STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	490 HILLSDALE DRIVE CHARLOTTESVILLE, VA 22901

(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 12/4/18 through 12/6/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/04/2018 through 12/06/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews.	F 000		
F 567 SS=C	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds.	F 567		1/18/19

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

Electronically Signed | 12/21/2018

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

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F 567	Continued From page 1 (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on Resident interview and staff interview and group interview, the facility failed to ensure money was available to residents after banking hours. Residents were unable to get petty cash (money less than $100.00) after banking hours. The findings include: On 12/04/18 at 10:02 AM Resident #70 was interviewed. Resident #70 was admitted to the facility on 5/5/17. The most current MDS (minimum data set) was a quarterly assessment	F 567	F567 Corrective Action(s): Resident #70 has been notified that the facility failed to provide access to money after banking hours and how those monies can now be accessed if desired. Identification of Deficient Practices/Corrective Action(s): All other residents who have monies deposited into a facility account have the potential to be affected by this alleged deficient practice. The Social Services Director and/or Business Office Manager	

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F 567	Continued From page 2 with an ARD (assessment reference date) of 11/7/18. Resident #70 was assessed as being cognitively intact. Diagnoses for Resident #70 included: Neuropathy, reflux, and diabetes. During the interview Resident #70 verbalized that he was not sure if money was available to him at anytime. On 12/4/18 during a group interview with 12 residents, the residents were asked if money was available after banking hours and on weekends. The group verbalized money was not available after banking hours. On 12/4/18 at 3:25 PM Licensed Practical Nurse (LPN #2) was interviewed regarding money availability after banking hours. LPN #2 verbalized there was no money available on weekends or after banking hours. On 12/04/18 at 3:42 PM The regional director business manager (other staff, OS #6) was also interviewed regarding availability of money after banking hours. OS #6 verbalized that banking hours are from 9:00 AM to 7:00 PM Monday through Friday and on weekends from 9:00 AM to 3:00 PM. When asked about the availability of money after banking hours, OS #6 verbalized that the facility does not have money available after banking hours. On 12/5/18 at 10:19 AM the above finding was brought to the attention of the Administrator and Director of Nursing (DON). No other information was provided prior to exit conference on 12/6/18.	F 567	will conduct a 100% audit of all residents who have monies in a bank account with the facility. Residents will be notified of how to access their monies after normal banking hours. Systemic Change(s): The Administrator and/or Business Office Manager will in-service the facility□s social worker(s), nursing staff and front office staff on the requirement that monies are made available to residents after regular banking hours. Residents will be informed at admission and during resident council meetings annually of how to obtain monies after regular banking hours. Monitoring: The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Business Office Manager will review banking transactions to verify that residents are able to withdraw monies after hours. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 1/18/2019	
F 604	Right to be Free from Physical Restraints	F 604		1/18/19

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F 604 SS=D	Continued From page 3 CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, facility staff failed to ensure one of 26 residents was free from physical restraints, Resident #109.	F 604	F604 Corrective Action(s): Resident #109□s stretch band was removed 12/4/18 and is no longer in use. The resident□s left leg immobilizer has	

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F 604	Continued From page 4 Resident #109 was observed with her left leg tied to the leg of her wheelchair using a theraband on two separate occasions on 12/04/18. Findings included: Resident #109 was admitted to the facility on 10/16/18 with diagnoses of s/p (status post) fracture of left knee without surgical repair and vascular dementia. The most recent MDS (Minimum Data Set) was a thirty day assessment with an ARD (Assessment Reference Date) of 11/13/18. Resident #109 was assessed as severely impaired in her cognitive status with a total cognitive score of 7 out of 15. Resident #109 was observed in her room on 12/04/18 at 9:30 a.m., sitting in her w/c (wheelchair). Her left leg was in an immobilizer, bent at the knee and not on the w/c leg rest. A red, stretch band (theraband) was noted tied around the w/c leg and this resident's left, lower leg. The resident stated, "I do exercises with that. It hurts when I do it. Yes, I get pain medicine and it does help." At approximately 10:15 a.m. Resident #109 was observed sitting at the nurse's station in her w/c with her left leg elevated on the w/c leg rest, with her immobilizer in place. Resident's leg was stretched outright and had a red, rubber, stretch band (theraband) tied around the leg rest and the resident's lower, left leg. LPN #1 (Licensed Practical Nurse), Manager on Unit Three and this surveyor went to the therapy department and spoke with Resident #109's PTA (Physical Therapy Assistant). The PTA stated when asked	F 604	been removed and she now has full range of motion with no restrictions. Identification of Deficient Practices & Corrective Action(s): All residents requiring leg immobilization have the potential to be affected by this alleged deficient practice. A 100% review of all residents in therapy will be conducted by the Therapy Director and/or designee to ensure stretch bands are not used as a restraining device. Systemic Change(s): The Director of Therapy and Unit Managers will audit all residents requiring leg immobilization to ensure stretch bands are not in use. The Director of Therapy will in-service all therapy staff on proper positioning devices and the discontinuance of stretch bands as positioning devices. The Assistant Director of Nursing and or designee will in-service nursing staff and restorative aides on proper positioning devices and the discontinuance of stretch bands as positioning devices. Monitoring: The Director of Therapy will audit all residents requiring leg immobilization on therapy to ensure stretch bands are not used as positioning devices weekly x 4 weeks. Unit Managers will audit 100% of residents requiring leg immobilization on their units to ensure stretch bands are not being used as positioning devices weekly x 4 weeks. Any variances will be corrected and continued education	

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F 604	Continued From page 5 about the stretch band, "We use that to keep her leg up on the leg rest because her leg falls off. I have not seen her today. I have her scheduled at 2:00 p.m. I do not know who tied the stretch band around her leg. It should be just looped around and not tied in a knot so the resident can remove it." LPN #1 and this surveyor went back to Resident #109 sitting in the hallway and observed the stretch band tied in a double knot around her leg at mid shin and the w/c leg. LPN #1 removed the band and the resident's shin was assessed. No redness or open areas were noted. LPN #1 stated, "I do not know who did this, but I will find out." CNA #2 (Certified Nursing Assistant) came to the conference room at approximately 10:25 a.m. and stated, "I was instructed by therapy to tie her leg with this stretch band. [She had the actual red, stretch band that LPN #1 had removed from Resident #109's leg earlier]. We do that to keep her leg from falling off the leg rest. I tied it loosely, one time. I did not tie it in a knot. I moved her to the hallway and then went on break. I am not sure how it got tied in a double knot. She has been here for awhile and we have been doing that all along. I don't remember who told me to do that from therapy." On 12/05/18 at 8:00 a.m., the Rehab Director was interviewed regarding Resident #109's plan of care for therapy. This resident's actual plan of care was reviewed and no notations were discovered regarding tying the resident's leg to the w/c with a theraband to keep her leg in position on the w/c leg rest. The Rehab Director stated, "In the beginning she was in a lot of pain and would internally rotate her leg for comfort. Her leg would fall off the leg rest, so we	F 604	provided. Results of the audits will be presented to the Quality Assurance Committee x 4 weeks. Continued compliance will be monitored through the facility□s Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: 1/18/2019	

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F 604	Continued From page 6	F 604		

implemented using a theraband looped around her leg and the chair to keep her leg from falling off. I only ever saw the band tied loosely with a bow, never in a knot and she was able to untie the bow."

At 8:10 a.m. the Physical Therapist (PT) that completed Resident #109's admission assessment and instituted her plan of care was interviewed. The PT stated, "Yes, we would use the theraband to keep her leg in place. We would loop it around the chair and her leg loosely with a bow, never in a knot. No, I never instructed anyone to tie her leg to the chair."

There was no physician's order in the clinical record for the use of the theraband, nor restraint assessments, documentation or other interventions attempted prior to the use of the theraband as a restraint.

The facility's physical restraint policy was requested and received on 12/06/18 at 9:35 a.m. from the DON (director of nursing). The policy, "Restraints: Physical Restraint Evaluation" included, "Policy: Restraints shall only be used for the safety and well-being of our guests and only after all other alternatives have been tried unsuccessfully. Restraints must be used only as a last resort, and the medical record must indicate the events which led up to the necessity for restraint usage. Restraints are not to be used for a punishment, for the convenience of the staff, or as a substitute for supervision...A Restraint is any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the guest's body that the guest cannot remove easily which restricts freedom of movement or normal access to one's body..."

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F 604	Continued From page 7 The Administrator and Director of Nursing were informed of the above findings during an end of the day meeting with the survey team on 12/05/18 at 4:20 p.m. No further information was received by the survey team prior to the exit conference on 12/06/18.	F 604		
F 623 SS=C	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 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;	F 623		1/18/19

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F 623	Continued From page 8 (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. §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	F 623		

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F 623	Continued From page 9 (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 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 record review and staff interview the facility failed to notify the Office of the State Long-Term Care Ombudsman and the responsible party (RP) in writing of discharge to the hospital for two of 26 Resident's, Resident #37 and Resident #117. 1. Resident #37 was discharged to hospital and the facility did not notify the State Ombudsman's office or the RP in writing. 2. Resident #117 was discharged to hospital and	F 623	F623 Corrective Action(s): Resident #37 and #117□s resident representative and Ombudsman office has been notified that the facility failed to provide a discharge/transfer notice for the resident□s transfer to the hospital on 10/2/18 (#37) and 9/5/18 (#117). Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or	

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F 623	Continued From page 10 the facility did not notify the State Ombudsman's office or the RP in writing. The Findings Include: 1. Resident #37 was admitted to the facility on 6/10/16 with a readmission on 10/2/18. The most current MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 10/10/18. Resident #37 was assessed as short and long-term memory impairment and severely cognitively impaired. Diagnoses for Resident #37 included: Traumatic subarachnoid hemorrhage, dementia, and muscle weakness. According to documentation in Resident #37's nursing notes dated 10/1/18, Resident #37 was discharged to the hospital on 10/1/18 due to a fall, and returned to the facility on 10/2/18. On 12/5/18 at 9:00 AM the Director of Nursing (DON) was asked to present evidence that Resident #37's responsible party and the State Ombudsman's office had been notified in writing of the discharge to the hospital. On 12/05/18 10:19 AM during a meeting with the DON and Administrator they were asked about written notification in regard to being discharged to the hospital. The DON and Administrator verbalized unawareness of the regulation. No other information was presented prior to exit conference on 12/6/18. 2. Resident #117 was admitted to the facility on 8/18/18. The most current MDS (Minimum Data Set) was a 14 day assessment with an ARD	F 623	transferred from the facility have the potential to be affected by this alleged deficient practice. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified will be corrected at time of discovery and the required notifications to the residents responsible party and the state ombudsman will be made. Systemic Change(s): The Administrator and/or Regional Nurse Consultant will in-service the facility s social worker(s) and nursing administration on the requirement that a resident s responsible party and the state ombudsman be notified of resident discharges/transfers. Monitoring: The Social Services Director and Nursing Management will be responsible for maintaining compliance. The Social worker, and Nursing Management will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and/or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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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 11 (Assessment Reference Date) of 8/31/18. Resident #117 was assessed as being cognitively intact with a score of 15 out of 15. Diagnoses for Resident #117 included: Intracranial abscess, muscle weakness, delusional disorder. According to documentation in Resident #117's nursing notes dated 9/5/18, Resident #117 was discharged to the hospital on 9/5/18 due to a fall and did not return. On 12/5/18 at 9:00 AM the Director of Nursing (DON) was asked to present evidence that Resident #117's responsible party and the State Ombudsman's office had been notified in writing of the discharge to the hospital. On 12/05/18 10:19 AM during a meeting with the DON and Administrator, they were asked about written notification in regard to being discharged to the hospital. The DON and Administrator verbalized unawareness of the regulation. No other information was presented prior to exit conference on 12/6/18.	F 623	Completion Date: 1/18/2019	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths,	F 636		1/18/19

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F 636	Continued From page 12 goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not	F 636		

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F 636	Continued From page 13 apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident interview, and staff interview, the facility failed, for one of 26 residents in the survey (Resident # 30), to ensure a complete and accurate Minimum Data Set (MDS-an assessment tool). Resident # 30's use of a CPAP (Continuous Positive Airway Pressure) was not identified on his Admission Minimum Data Set. The findings included: Resident # 30, a 66 year-old male, was admitted to the facility on 12/20/17 with diagnoses that included hypertension, hyperlipidemia, Parkinson's Disease, depression, difficulty walking, generalized muscle weakness, malignant neoplasm of the prostate, and obstructive sleep apnea. According to the most recent Minimum Data Set (MDS), a Quarterly assessment with an Assessment Reference Date (ARD) of 10/5/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. During the initial tour of the facility, the resident	F 636	F636 Corrective Action(s): Records were reviewed and MDS assessments were modified as needed to reflect CPAP use for this resident. Current MDS assessment was updated to reflect CPAP use. Identification of Deficient Practices & Corrective Action(s): All residents requiring a CPAP have the potential to be affected by this alleged deficient practice. A 100% review of all resident rooms for CPAP medical equipment will be conducted by the DON, ADON, and/or designee to identify residents who have CPAP medical equipment. This list will be given to the MDS department to verify proper physician order, coding/corrections and accuracy on MDS assessments. Systemic Changes: The UM's will review new guests who are admitted with CPAP use and will be added to the current list of guest's with CPAP machines. The updated list will be	

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F 636	Continued From page 14 was not in the room at the time, but his roommate was present. While in the room, the surveyor observed a CPAP unit on the night stand next to Resident # 30's bed. Attached to the unit was the oxygen tubing, and attached to the end of the tubing was the frame for the CPAP mask. At 2:10 p.m. on 12/5/18, Resident # 30 was interviewed regarding his CPAP use. "I use it every night," Resident # 30 said. When asked where the CPAP came from, Resident # 30 said, "I brought it with me from home when I was admitted. It was already set up for use." Resident # 30's Admission MDS, with an ARD of 12/27/17, was reviewed. Under Section O (Special Treatments and Programs), at Item O0100-G, BiPAP/CPAP, the resident was not identified as using either a BiPAP or CPAP while not a resident of the facility, or while a resident of the facility. (CPAP use is only addressed on full MDS assessments, including Admission and Significant Change assessments). At 9:05 a.m. on 12/6/18, RN # 3 (Registered Nurse), the MDS Coordinator on Unit 2, was interviewed regarding Section O (Special Treatments and Programs) on Resident # 30's admission MDS. When asked how data is obtained to enter on Section O of the MDS, RN # said, "We get it from the physician's orders or from nursing. Sometimes we get it from interviews." RN # 3 was not aware the resident had a CPAP on admission. The resident's assessment under Section O of his Admission MDS, in which he was identified as not using a BiPAP or CPAP, was discussed	F 636	given to the MDS department once a week. MDS staff will observe the guest's room for CPAP equipment during the assessment process and then complete the MDS for proper coding/corrections and accuracy on assessments. CRS will in-service MDS staff on proper coding for medical equipment in use. Monitoring: The DON/Designee will review the list of guests who have a CPAP to ensure proper coding of the MDS for accuracy once a week for four weeks. Any inaccuracies will be corrected. These will be reported to the DON/Designee and then reviewed in QA. Any variances will be corrected and continued education provided. Results of the audits will be presented to the Quality Assurance Committee x 4 months. Continued compliance will be monitored through the facility's Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: 1/18/2019	

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F 636	Continued From page 15 during a meeting at 4:30 p.m. on 12/5/18 that included the Administrator, DON, ADON, and the survey team.	F 636		
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 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	F 656		1/18/19

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F 656	Continued From page 16 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, resident interview, staff interview, facility document review, and clinical record review, facility staff failed to develop a comprehensive care plan for the use of a restraint for one of 26 residents, Resident #109. Resident #109 was observed with her left leg tied to the leg of her wheelchair using a theraband on two separate occasions on 12/04/18, however the use of the theraband was not included in the comprehensive care plan. Findings included: Resident #109 was admitted to the facility on 10/16/18 with diagnoses of s/p (status post) fracture of left knee without surgical repair and vascular dementia. The most recent MDS (minimum data set) was a thirty day assessment with an ARD (Assessment Reference Date) of 11/13/18. Resident #109 was assessed as severely impaired in her cognitive status with a total cognitive score of seven out of 15. Resident #109 was observed in her room on 12/04/18 at 9:30 a.m., sitting in her w/c (wheelchair). Her left leg was in an immobilizer,	F 656	F656 Corrective Action(s): Resident #109□s comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident□s specific immobilizer. Identification of Deficient Practices & Corrective Action(s): All residents requiring leg immobilization have the potential to be affected by this alleged deficient practice. A 100% review of all comprehensive care plans for guests requiring leg immobilization will be conducted by MDS staff, RCS and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. Systemic Changes: The nursing assessment process as evidenced by the 24 Hours Report and	

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F 656	Continued From page 17 bent at the knee and not on the w/c leg rest. A red, stretch band (theraband) was noted tied around the w/c leg and the resident's left, lower leg. The resident stated, "I do exercises with that. It hurts when I do it. Yes, I get pain medicine and it does help." At approximately 10:15 a.m. Resident #109 was observed sitting at the nurse's station in her w/c with her left leg elevated on the w/c leg rest, with her immobilizer in place. Resident's leg was stretched outright and had a red, rubber, stretch band (theraband) tied around the leg rest and the resident's lower, left leg. Subsequent review of Resident #109's clinical record did not reveal any physician orders for use of a restraint. No documentation was located in the record for use of a theraband for positioning in nursing progress notes, physical therapy notes or occupational therapy notes. Review of the comprehensive care plan (CCP) did not include any interventions for use of a theraband for positioning. LPN #5 (licensed practical nurse), MDS coordinator was interviewed on 12/05/18 at 9:25 a.m. LPN #5 stated, "I didn't know anything about the use of a theraband until yesterday, so I added it to her care plan. Then, she went to the doctor and he changed her order to allow some flexion with her immobilizer in place. Her leg no longer needs to stay elevated on the w/c leg rest, so I removed it from her care plan this morning." The Administrator and Director of Nursing were informed of the above findings during an end of the day meeting with the survey team on 12/05/18 at 4:20 p.m. No further information was received	F 656	documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be in-serviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans. Monitoring: The RCS and MDS staff are responsible for maintaining compliance. The MDS staff and/or RCS will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the MDS staff or RCS for immediate correction. Detailed findings of the interdisciplinary team□s audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 1/18/2019	

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F 656	Continued From page 18 by the survey team prior to the exit conference on 12/06/18.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to implement interventions for the prevention of pressure ulcers for one one of 22 residents in the survey sample (Resident #31). The facility staff failed to implement interventions for the prevention of pressure injury/ulcers for Resident #31. Resident #31, an 80 year old, frail female resident with a body weight of approximately 87 lbs (pounds) had very fragile skin, the resident was not provided interventions to protect the resident's compromised skin integrity. Findings included:	F 686	F 686 Corrective Action(s): Resident #31□s wheelchair was replaced with a high back chair on 12/6/18. The oxygen tank was stored properly to avoid pressure to the resident□s skin. Treatment to the area was given. No further pressure problems have been noted and the area involved is healed. Identification of Deficient Practices & Corrective Action(s): All residents on oxygen requiring a wheelchair have the potential to be affected by this alleged deficient practice. The Director of Therapy and Unit Managers will audit residents with	1/18/19

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F 686	Continued From page 19 Resident #31 was admitted to the facility on 7/22/18. Diagnoses for Resident #31 included, but not limited to: dysphagia, muscle weakness, emphysema, COPD, anxiety disorder, hypokalemia, anemia, high blood pressure, depression, and difficulty walking. The most current MDS (minimum data set) was a significant change assessment dated 10/05/18. This MDS assessed the resident with a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. The resident required extensive assistance of one person for all ADL's (activities of daily living) except for eating (supervision/setup only) and walking in room/walking in corridor (activity did not occur/ADL activity itself did not occur), the resident required total assistance for bathing. The resident's mode of transportation was documented for a w/c (wheelchair) use. The resident was documented as weighing 95 lbs on this MDS and as receiving a pressure reducing mattress, pressure ulcer/injury care, applications of ointments/medications (other than to feet) and as receiving applications of non-surgical dressings (other than to the feet) for skin. The resident was documented as requiring oxygen. The resident also triggered in the CAA's (care area assessment) section of this MDS for, but not limited to, ADL's and pressure ulcers. On 12/04/18 at 11:11 AM Resident #31, was observed in her room sitting in her w/c. The resident stated that she has had the shingles and didn't think she was going to get over it. The resident stated that her feet are swelled (visibly swollen on observation). The resident's shoes were ill fitting, with the resident's feet swelled out of the shoes, with the shoes pressing on top of	F 686	wheelchairs and oxygen to ensure no pressure areas are noted due to the chairs and oxygen tanks. Those found out of compliance will be repositioned to avoid pressure to the resident□s skin. Systemic Change(s): The Director of Therapy and Unit Managers will audit residents with wheelchairs and oxygen to ensure no pressure areas are noted due to the chairs and oxygen tanks. Those found out of compliance will be repositioned to avoid pressure to the resident□s skin. The Assistant Director of Nursing and or designee will in-service therapy and nursing staff on proper positioning of residents in wheelchairs and oxygen tank positioning. Monitoring: The Unit Managers will audit 100% of residents in wheelchairs with oxygen to ensure proper placement of oxygen and proper wheelchairs are used weekly x 4 weeks. Any variances will be corrected and continued education provided. Results of the audits will be presented to the Quality Assurance Committee x 4 weeks. Continued compliance will be monitored through the facility□s Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: 1/18/2019	

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F 686	Continued From page 20	F 686		

the resident's feet.

On 12/04/18 at 11:52 AM Resident #31 stated that she has 'spots' on her from the shingles and has some spots on her back that hurt. The resident stated that the dressing on her back had been changed, but did not mind if it was observed on the next dressing change.

On 12/04/18 at 1:22 PM Resident #31 was observed again, sitting in her w/c in the same position. The resident stated that the w/c isn't comfortable. The resident was sitting in a w/c with moderate back support (regular length, not a high back w/c), which comes up to about the resident's bra strap area or just below the bra strap area on the spine. The resident was approximately 87 lbs (according to the clinical record). The resident was on continuous oxygen via NC (nasal cannula) attached to an oxygen concentrator. The resident's w/c had a portable oxygen tank cylinder attached to the back of the resident's w/c, the oxygen cylinder had an 'O-ring' on top of the oxygen tank and when the resident was relaxed and leaning back in the w/c, the resident's protruding spine is resting on the hard, metal 'O-ring' on the oxygen cylinder.

RN (Registered Nurse) #2 was interviewed regarding Resident #31. The RN was asked if the resident had a dressing change to the areas on her back. The RN stated that she didn't know, that RN #1 was the wound nurse and was supposed to have dressed the wound this morning. The RN stated that during the medication pass and pour, the resident's dressing was off and it was reported to the wound nurse.

RN #2 was asked to observe the resident in her

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F 686	Continued From page 21 room in her w/c and was asked to look at the resident's back. The resident sitting in the w/c with the resident's back resting on the portable oxygen tank O-ring', the RN asked the resident to lean forward and the RN pulled up the back of the resident's shirt. The resident had several small open areas which appeared to be the same as the other shingles lesions and had a linear indention approximately 3 inches long, which was darkened. The RN stated that the resident is supposed to have a dressing on that area and that during the medication pass this morning the dressing/bandage came off and the wound nurse was supposed to re-dress the area. The RN stated in reference to the resident's spine resting on the 'O-ring' on the oxygen cylinder on the w/c, "She needs a high back w/c." 12/04/18 01:58 PM Resident's w/c back, was observed not tall and not padded to provide support the resident's spine No areas on the skin assessments for the spine were listed in the clinical record. The resident's current CCP was reviewed and documented interventions for skin dated 07/13/18, which included: perform weekly skin assessments and report abnormal findings, conduct a weekly head to toe skin assessment, document and report abnormal findings, cue resident to reposition, encourage to float heels while in bed, pressure reduction mattress, provide assistance to reposition frequently and as needed, and use draw sheet or pad to help move up in bed. On 12/05/18 at 08:30 AM The resident was observed eating breakfast and a dressing change	F 686		

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to be performed by the RN #1 after the resident finished eating. The resident's w/c is the same as observed the day before. The moderate back, small w/c with the oxygen cylinder tank attached on the back with the metal "O" ring around the top of the tank. The oxygen cylinder tank is in a cloth sleeve the length of the tank and attached to the w/c via snap straps over the handles of the w/c and at the lower frame of the w/c. RN #1 stated that the resident's dressing changes have been changed, due to irritation.

On 12/05/18 at 08:59 AM Resident #31 was observed in bed and stated that she has one bump on her back and stated "it's probably where that knob is poking me in the back."

On 12/05/18 at 09:04 AM The Rehab director was interviewed regarding w/c positioning and was asked who looks at that. Per the Rehab director, it is primarily OT (Occupational Therapy) for positioning. The director stated, we have to get an order for w/c positioning for evaluation and stated that almost all of our residents are seen by therapy. The director stated we do screens once a week about 5 people, and will do everybody in the facility, it usually takes about 11 weeks to see everyone.

On 12/05/18 at 09:47 AM, RN #1 changed the dressing for Resident #31, while in bed. The resident was observed with her spine protruding at mid back. The resident had the same shingles lesions which appeared to have blistered and peeled off and an indentation across her back, which appeared to be from the edge of the thick pad under the resident. RN #1 stated, the resident isn't padded to prevent pressure back here and I will have to get someone to help me

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F 686	Continued From page 23 adjust her. At approximately 10:30 AM the resident was observed in the hall with restorative therapy. The resident was sitting in her w/c with no support and/or cushioning to prevent pressure related issues to the resident's bony prominence's. The restorative aide took the resident back to her room and was asked if she was aware of the resident's w/c with the 'O-ring' and the resident leaning back on it, with the resident's spine resting on the hard metal ring. The restorative aide stated that the resident usually has a pillow behind her back. The restorative aide was made aware that the resident did not have a pillow/cushion or support for her back during multiple observations the day before or for today, until this point. The restorative aide put a pillow behind the resident's back. At approximately 10:45 AM the rehab director (RD) was interviewed again and asked to look at the resident. The rehab director looked at the resident in the w/c and stated that the oxygen tank cylinder was not attached to the w/c correctly to prevent the 'O-ring' from being right on the resident' spine. The RD stated that the resident's skin is very fragile and should have padding or support, as well. The RD repositioned the oxygen cylinder. The resident stated, "She found the problem and fixed, thank you." On 12/05/18 at 4:21 PM at the end of day meeting with the DON, ADON, Administrator, the corporate MDS nurse, and clinical corporate nurse was conducted and they were made aware of the above concerns regarding interventions not implemented for the prevention of pressure injury/ulcer for Resident #31 for the resident's	F 686		

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F 686	Continued From page 24 back. No further information and/or documentation was presented prior to the exit conference on 12/06/18.	F 686		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure that one of 26 residents maintained acceptable parameters of nutritional status, Resident #39.	F 692	F692 Corrective Action(s): Resident #39 will be provided with total assistance with meals. Weekly weights will be obtained. Any weight loss will be	1/18/19

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F 692	Continued From page 25 Resident #39 was identified as having a significant weight loss. The facility staff failed to monitor the effectiveness of ordered nutrition supplements, and the resident continued to experience unplanned weight loss. At the time of the survey, the resident had lost an additional 1.5 pounds in three weeks. Findings were: Resident #39 was most recently admitted to the facility on 04/09/2017 with the following diagnoses, but not limited to: Type II diabetes mellitus, contractures of both hands, hypertension, Alzheimer's disease, major depressive disorder, and dysphagia. The most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 10/12/2018, assessed Resident #39 as severely impaired with a cognitive summary score of "03". Resident #39 was coded as needing set-up and supervision with meals. The next most recent MDS was a quarterly assessment with an ARD of 7/13/2018. Resident #39 was coded as needing supervision with one person physical assist on this assessment. Resident #39 was coded on the 10/12/2018 MDS as not experiencing any significant weight loss from the previous assessment, even though her weight declined from 96 pounds in July, to 77 pounds on the October assessment (20% weight loss). On 12/04/2018 at approximately 9:00 a.m., Resident #39 was observed in the Assistive	F 692	reported to the physician and dietician for follow up interventions and orders. The Registered Dietician will review the resident weekly in our Nutrition at Risk Meeting. The Unit Manager will review the resident□s percentage of intake of supplements and report to the physician and dietician any decreased percentages. Identification of Deficient Practices & Corrective Action(s): All residents have the potential to be affected by this alleged deficient practice. The Registered Dietician and Unit Manager will audit all current residents for significant weight loss in our Nutrition at Risk Meeting. Those found out of compliance will be assessed, orders reviewed and interventions put in place. Systemic Change(s): The Registered Dietician and Unit Manager will review residents with significant weight loss weekly in our Nutrition At Risk Meeting. Those found out of compliance will be assessed, orders reviewed and interventions put in place. The Assistant Director of Nurses and or designee will in-service Nurses and Dietary Administrative staff on the effectiveness of ordered nutrition supplements and unplanned weight loss. Monitoring: The Registered Dietician and DON will audit 100% of residents with significant weight loss intake of supplements weekly x 2 months. Any variances will be corrected and continued education	

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F 692	Continued From page 26 Dining Room eating her breakfast. She was wearing a clothing protector and was sitting at a table with other residents. Her diet was pureed and a plate guard was in place. While Resident #39 was feeding herself, her tongue was observed thrusting out of her mouth with each bite. There was puree food on the table around her plate and down the front of her clothing protector. She took her spoon and attempted to scrape up the spilled food. Her hands were contracted and several bites were spilled before reaching her mouth. No assistance was observed from the staff in the room. The clinical record was reviewed. Weights (in pounds) recorded were: 05/24/2018: 97.5 06/05/2018: 95.7 07/05/2018: 95.7 08/02/2018: 85.2 08/29/2018: 79.3 09/03/2018: 77.0 09/12/2018: 82.7 09/17/1018: 87.1 10/05/2018: 76.6 wheelchair 10/31/2018: 84.3 wheelchair 11/06/2018: 84.2 standing 11/06/2018: 84.2 11/12/2018: 80.9 wheelchair 11/14/2018: 81.3 wheelchair There were no weights obtained after 11/14/2018. A "Nutritional Re-Evaluation" dated 10/09/2018 was observed an contained the following information: "Most recent Height: 58 Most recent weight: 76.6 Usual Body Weight: 75-90 lb	F 692	provided. Results of the audit will be presented to the Quality Assurance Program x 4 weeks. Continued compliance will be monitored through the facility□s Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: 1/18/2019	

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F 692	Continued From page 27 BMI: 16 IBW: 84% Percent of Weight Change in 1 month: 0 Percent of Weight Change in 3 months: 20 Percent of Weight Change in 6 months: 20 Current Weight Trend: Guest with significant weight loss over the past 90/180 days Needs Supplemental/Fortified Foods: SF [sugar free] healthshakes TID [3 times per day], Boost Breeze BID [twice a day] at meals, Glucerna added BID. Ability to Chew/Swallow: no difficulties noted % of Food Intake: 50-75% Fluid Intake Consistency: 75% Ability to Feed Self: Max assistance Adaptive Devices: [none listed] Dietary Note: Guest with significant weight loss. Weight's have been fluctuating but appears to have had overall loss. Diet changed to Pureed in August with improvement noted in appetite and intake. Multiple supplements provided. Observed at noon meal drinking boost breeze. Supplements alone provide: 1440 kcals, 58 g protein, which should be sufficient to meet baseline nutrition needs. Needs increase assistance with feeding. Remains significantly underweight for height. Guest screens at high nutritional risk a this time. P: 1. Continue to follow in NAR [nutrition at risk]; 2. Encourage po intake >75% of meals and supplements; 3. Follow weights; 4. Follow per protocol." A "Nutritional Risk Score" dated 10/09/2018 was also observed. Resident #39 was identified to have a "high Risk" score of "12". The care plan was reviewed and contained the following information: "Potential for wt [weight] loss guest is on a	F 692		

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therapeutic diet with poor po intake... Goal: Guest will maintain weight within 1-3 lbs and consume at least 50 - 75% of meals thru next review...Interventions: Encourage to eat slowly, Follow NAR [nutrition at risk] protocol; meals to be eaten in Assertive [sic] Dining Room; Obtain weight at a minimum of monthly. Report significant weight changes of 5% X 30 days, 7.5% X 90 days, or 10% X 180 days to physician and dietician; Offer HS [hour of sleep] snacks while awake; Provide supplements per order; provide diet as ordered; staff to set up meals and assist as needed."

On 12/04/2018 at approximately 1:00 p.m., Resident #39 was observed in the assistive dining room eating lunch. Per CNA (certified nursing assistant) #1 there are usually "Three CNAs in here with about 15 residents." She explained that residents were seated according to the amount of assistance needed. She pointed to the table where Resident #39 had eaten breakfast and stated, "Those residents don't need much help...they are pretty independent...this table [where CNA #1 was sitting] need the most assistance." Resident #39 was sitting at the table with CNA #1 for her lunch time meal.

Resident #39 was observed feeding herself lunch. She was observed to consistently place the spoon to the left of her mouth and drag it into her mouth. As the food entered her mouth her tongue would thrust and the food would go down her chin, or the spoon in her contracted hand would spill before she could get the food into her mouth. She spilled food, down her clothing protector and onto the table. She attempted to get the spilled food up with spoon and put it into her mouth. There was no assistance from staff.

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F 692	Continued From page 29 When Resident #39 was done she took off clothing protector and pushed away from the table. CNA #1 was asked what assistance Resident #39 needed as her last nutritional evaluation indicated she was "Extensive assistance". CNA #1 stated that resident is "usually seated at a table with a staff member and is assisted and queued while eating...she has a plate guard to help her." She stated that when food is served they assist her with a first few bites and then she "Gets to going pretty good..when she slows down we offer to her...you saw what she just did...she was done so she took off her clothing protector and pushed away...she let's you know what she wants." Further review of the clinical record was conducted on 12/05/2018. A "Weight Change Note" dated 08/30/2018 was observed in the progress note section and contained the following: "WEIGHT WARNING: Value: 79.3 Vital Date: 2018-08-29 09:56:00.0 MDS: -5% change over 30 day(s) [6.9%, 5.9] MDS: -10% change over 180 day(s) [15.4%, 14.4] -5.0% change [6.9%, 5.9] -7.5% change [17.1%, 16.4] -10% change [15.4%, 14,4] Resident continues with gradual weight loss. Meal recently downgraded to puree with increase meal intake noted. New order per Dietitian to increase Med Pass BID. Order transcribed and faxed to pharmacy. RP [responsible party] aware of weight loss." The physician order sheet was reviewed. The	F 692		

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F 692	Continued From page 30 following orders regarding diet and supplements were observed: 9/9/2018 Glucerna BID 8/13/2018 Consistent Carbohydrate Diet, Pureed texture, regular consistency (downgraded from CCD Reg texture reg consistency) 1/10/2018 Sugar Free Health Shake TID (Increased from BID orig order 11/14/2017) 12/12/2017 Boost BID The MAR (medication administration record) was reviewed. The Boost and the Sugar Free Health Shakes had check marks on each day with a nurse's initials. The amount of the supplement consumed was not documented. The Glucerna also had check marks but the total amount of supplement consumed was also documented. At approximately 11:45 a.m. on 12/05/2018, the DM (dietary manager) was interviewed regarding Resident #39. She stated that she handled likes and dislikes for the residents, and the RD (registered dietitian) handled the clinical side. She was asked about Resident #39's weights. She stated, "She should be weighed weekly, she is a significant loss...let me see what I can find." She returned with a handwritten form. She stated, "This is from our NAR (Nutrition at Risk) meetings. We do these at our meetings." The RD note on the NAR was dated 11/15/2018 and contained the following information: Current Wt: 81.3 lb Prior Wt: 75.6 lb Current Diet CCD Puree with supplements Notes: Observed guest at noon meal. Ate 100% of her tray. Uses divided plate & sides to feed self with supervision. Tolerates pureed diet well. Wt [increased] 7 lb/6% + 30 days...wt gain	F 692		

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F 692	Continued From page 31 desired...remains thin for ht [height]. Recommendations: 1) Cont current nutr [nutrition] plan. 2) goal is for additional wt gain 1-2 lb/month." The DM stated, "I called her [the RD] and she will be here today at 2:00 to talk to you about [name of resident]." The RD was interviewed on 12/05/2018 at 2:00 p.m. Resident #39's weights were discussed. A weight of 79.8 lbs, obtained earlier that day was observed in the clinical record, indicating an additional weight loss of 1.5 lbs since November 14th. The RD stated that the resident had been discussed in the NAR meeting the previous day. She was asked what was discussed. She stated, "That she should have been getting weekly weights...that's all we discussed about her." The RD was asked if a weight was requested or if she had documented the discussion anywhere. The RD stated that she had documented on Resident #39 on 11/15/2018 and would document on her again on 12/15/2018. She stated, "We have a plan in place." She pointed to the NAR note from 11/15/2018 and stated, "We are going to continue her current nutrition plan and our goal is for additional weight gain of 1-2 pounds per month...she is eating 75 percent of her meals and she is getting supplements." The dining observation of breakfast and lunch on 12/05/2018 were discussed with the RD. She stated, "Yes she has a tongue thrust that makes it difficult for her to eat...but her supplements alone provide adequate calories and protein for her to gain weight." The MAR was shown to the RD and she was asked how she knew how much of each supplement Resident #39 was taking in since the amount consumed was not recorded. She	F 692		

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stated, "They are giving them to her." The RD was asked what the next step was for Resident #39 as no new interventions had been implemented since 09/09/2018 and she continued to lose weight. She stated, "I don't think it is her diet...maybe it is something medical." She was asked if the she had spoken to the physician about the weight loss. She stated, "He is aware." She was asked what he wanted to do. She stated, "I don't know what his plan is." The RD was asked about the possibility of fortified foods. She stated, "She is a diabetic...fortified foods are high in carbohydrates and fat...I don't want to overload her...the way I see it she is a tiny little lady and she is over 90 years old...I will look at her again and document on her on December 15th."

On 12/05/2018 at approximately 4:30 p.m., an end of the day meeting was held with the DON (director of nursing), the ADON (assistant director of nursing) the administrator and the corporate consultants. The above information was discussed and any further documentation from the physician or the nurse practitioner regarding Resident #39's weight loss was requested. The DON was also asked to provide any documentation regarding the amount of supplements consumed by Resident #39. A copy of any policies or procedures regarding the Nutrition at Risk Protocol were also requested.

On 12/06/2018 at approximately 8:00 a.m., LPN (licensed practical nurse) #4 was interviewed regarding documentation on the MARS for Resident #39's supplements. He looked at the MAR and stated, "The check mark means that she got the supplement, we gave it to her...the Boost it comes with her tray and the CNA

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F 692	Continued From page 33 [certified nursing assistant] writes down the totals... the health shakes are given as snacks...the CNAs write down those amounts, but the glucerna the nurses give, that is why there is a place to enter the amount that she actually drank." LPN #4 was asked if the CNAs documented the supplements separately during the meal times or in the daily intake totals. He stated, "No, it is all together in the percentage of the meal eaten and in the fluid taken in...it is not broken down between the food and the supplements..." LPN #4 was asked how someone could tell how much of each supplement Resident #39 was actually taking in. He stated, "I see what you are saying, we maybe should enter it on the MAR to see how much she is drinking of her supplements." At approximately 9:00 a.m., the DON came to the conference room. She stated, "I don't have any documentation from the physician about her weight loss....she [Resident #39] is being seen by speech therapy this morning." The DON also presented the "Nutrition At Risk Overview" which contained the following information: "If, despite appropriate interventions by the disciplinary team, the guest is not consuming sufficient nutritional support to meet his/her nutritional needs, the responsible party, guest and the physician shell be consulted for guidance regarding the course of care desired...there shall be documented clinical basis for any conclusion that the nutritional status or significant weight change is likely to stabilize, improve or decline further by the physician within the medical record (e.g., documentation as to why weight loss is clinically unavoidable)." At approximately 9:30 a.m., the speech therapist was interviewed. She stated that she had worked	F 692		

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F 692	Continued From page 34 with Resident #39 in August (2018) due to her difficulty chewing and her weight loss. She stated, "Her problem is mostly oral due to her Tardive Dyskinesia and she doesn't wear her dentures...she has them but her tongue thrust from her Tardive Dyskinesia is so strong she pushes them out even when an adhesive is used....I downgraded her diet to puree and she did better with that....I went in her room today to watch her eat breakfast. She had just gotten out of the shower and a CNA was in there feeding her this morning...she normally feeds herself but they were feeding her this morning." The observations from earlier in the week were discussed. She stated, "I can't downgrade her any further...I'll watch her at lunch today and see if there is anything else we can do." No further information was obtained prior to the exit conference on 12/06/2018.	F 692		
F 695 SS=E	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 observation, clinical record review, resident interview, staff interview, and review of facility documents, the facility failed for one of 26 residents in the survey sample (Resident # 30), to	F 695	F 695 Corrective Action(s): A physician□s order was obtained for resident #30□s CPAP machine on 12/5/18	1/18/19

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	495377	A. BUILDING _____ B. WING _____	C 12/06/2018

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THE LAURELS OF CHARLOTTESVILLE	490 HILLSDALE DRIVE CHARLOTTESVILLE, VA 22901

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F 695	Continued From page 35 ensure the resident had a physician's order for the use of a CPAP (Continuous Positive Airway Pressure) unit. Resident # 30 used a CPAP unit for 11 and a half months without a physician's order. The findings were: Resident # 30, a 66 year-old male, was admitted to the facility on 12/20/17 with diagnoses that included hypertension, hyperlipidemia, Parkinson's Disease, depression, difficulty walking, generalized muscle weakness, malignant neoplasm of the prostate, and obstructive sleep apnea. According to the most recent Minimum Data Set, a Quarterly assessment with an Assessment Reference Date (ARD) of 10/5/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. During the initial tour of the facility, the resident was not in the room at the time, but his roommate was present. While in the room, the surveyor observed a CPAP unit on the night stand next to Resident # 30's bed. Attached to the unit was the oxygen tubing, and attached to the end of the tubing was the frame for the CPAP mask. A thorough review of Resident # 30's Electronic Health Record (EHR) failed to reveal any orders for the resident's use of a CPAP unit. Resident # 30's care plan, dated 12/20/17, included the following problem, "Respiratory, (Name of resident) has a DX (diagnosis) of obstructive sleep apnea. Potential for respiratory distress." The goal for the problem was, "(Name	F 695	and the settings were verified for this patient. Identification of Deficient Practices & Corrective Action(s): All residents requiring a CPAP machine have the potential to be affected by this alleged deficient practice. A 100% review of all resident rooms for medical equipment in use without orders will be conducted by the DON, ADON, and/or designee to identify residents who have medical equipment with no physician orders. Residents identified with medical equipment without a physician order will have their physician contacted for clarification for continued use. Systemic Change(s): The Unit Managers will audit residents on CPAP machines to ensure orders are obtained. Those found out of compliance will be corrected. The Assistant Director of Nursing and or designee will in-service nursing staff on obtaining orders for CPAP machines. Monitoring: Unit Managers will audit 100% of residents on CPAP machines to ensure orders are entered and correct weekly x 4 weeks. Any variances will be corrected and continued education provided. Results of the audits will be presented to the Quality Assurance Committee x 4 weeks. Continued compliance will be monitored through the facility□s Quality Assurance Program. Additional education and monitoring will be initiated for any	

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F 695	Continued From page 36 of resident) will be free from s/sx (signs and symptoms) of respiratory difficulty qd (everyday) through next review." The interventions to the stated problem were: "Administer medications and and treatments per physician orders; Encourage fluids as appropriate/tolerated; Encourage frequent rest periods; Observe guest's respiratory status PRN (as needed), Report abnormalities to physician; Observe for and document signs and symptoms of respiratory difficulty, report abnormal finding to physician." There was no mention in the Resident # 30's care plan of his CPAP use. At approximately 8:00 a.m. on 12/5/18, the surveyor spoke with the Director of Nursing (DON), and explained there was no order in Resident # 30's EHR for his use of a CPAP unit. The DON said she would look for the order. During a meeting with the DON and the ADON (Assistant Director of Nursing) at 10:15 a.m. on 12/5/18, the DON was asked about the CPAP order for Resident # 30. "The order for the CPAP was obtained this morning," the DON said. Neither the DON nor the ADON could offer an explanation as to why there had not been an order for Resident # 30's CPAP until 12/5/18. Further review of Resident # 30's EHR revealed the following order, dated 12/5/18 at 8:27 a.m., "CPAP with nasal mask to be worn during HS (at night)." During the 10:15 a.m. meeting with the DON and ADON, the surveyor requested a copy of the	F 695	identified concerns. Completion Date: 1/18/2019	

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F 695	Continued From page 37	F 695		

facility policy regarding CPAP use. At approximately 10:30 a.m. on 12/5/18, the ADON gave the surveyor the facility's policy on "CPAP-Continuous Positive Airway Pressure." The following was noted during review of the policy:

"Policy:
CPAP MUST NOT be use for life support. It is not a ventilator. CPAP requires a physician's order and the initial settings must be established by a respiratory therapist/respiratory provider. All orders must include the following:
1. CPAP unit (CPAP)
2. Pressure setting(s)
3. Oxygen order (if applicable)
4. Delivery device and size (mask)
5. Frequency of therapy (continuous, at HS, etc.)
6. Need for humidifier

The order obtained on 12/5/18 for CPAP use by Resident # 30 failed to include any information regarding pressure settings, an oxygen order, delivery device size, or need for humidifier.

At 11:15 a.m. on 12/5/18, the Rehab Director was interviewed regarding the availability of a Respiratory Therapist. The Rehab Director said, "We do not have Respiratory Therapist on staff." Asked how CPAP units are set up for residents, the Rehab Director said, "Nurses take care of the settings on CPAP. They get them from the physician, or from home if the resident brings it (CPAP) in."

At 2:10 p.m. on 12/5/18, Resident # 30 was interviewed regarding his CPAP use. "I use it every night," Resident
30 said. When asked where the CPAP came

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F 695	Continued From page 38 from, Resident # 30 said, "I brought it with me from home when I was admitted. It was already set up for use." Resident # 30's CPAP use was discussed during a meeting at 4:30 p.m. on 12/5/18 that included the Administrator, DON, ADON, and the survey team.	F 695		
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	F 758		1/18/19

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F 758	Continued From page 39 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed for one of 26 residents in the survey sample (Resident # 30), to ensure the resident was free from unnecessary medications. Resident # 30 had an order for a PRN (as needed) psychotropic medication that extended for more than 14 days, and that did not have an end date. The findings were: Resident # 30, a 66 year-old male, was admitted to the facility on 12/20/17 with diagnoses that included hypertension, hyperlipidemia, Parkinson's Disease, depression, difficulty walking, generalized muscle weakness, malignant neoplasm of the prostate, and obstructive sleep apnea. According to the most	F 758	F758 Corrective Action(s): Resident #30□s Lorazepam was discontinued 12/17/18. Identification of Deficient Practices & Corrective Action(s): All residents receiving prn psychotropic medications have the potential to be affected by this alleged deficient practice. The Unit Manager will audit all residents on psychotropic medications to ensure all currently have stop dates. Systemic Change(s): The Unit Manager will audit all residents on prn psychotropic medications to ensure stop dates are implemented. The	

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F 758	Continued From page 40 recent Minimum Data Set, a Quarterly assessment with an Assessment Reference Date of 10/5/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Review of the Electronic Medication Administration Record (EMAR) in the resident's Electronic Health Record (EHR) for the month of December 2018, revealed the following medication order: Lorazepam Tablet 0.5 mg. (milligrams). Give 0.25 mg by mouth every 24 hours as needed for moderate anxiety, 0.5 mg QD (everyday) for breakthrough. Take at least 8 hours after AM dose. The start date for the PRN Lorazepam was 9/13/18. There was no end date for the Lorazepam order. According to a review of the EMAR's in Resident # 30's EHR, beginning with the order dated 9/13/18, and extending through October, November, and as of 12/5/18, the date of record review, the resident had not received any PRN Lorazepam. (NOTE: Lorazepam [Ativan] is a short acting benzodiazepine used in the treatment of anxiety and anxiety with depression. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722.) At 10:15 a.m. on 12/5/18, the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) were interviewed regarding the order for PRN Lorazepam for greater than 14 days and	F 758	Assistant Director of Nurses and or designee will in-service nurses on stop dates for prn psychotropic medications. Monitoring: Unit Managers will audit 100% of residents on prn psychotropic medications to ensure stop dates are in place weekly x 4 weeks. Any variances will be corrected and continued education provided. Results of the audit will be presented to the Quality Assurance Committee x 4 weeks. Continued compliance will be monitored through the facility□s Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: 1/18/2019	

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F 758	Continued From page 41 without an end date. Neither the DON nor the ADON was aware of the order, and both were unable to explain why the resident's physician would have written the order for longer than 14 days, and without an end date. The PRN order for Lorazepam was also discussed during a meeting at 4:30 p.m. on 12/5/18 that included the Administrator, DON, ADON, and the survey team.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		1/18/19

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F 761	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure Tuberculin PPD (purified protein derivative) solution was disposed of within 30 days of opening per manufacturer's instructions, in one of three refrigerators in the facility. One multi-dose vial of PPD solution was observed opened and available for administration on the 100 unit refrigerator. The vial and box were dated 10/24/2018. The findings were: On 12/05/2018 at approximately 9:30 a.m., the refrigerator on the 100 unit was inspected with LPN (licensed practical nurse) # 2. Observed in the refrigerator was an opened multi-dose vial of Tuberculin PPD solution. The box and the vial were both dated 10/24/2018. LPN #2 was asked what the date indicated. She stated, "That's when it was opened." She was asked how long a multi-dose vial of PPD solution could be opened before it would need to be discarded. She stated that she thought the vial was good until the expiration date. She looked at the vial and stated, "It expires May 2020." She was asked if the vial would be considered OK to use until that time. She stated, "Yes, I think so." At approximately 9:45 a.m., the DON (Director of Nursing) was asked for the facility policy on storage of multi-dose vials and their usage. A copy of the facility policy, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" was presented. Per the facility	F 761	F761 Corrective Action(s): The expired PPD solution was discarded on 12/5/18. Identification of Deficient Practices & Corrective Action(s): All residents have the potential to be affected by this alleged deficient practice. The Unit Manager will audit 100% PPD solutions on each unit to ensure solutions are discarded before the expiration date. Systemic Change(s): The Unit Manager will audit 100% PPD solutions weekly to ensure solutions are discarded before the expiration dates. The Assistant Director of Nurses and or designee will in-service nurses on expiration dates and disposal of PPD solutions. Monitoring: Unit Managers will audit PPD solution dates weekly x 4 weeks. Those found out of compliance will be destroyed and continued education provided. Results of the audits will be presented to the Quality Assurance Committee x 4 weeks. Continued compliance will be monitored through the facility□s Quality Assurance Program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: 1/18/2019	

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F 761	Continued From page 43 policy, "...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Facility staff may record the calculated expiration date based on date opened on the medication container." Also presented was the package insert from the Tuberculin PPD box. Per the manufacturer's guidelines, "Storage...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The above information was discussed during an end of the day meeting on 12/05/2018 with the DON, the ADON (Assistant Director of Nursing) and the Administrator. No further information was obtained prior to the exit conference on 12/06/2018.	F 761		
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	F 812		1/18/19

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F 812	Continued From page 44 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to procure, serve and store food in a sanitary manner in the main kitchen. Food temperatures were not obtained in a sanitary manner. The thermometer used to check the food temperatures was not properly sanitized before and between obtaining each food temperature. The findings include: On 12/04/18 at 7:30 AM the main kitchen was entered for initial tour. The steam table of prepared foods was set up for plating and distribution. Three dietary aides were in the kitchen for breakfast. Dietary Aide (DA) #7 stated that the food temperatures had not yet been obtained. This DA found a thermometer and attempted to calibrate the thermometer for approximately 10 minutes. The thermometer could not be calibrated by the DA. The DA was asked if this was the only thermometer in the kitchen. DA #9 stated that she would look in the office of the dietary manager. A few minutes later DA #9 came with a brand new thermometer, still in the packaging. DA #7 unwrapped the	F 812	F812 Corrective Action(s): Alcohol swabs were obtained and made available to dietary staff for sanitizing food thermometers. Staff were in-serviced on the proper procedures to follow for sanitizing food thermometers while checking food temperatures. Identification of Deficient Practices & Corrective Action(s): All residents have the potential to be affected by this alleged deficient practice. Alcohol swabs were provided to staff for proper sanitation procedures and staff were in-serviced on where to obtain alcohol swabs for future use. Systemic Changes: Dietary Manager will in-service dietary staff on proper sanitation procedures for thermometers while taking food temperatures and where to obtain needed supplies to properly perform the sanitation process. Monitoring: The Dietary Manager is responsible for	

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F 812	Continued From page 45 thermometer and rinsed in water and again began to calibrate the thermometer for approximately 5 minutes. DA #7 then stuck the thermometer down into the sausage for a temperature, removed the thermometer and then went to put the thermometer into the egg omelettes. DA #7 was asked if there were sanitary wipes available for the thermometer to be used before and between thermometer use. DA #7 then asked DA #9 to go and check to see if there were any sanitary wipes. DA #9 went to the dietary manager's office again and came out and stated that there were none. DA #7 then told DA #9 that she needed something to clean the thermometer with. DA #9 then left the area and returned with a dry wash cloth. DA #7 wet the wash cloth and wiped the thermometer (no soap and/or sanitation applied). DA #7 was asked if this was how they normally cleanse the thermometer. DA #7 stated, "I can user paper towels." DA #7 then went to the sink and pulled out some paper towels and proceeded to wipe the thermometer with a paper towel after each temperature was obtained. At approximately 9:00 AM, the dietary manager (DM) was interviewed and made aware of the above. The DM was asked how this process is normally performed. The DM stated that the thermometer is supposed to sanitized before and after each food temperature is taken and stated, "They know that." The DM stated that the wipes were in her office and they (the dietary aides) knew where they were. The DM was made aware that the DA's checked the office and area and the sanitizing wipes were not found. The DM was asked for a policy for proper sanitation of the thermometer for checking food temperatures.	F 812	maintaining compliance. The Dietary Manager will perform and monitor the food temperature testing process weekly for compliance. Any/all negative findings will be reported to the Dietary Manager for immediate correction. Detailed findings of the interdisciplinary team□s audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 1/18/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	490 HILLSDALE DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 46 On 12/04/18 at approximately 1:15 PM, a policy was presented and reviewed. The policy titled, "Thermometer calibration and sanitation" documented, "...thermometers shall be sanitized prior to use, between each food item tested and before storing...remove any visible soil with paper towel...using an alcohol prep swab or an approved sanitizer...wipe the stem of the thermometer...new alcohol swab shall be used for each sanitation..." The DON (director of nursing) and the administrator were made aware in a meeting on 12/04/18 at approximately 4:30 PM No further information and/or documentation was provided prior to the exit conference.	F 812		