/designee regarding proper labeling of medications when opened or first time use. Making sure that vials/pens are labeled outside the bottle and on the vial, and labeling an expiration date for disposal. Audit for medication storage will be checked weekly by the unit managers/designee for non-labeled medications and expired medication which will be removed and disposed. IV. Results of audit will be brought to monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and analysis and review. Recommendations implemented as indicated. The plan of correction to be monitored until substantial consistent compliance has been met. V. Correction to be completed by 2/15/19	

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F 761	Continued From page 140 https://www.rapidactinginsulin.com/novolog/using-novolog/storage-and-handling.html The humulin n manufacturer's website documented, "Throw away all opened vials after 31 days of use, even if there is still insulin left in the vial." This information was obtained from the website: http://uspl.lilly.com/humulinn/humulinn.html#ppi The humalog kwikpen manufacturer's website documented, "Throw away open vials 28 days after first use, even if there is insulin left in the vial." This information was obtained from the website: https://www.humalog.com/type-2-diabetes/?WT.srch=1&WT.mc_id=u100sem_ggl_br_br-core_43700026684272391_e&srcid=u100sem_ggl_br_br-core_43700026684272391_e&utm_campaign=u100sem&utm_source=ggl&utm_medium=ppc&utm_content=%7cbr%7cbr-core%7c43700026684272391%7ce&utm_keyword=humalog%2Bkwikpen&gclid=CI-yoYKbhOACFVPFswodfHIIFg&gclsrc=ds On 1/16/19 at 10:22 a.m., an interview was conducted with RN (registered nurse) #6. RN #6 confirmed there was no open date or modified expiration date labeled on all of the above insulins. RN #6 was asked what should be done when she opens a vial of insulin or an insulin flexpen. RN #6 stated, "You check the name, date of birth, compare to chart, and expiration date. We are supposed to put the date that it's opened." When asked why she should label the open date, RN #6 stated, "Just to make sure that it's not expired." RN #6 was asked how staff would know when open insulin should be discarded if it is not labeled with an open date or	F 761		

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F 761	Continued From page 141 modified expiration date. RN #6 stated, "They are not going to know unless it's written on there." On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Medications and Medication Labels" documented, "2. Multi-dose vials shall be labeled to assure integrity, considering the manufacturers' specifications (Example: Modified expiration dates upon opening the multi-dose vial)..." No further information was presented prior to exit. (1) Novolog is used to treat diabetes (a condition in which the body does not make insulin and cannot control the amount of sugar in the body). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605013.html (2) Humulin n is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682611.html (3) Novolog flexpen is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605013.html (4) Humalog kwikpen is used to treat diabetes. This information was obtained from the website: https://www.fda.gov/ForConsumers/ByAudience/ForWomen/WomensHealthTopics/ucm216233.ht	F 761		

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F 761	Continued From page 142 m	F 761		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, it was determined the facility staff failed to serve food at palatable temperatures during the lunch meal on 1/16/19 in the facility dining room. The findings include: Resident #99 was admitted to the facility on 9/1/18. Resident #99's diagnoses included but were not limited to urinary tract infection, diabetes and high blood pressure. Resident #99's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 1/8/19, coded the resident as being cognitively intact. On 1/15/19 at 12:46 p.m., an interview was conducted with Resident #99. When asked questions regarding the facility food, Resident #99 stated the food is "Horrible." The resident further stated the food is tough, overcooked and there is no variety.	F 804	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights. 1. The facility Dietary Department failed to serve food at a palatable temperatures during the lunch meal in dining facility to Resident #19. 2. The facility has determined that the residents that reside here have the ability to be affected by this deficient practice of temperature of food. 3. Current Dietary employees will be re-educated on the importance of serving food at the appropriate temperature by Dietary Manager. New Dietary employees receive education on Palatable/Pref temp of food for residents by Dietary manger and re-education will be provided upon discovery of non-compliance. 4. The DON/Dietary Manager/Designee will conduct a random audit of temp of food on 5 residents per week for 4 weeks to ensure the facility is practicing correctly. Results of audits will be discussed at morning meetings, monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction to be complete by 2/15/19	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 804	Continued From page 143 Resident #49 was admitted to the facility on 3/30/18. Resident #49's diagnoses included but were not limited to colon cancer, anxiety disorder and difficulty swallowing. Resident #49's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/18, coded the resident as being cognitively intact. On 1/15/19 at 1:56 p.m., an interview was conducted with Resident #49. When asked questions regarding the facility food, Resident #49 stated, "Lunch and dinner are not fit to eat," and voiced concern about the food taste and temperature. Resident #4 was admitted to the facility on 11/21/12. Resident #4's diagnoses included but were not limited to stroke, paralysis and difficulty swallowing. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/22/18, coded the resident's cognition as moderately impaired. On 1/15/19 at 2:00 p.m., an interview was conducted with Resident #4. When asked questions about the food, Resident #4 stated the food tasted, "lousy." Resident #19 was admitted to the facility on 4/15/15. Resident #19's diagnoses included but were not limited to diabetes, muscle weakness and anxiety disorder. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/6/18, coded the resident as being cognitively	F 804		

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F 804	Continued From page 144 intact. On 1/15/19 at 12:35 p.m., an interview was conducted with Resident #19. When asked questions regarding the food, Resident #19 stated, "The food is so bad I got to order out or I don't eat at all." Resident #19 voiced concern regarding the taste and temperature of the food. Resident #19 stated the food is lukewarm or colder. On 1/16/18 at approximately 11:15 a.m., an observation was made of the tray line in the kitchen. The holding temperatures were taken of all of the food from the tray line by OSM (other staff member) #9, the cook, using a calibrated facility thermometer. The temperature of the food in Fahrenheit is as followed: Pork loin 171 degrees Succotash - 161 degrees Ranch Potatoes - 170 degrees Chicken Pattie - 162 degrees Mashed Potatoes - 181 degrees Brussel Sprouts - 165 degrees Gravy - 161 degrees Flat Noodles- 163 degrees Puree Pork - 165 degrees Puree Cream Corn - 195 degrees Tomato Soup - 184 degrees The last resident was served in the dining room at 12:30 p.m. The temperatures of the test tray were obtained at 12:35 p.m. by OSM (other staff member) #8, the Account Manager using a calibrated facility thermometer. Test tray consisted of pork loin, succotash, ranch styled potatoes, chicken patty, mashed potatoes, Brussel sprouts, gravy, Flat Noodles, Puree Pork,	F 804		

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F 804	Continued From page 145 Puree Cream Corn and tomato soup. The recorded serving temperatures in Fahrenheit were as follows: Pork loin 139 degrees Succotash - 134 degrees Ranch Potatoes - 107 degrees Chicken Pattie - 130 degrees Mashed Potatoes - 135 degrees Brussel Sprouts - 138 degrees Flat Noodles- 106 degrees Puree Pork - 138 Puree Cream Corn - 118 Tomato Soup - 144 Two surveyors and OSM #8, the Account Manager then tested the test tray for taste and palatability. All three stated they thought the food in particular, the potatoes and noodles could be hotter. On 1/16/18 at approximately 12:40 p.m., an interview was conducted with OSM #8. OSM #8 was asked to describe the food's temperature and palatability, OSM #8 replied, "The noodles and potatoes should be hotter." The facility policy titled, "Food: Quality and Palatability" documented in part, "It is the center policy that, food is prepared by methods that conserve nutritive value, flavor and appearance. Food is palatable, attractive and served at the proper temperature. On 1/16/19 at approximately 12:50 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings.	F 804		

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F 804	Continued From page 146 No further information was obtained prior to exit.	F 804		
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and serve food in accordance with professional standards of food service safety. The facility staff failed to ensure hair was covered in the food preparation area. The findings included: On 1/15/19 at approximately 11:55 a.m., an	F 812	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights. 1. The facility Dietary Department failed to ensure hair was covered in the food preparation area. 2. The facility has determined that the residents that reside here have the ability to be affected by this deficient practice of improper hair coverage. 3. Current Dietary employees will be re-educated by Dietary Manager on the importance of covering the entire head of hair. New Dietary employees receive education from Dietary Manager on proper coverage by a hair net and re-education will be provided upon discovery of non-compliance. 4. The Dietary Manager/Designee will conduct a random audit of employee's hair nets during preparation of food 3 txs a week for 4 weeks to ensure the facility is practicing correctly. Results of audits will be discussed at morning meetings, monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for t rends analysis and ensure substantial compliance has been maintained. 5. Correction to be complete by 2/15/19	

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F 812	Continued From page 147 observation was made with OSM (other staff member) #8, the Account manager, during tray line in the kitchen. Multiple staff, including OSM #9, the Cook had hairnets that covered the crown of the head but left the sides and their fringes of her hair uncovered. On 1/16/19 at approximately 11: 30 a.m., observation was made of tray line in the kitchen with OSM #8. Again, observation was made of multiple kitchen staff including OSM #9, the Cook. OSM #9 was again observed with a hair net that covered the crown of the head but left the sides and their fringes of her hair uncovered. On 1/16/19 at approximately 11:42 a.m., an interview was conducted with OSM #8. When asked if all hair is supposed to be covered by a hair net, OSM # 8 replied, "The hair should be completely covered." On 1/16/19 at approximately 11:45 a.m., an interview was conducted with OSM #9. When asked if all hair is supposed to be covered by a hair net, OSM #9 replied, "Yes, all hair should be covered." Review of the facility policy titled, "Staff Attire" dated May 2014 documented, "The Food Services Director ensures that all staff members have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained." On 1/16/19 at approximately 12:45 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings.	F 812		

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F 812	Continued From page 148 No further information was obtained prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights. 1. Resident #80 the facility staff failed to maintain a complete accurate clinical record for this resident. 2. The facility has determined that residents that reside in this facility have the ability to be affected by this deficient practice. 3. Medical Records will be Re-educated on updating and following the policy of the facility for t hinning charts. DON/Designee will audit completed charts 5 txs a week for 4 weeks to ensure facility has developed and following required Medical Records state law. 4. Results of audits will be discussed at morning meetings with Care Keepers, monthly/quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction will be complete by 2/15/19	

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F 842	Continued From page 149 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 42 residents in the survey sample, Resident #80.	F 842		

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F 842	Continued From page 150 The facility staff failed to document the administration of two doses of an antibiotic for Resident #80. The findings include: Resident #80 was admitted to the facility on 3/10/17 with a most recent readmission on 10/30/18 with diagnoses that included but were not limited to: diabetes, dementia, breast cancer, diverticulitis [inflammation of an abnormal sac at a weakened point in the digestive tract, especially the colon (1)], urinary tract infection, macular degeneration [A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. (2)], high blood pressure and atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)]. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 12/27/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as having highly impaired vision. Resident #80 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. The resident was coded as being frequently incontinent of both bowel and bladder. The physician order dated, 10/7/18, documented, "Rocephin Solution Reconstituted [a broad	F 842		

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F 842	Continued From page 151 spectrum antibiotic used to treat infections. (4)] 1 GM (gram) inject 1 gram intramuscularly one time a day for UTI (urinary tract infection) until 10/9/18." The medication administration record (MAR) for October 2018 documented the above medication order. The MAR failed to evidence documentation that the medication was administered on 10/7/18 or 10/8/18. The comprehensive care plan dated, 9/13/18, documented in part, Focus: Infection actual or at risk for related to: UTI (urinary tract infection), ESBL [Extended spectrum beta-lactamase - a drug resistant organism (5)]." The "Interventions" documented in part, "Administer antibiotics and treatment as ordered." The nurse's note dated, 10/7/18 at 4:06 p.m. documented in part, "Resident very confused this shift. Alert but altered mental status. she denies pain or discomfort. C&S (culture and sensitivity) still pending at this time. This nurse called the NP (nurse practitioner) on call to receive an order for Rocephin 1 gram IM (intramuscularly) X (times) 3 days. Residents (sic) son and daughter notified. Resident asked by this nurse if she would agree to go to the ER (emergency room) to be evaluated and treated however, the resident declines. VS (vital signs) WNL (within normal limits). Call bell within reach." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/17/19 at 9:50 a.m. When shown the order for the Rocephin and the MAR for October. When asked if staff should document when they administer a medication, ASM #2 stated the	F 842		

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F 842	Continued From page 152 nurse should sign the medication off on the MAR once it has been administered. ASM #2 was asked to find out if the two doses of Rocephin had been administered. On 1/17/19 at 12:28 p.m., ASM #2 presented two vials of Rocephin 1 gm vials to this surveyor. When asked what the vials indicated, ASM #2 stated that one of the missed doses was given from what the pharmacy had sent to the facility. ASM #2 stated the facility returns medications to the pharmacy when they are discontinued. These vials had not yet been picked up by the pharmacy. An interview was conducted with LPN (licensed practical nurse) #10, the nurse who took the order for the Rocephin and cared for Resident #80 on 10/7/18, on 1/17/19 at 1:12 p.m. When asked if she was familiar with Resident #80, LPN #10 acknowledged she recalled the resident. LPN #10 was no longer employed at the facility. When asked if she recalled giving the resident Rocephin IM on 10/7/18, LPN #10 stated, "Yes, I am absolutely positive that I gave it." When asked if she documented it, LPN #10 stated she could not recall that. When asked where she got the medication from, LPN #10 stated, "We carry Rocephin in the STAT (immediate emergency box of medications) box and I got it from there to give the first dose." When asked where the administration of the Rocephin should be documented, LPN #10 stated, "I should have documented in on the MAR and in my nurses notes." The facility policy, "Medication Administration General Guidelines" documented in part, "Documentation: 1. The individual who	F 842		

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F 842	Continued From page 153 administers the mediation dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner." ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concern on 1/17/19 at 4:09 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 173. (2) This information was obtained from the following website:	F 842		

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F 842	Continued From page 154 https://medlineplus.gov/maculardegeneration.html. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0d37e43b-ff8d-495d-b9af-4fd5fce53d56. (5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmed/12558458	F 842		
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	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 880	Continued From page 155 §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.	F 880	Facility staff failed to have a complete infection control program and provide respiratory care and services in a sanitary manner for resident #22 1. The facility staff reviewed the infection control program and an annual review signature sheet was placed in the infection control book. Resident #22 nebulizer mask and tubing was removed and disposed of, new tubing and nebulizer mask obtained and placed in a clear bag at bedside. 2. Resident's that reside in this facility who currently have infections and are on antibiotics have the potential to be affected by this deficient practice. Resident's that reside in this facility who use a nebulizer have the potential to be affected by the deficient practice. 3.Nursing staff to be Re- educated on the importance and need for the annual Review and signature sheet in the infection control book by DON/Designee. Nursing staff to be Re- educated by DON/designee regarding appropriate storage of nebulizer/tubing equipment. Daily rounds to be completed by the unit manager/ designee to ensure proper storage of nebulizer equipment when not in use and will be reported during daily stand-up meeting. The care keepers will follow up once per shift to ensure that the nebulizer equipment is properly stored and discuss results during afternoon stand down meeting x 4 weeks. 4. Results of the audit will be brought to monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trend and Analysis and review. Recommendations implemented as indicated. The Plan of correction to be monitored until substantial consistent Compliance has been met. 5. Correction to be completed by 2/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 01/17/2019

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F 880	Continued From page 156 §483.80(f) Annual review. 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 observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to have a complete infection control program and provide respiratory care and services in a sanitary manner for one of 42 residents in the survey sample, Resident #22. 1. The facility staff failed to complete an annual review of the facility infection control program. 2. The facility staff failed to provide respiratory care in a sanitary manner for Resident #22. The findings include: 1. On 1/17/19 at approximately 4:23 p.m., an observation was made while reviewing the facilities infection control and prevention program (IPCP) with ASM (administrative staff member) #2, the Director of Nursing. On review it was noted that the IPCP had no evidence of annual review. On 1/17/19 at approximately 4:27 p.m. an interview was conducted with ASM #2. ASM was asked if the facility had evidence of annual review of its IPCP, ASM #2 replied, "I am still new let me get with the administrator to see if we can find it." On 1/17/19 at approximately 4:32 p.m. this surveyor was informed by ASM #1, the Executive Director, the facility had no evidence of annual review of its IPCP. When asked if he performed	F 880		

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F 880	Continued From page 157 any annual review of the facilities policies and procedures, ASM #1 replied "Just emergency preparedness but no others." On 1/17/19 at approximately 4:39 p.m., an interview was conducted with ASM #3, regional director of clinical services. ASM #3 was asked if the facility had evidence of annual review of its IPCP, ASM #3 replied, "I spoke to corporate and since the DON (director of nursing) and the administrator are new they have not been through an annual review of their policies including the IPCP." The facility policy "Antibiotic Stewardship Program (ASP)" documented in part, "This policy, including the Procedure section, will be reviewed yearly to ensure that all objectives and conditions are being met, to streamline procedures and algorithms, and to identify opportunities for enhancement of the ASP" On 1/17/18 at approximately 4:41 p.m., ASM #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 2.The facility staff failed to provide respiratory care in a sanitary manner for Resident #22. Resident #22 was admitted to the facility on 10/19/2018. Diagnoses included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), diabetes, chronic respiratory failure	F 880		

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F 880	Continued From page 158 (2), shortness of breath, gastroesophageal reflux disease (GERD) (3) and cellulitis (4). The most recent MDS (minimum data set), a thirty day assessment, with an ARD (assessment reference date) of 11/14/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The physician order dated January 2019, documented "DuoNeb Solution 0.5-2.5 mg/3 ml (milligrams per milliliter) 1 inhalation inhale orally three times a day for wheezing." (5) Review of the MAR (medication administration record) dated January 2019, documented "DuoNeb Solution 0.5-2.5 mg/3 ml (milligrams per milliliter) 1 inhalation inhale orally three times a day for wheezing" was documented as having been administered. On 1/15/19 at approximately 12:34 p.m., an observation was made of Resident #22. Resident #22's nebulizer mask was on his bedside table without any cover and not in use by the resident. On 1/15/19 at approximately 4:39 p.m., a second observation was made of Resident #22. Resident #22's nebulizer mask remained on his bedside table without any cover and not in use by the resident. On 1/16/18 at approximately 3:40 p.m., an interview was conducted with Resident #22, regarding the nebulizer not being stored in a bag when not in use. Resident #22 stated, "I use to have one (a bag) but someone threw it away."	F 880		

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F 880	Continued From page 159 On 1/16/18 at approximately 3:45 p.m., an interview was conducted with CNA (certified nursing assistant) #24. When asked how Resident #22's nebulizer mask should be stored when not in use, CNA #24 replied, "They are supposed to be covered with a towel or placed in a bag." When asked why a resident's nebulizer mask is supposed to covered while not is use, CNA #24 replied, "If the mask does not get put in bag it can get contaminated." On 1/16/18 at approximately 3:52 p.m., a third observation was made of Resident #22's room with LPN (licensed practical nurse) #6. Resident #22's nebulizer mask was observed on his TV stand, without any cover and not in use by the resident. LPN #6 was asked how a nebulizer mask is supposed to be stored when not in use; LPN #6 replied, "We store them in a bag." When asked why are nebulizer mask supposed to be covered, LPN #6 "To keep it clean." The facility supplied policy on the storage of respiratory equipment "Equipment Management" documented in part, "Equipment will be cleaned, disinfected or sterilized following guidelines and manufacturers' recommendations." In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." On 1/17/18 at approximately 3:51 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical	F 880		

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F 880	Continued From page 160 Services were made aware of the findings. No further information was provided prior to exit. 1. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 3. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 4. A common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was obtained from the website: https://medlineplus.gov/ency/article/000855.htm. 5. Duo Neb Ipratropium/albuterol oral inhalation is used to prevent wheezing, shortness of breath, coughing, and chest tightness in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and	F 880		

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F 880	Continued From page 161 emphysema (damage to the air sacs in the lungs). Ipratropium is in a class of medications called bronchodilators. It works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695021.html.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to provide the required annual in-service training's for 12 of 14 CNAs (certified nursing assistants) who were employed at the facility for	F 947	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of correction prepared and executed as a means to continuously improve quality of care and to comply with applicable state and federal rights.	

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F 947	Continued From page 162 at least one year. The facility staff failed to provide the required annual 12 hours of training's for CNAs #1, #2, #4, #11, #12, #13, #14, #15, #16, #17, #20 and #21. The findings include: On 1/17/19 at 3:30 p.m., the training transcripts for all CNAs who were employed at the facility for at least one year were reviewed with OSM (other staff member) #2 (the human resources generalist). The following CNAs were noted to have less than 12 hours of annual in-service trainings: CNA #1, hired on 8/8/17 CNA #2, hired on 3/7/17 CNA #4, hired on 11/10/17 CNA #11, hired on 6/27/17 CNA #12, hired on 4/17/80 CNA #13, hired on 5/10/01 CNA #14, hired on 6/5/03 CNA #15, hired on 10/9/11 CNA #16, hired on 7/30/86 CNA #17, hired on 12/20/17 CNA #20, hired on 12/2/82 CNA #21, hired on 9/30/14 After review, OSM #2 stated the concern regarding CNA in-service trainings was currently in the QAPI (quality assurance and performance improvement) process but was not complete. On 1/17/19 at 1:29 p.m., a policy regarding CNA training's was requested via a list provided to ASM (administrative staff member) #1 (the executive director). On 1/17/19 at 3:40 p.m., ASM #1 was made	F 947	1. The facility staff failed to complete required In-Service Training for 12CNA's that have worked over the past 12 months CNA# 1,2,4,11,12,13,14,15, 16,17,20,and 21. 2. The facility has determined that residents that reside in this facility have the ability to be affected by the deficient practice. 3. Human Resource Director/DON/Designee will be re-educated by Administrator on completing required in-services timely. Administrator will re-educate in the event that the deficient practice occurs and maintain compliance. 4. The HR/DON/Designee will provide each of the 12 CNA's with In-service totaling 12hours what is required per year for each of the CNA's by correction date. HR and DON will conduct audits of CNA's weekly for 4 weeks to ensure the facility is practicing correctly with in-service training for CNA's. Results of audits will be discussed at monthly/ quarterly Quality Assurance Performance Improvement (QAPI) Committee for trends analysis and ensure substantial compliance has been maintained. 5. Correction will be complete by 2/15/19	

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F 947	Continued From page 163 aware of the above concern. No further information was presented prior to exit.	F 947		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495140	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/17/2019

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ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 42 residents in the survey sample, Resident #106. The facility staff failed to accurately code Resident #106's discharge destination on the resident's discharge MDS assessment with an ARD (assessment reference date) of 11/5/18. The findings include: Resident #106 was admitted to the facility on 10/3/18. Resident #106's diagnoses included but were not limited to high blood pressure, heart failure and morbid obesity. Resident #106's discharge MDS assessment with an ARD of 11/5/18 coded the resident as being cognitively intact. Review of Resident #106's clinical record revealed the resident was discharged to the community on 11/5/18. Section A2100 "Discharge Status" of Resident #106's discharge MDS with an ARD of 11/5/18 coded the resident as being discharged to an acute hospital. On 1/16/19 at 3:05 p.m., an interview was conducted with RN (registered nurse) #1 and RN #2 (both MDS coordinators). RN #1 was shown discharge nurse's note for Resident #106 and section A2100 of the resident's discharge MDS assessment. RN #1 confirmed the MDS was inaccurately coded. RN #1 stated some information is automatically transmitted from another system to the MDS but it was her responsibility to make sure the information is correctly coded. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 1/16/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The CMS RAI manual documented, "A2100...Coding Instructions: Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home...Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons..." No further information was presented prior to exit.