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	495246	A. BUILDING _____ B. WING _____	C 02/07/2019

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WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(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 657	Continued From page 104 ordered. 5. The facility staff failed to review and revise Resident #1's care plan to include oxygen administration. 6. The facility staff failed to review and/or revise Resident # 309's care plan to reflect the physician's order to discontinue a Foley catheter. The findings include: 1. The facility staff failed to evidence that Resident #39's comprehensive care plan was reviewed and/or revised after a fall on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19. Resident #39 was most recently readmitted to the facility on 12/6/18 with the diagnoses of but not limited to dementia, diabetes, chronic back pain, high blood pressure, history of femur fracture, overactive bladder, adjustment disorder with anxiety, and osteoarthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/3/18. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for eating; and supervision for hygiene, toileting, dressing, and transfers. A review of the nurse's notes revealed one dated 11/8/18, which documented, "A change in condition has been noted. The symptoms include: Falls 11/8/18 in the afternoon...Orders obtained include: NNO (no new orders)..." This note did not document the circumstances	F 657	3. Nurse Practice Educator, ADON and or designee to in-service 100% of licensed nursing staff on process for reviewing and revising a care plan. 4. ADON, Nurse Practice Educator and or designee will audit 20 care plans weekly for 4 weeks, then randomly thereafter, to ensure care plans are reviewed and revised as appropriate. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/19	

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F 657	Continued From page 105 surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 11/8/18 documented, "Resident feel {sic} in dining room trying to reach across the table to get her stuffed cats. Resident fell to floor and hit her head. Resident stated that her head no long {sic} hurt after a few mins (minutes) and was able to get up from the floor with assistance. Resident was assessed for any injuries and none were found....Interventions added immediately after fall and care plan updated: Resident was educated on not leaning while in chair." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and/or revised following this fall. A review of the nurse's notes revealed one dated 12/24/18, which documented, "A change in condition has been noted. The symptoms include: Falls 12/24/18 in the morning....Change reported to Primary Care Clinician...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 12/24/18 documented, "Resident was found on the floor beside her bed with no injuries, tolerated ROM (range of motion) well with no difficulty, vital signs were taken and neuro (neurological) checks	F 657		

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F 657	Continued From page 106 initiated....Interventions added immediately after fall and care plan updated: Resident had disabled alarm prior to fall, alarm was replaced." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and/or revised following this fall. A review of the nurse's notes revealed one dated 1/1/19, which documented, "A change in condition has been noted. The symptoms include: Falls....Change reported to Primary Care Clinician....Orders obtained included: Continue to monitor aware of the complaints of buttocks pain no bruising present" This note did not document the circumstances surrounding the fall and if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/1/19 documented, "The resident was toileted by the CNA (Certified Nursing Assistant) was instructed to pull call bell when she was done. The resident did not was noted to be lying on the floor near her bed....Interventions added immediately after fall and care plan updated: Staff to remain with the resident while in the bathroom." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and/or revised following this fall. A review of the nurse's notes revealed one dated 1/6/19, which documented, "A change in condition has been noted. The symptoms include: Falls	F 657		

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F 657	Continued From page 107 1/6/19 in the morning." A second note dated 1/6/19 documented, "....The resident has no new changes in the ROM, usual complaints of general body ache...." A third note dated 1/6/19 documented, "....NP (nurse practitioner)...aware of the falls this am there are no new orders." There was no incident report related to this fall provided. These notes did not document the circumstances surrounding the fall and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and/or revised following this fall. A review of the nurse's notes revealed one dated 2/3/19, which documented, "A change in condition has been noted. The symptoms include: Falls in the morning....Change reported to Primary Care Clinician....Orders obtained included: Continued observation...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 2/3/19 documented, "The resident had just been toileted and wanted to make her bed which was already done by the CNA (Certified Nursing Assistant). She wanted to place her blankets and	F 657		

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F 657	Continued From page 108 had taken her shoes off and her feet slipped and she was found in a kneeling position next to her bed. The residents shoes were placed on and she was assisted via a gait belt which she pushed herself up and placed into her w/c (wheelchair). Neuro checks were initiated....Interventions added immediately after fall and care plan updated: Continued education and encouragement to be compliant." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and/or revised following this fall. On 2/06/19 at 1:47 p.m., an interview was conducted with CNA #1 (Certified Nursing Assistant). When asked what a care plan is, CNA #1 stated, "All the basic information about how to care for a resident." When asked if she has access to the residents care plan, CNA #1 stated, "Yes, it's on our tablet." On 2/06/19 at 2:17 p.m., in an interview with LPN #2 (Licensed Practical Nurse), when asked what the purpose of a care plan, LPN #2stated, "It has all you need so you know what to do for a particular resident." When asked what information is on a care plan, LPN #2 stated, "diagnoses, skin integrity, UTI (urinary tract infection)." When asked who has access to the care plan, LPN #2 stated, "nursing and administration." When asked who can review and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the	F 657		

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F 657	Continued From page 109 purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, adl (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, she was notified that the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any injuries, and if there were any care plan reviews or revisions. A review of the facility policy, "Person-Centered Care Plan" documented, "A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments....7. Care plans will be:...7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals...." No further information was provided by the end of the survey.	F 657		

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F 657	Continued From page 110	F 657		

2. The facility staff failed to evidence that Resident #31's comprehensive care plan was reviewed and/or revised after a fall on 1/18/19.

Resident #31 was admitted to the facility on 5/26/18 with the diagnoses of but not limited to high blood pressure, cardiomyopathy, stroke, atrial fibrillation, pacemaker, dementia, contracture, seizures, chronic kidney disease and acute kidney failure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/5/18. 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; extensive care for transfers, dressing, toileting and hygiene; and limited assistance for eating.

A review of the nurse's notes revealed one dated 1/18/19, which documented, "A change in condition has been noted. The symptoms include: Falls 1/18/19 at night....Change reported to Primary Care Clinician...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall.

A review of the "Event Summary Report" dated 1/18/19 documented, "Resident was found face down beside his bed with no injuries, tolerated ROM [range of motion] well, res [resident] stated "I am trying to grab something from the floor" denies any pain/discomfort....Interventions added

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F 657	Continued From page 111 immediately after fall and care plan updated: Educated resident to use call bell at all times." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and/or revised following this fall. On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, she was notified that the legal clinical record did not reflect the above data regarding how this fall occurred, if there were any injuries, if there were any care plan reviews or revisions. No further information was provided by the end of the survey. 3. The facility staff failed to evidence that Resident #15's comprehensive care plan was reviewed and/or revised after a fall on 1/28/19. Resident #15 was admitted to the facility on 7/9/15 with the diagnoses of but not limited to atrial fibrillation, high blood pressure, hypothyroidism, acute kidney injury, pacemaker, and congestive heart failure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/18/18. The resident was coded as mildly cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing;	F 657		

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F 657	Continued From page 112 supervision for transfers and toileting; and was independent for dressing, eating, and hygiene. A review of the clinical record revealed a nurse's note dated 1/28/19, which documented, "A change in condition has been noted. The symptoms include: Fall on 1/28/19 at night....Change reported to Primary Care Clinician....Orders obtained include: Have PT (physical therapy) eval (evaluate) for functional status." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/28/19 documented, "heard res (resident) calling help, entered res room and observed her sitting on the floor between w/c [wheelchair] and bed., holding on to bed and w/c, on neuro [neurological] checks, abrasion to upper mid-back, no bleeding. NP (nurse practitioner) made aware and ordered PT [physical therapy] to eval [evaluate], res rp (responsible party) made aware of fall with abrasion and res need for more assist with ADLs (activities of daily living)....Interventions added immediately after fall and care plan updated: Refer to PT, enc (encourage) res to call for assist before getting oob (out of bed)." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and/or revised following this fall. On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff	F 657		

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F 657	Continued From page 113 Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, she was notified that the legal clinical record did not reflect the above data regarding how the fall occurred and if there were any injuries, and if there were any care plan reviews or revisions. No further information was provided by the end of the survey. 4. The facility staff failed to evidence that Resident #35's comprehensive care plan was updated to include the resident's behaviors of going on leave of absences from the facility unsupervised, and his non-compliance with returning within the specified 4-hour window as ordered. Resident #35 was admitted to the facility on 5/22/18 with the diagnoses of but not limited to hip fracture, atrial fibrillation, high blood pressure, falls, inguinal hernia, and cardiomyopathy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/23/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for transfers, locomotion, dressing, eating, toileting and required supervision for hygiene. A review of the clinical record revealed the following: A physician's order dated 8/2/18 that the resident	F 657		

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F 657	Continued From page 114 might go on LOA (leave of absence) for 4 hours on 8/3/18 to go to the bank. A physician's order dated 8/13/18 that the resident might go on LOA for 4 hours on 8/13/18. A physician's order dated 8/15/18 that the resident might go on LOA for 4 hours on 8/15/18. A physician's order dated 8/21/18 that the resident might go on LOA for 2 hours on 8/21/18. A physician's order dated 8/22/18 that the resident might go on LOA for 4 hours daily. A review of the nurse's notes revealed the following: A nurse's note dated 8/15/18 that documented, "Resident has order for LOA for 4 hrs [hours], resident left the facility at 99:45 {sic} but not back at 3pm. Safety maintained will continue to monitor." A nurse's note dated 8/15/18 that documented, "A change in condition has been noted. The symptoms include: Behavioral symptoms (e.g. agitation, psychosis) 8/15/18 in this afternoon...." No further information was documented. A nurse's note dated 8/16/18 documented, "Late Entry for 8-15-18 resident was observe by this writer and other staff news paper (sic.) on the floor resident pouring A-Jax / urine on the news paper (sic.) and pouring A Jax in urinal full of urine. This writer ask why and resident stated I wanted to see what dish detergent works the best. Call NP (nurse practitioner) to make aware of the altered mental status N.O. (new order) CBC {1} and BMP {2} in the AM resident own RP [responsible party]." A nurse's note dated 8/30/18 documented,	F 657		

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F 657	Continued From page 115 "Resident signed out at 1:30pm, today and stated that he was going to (name of bank) and not going to church tonight. Cousin and friend were contacted at 10pm today because resident was not back at facility. Unit manager on call was contacted. Resident made contact with facility soon after and was reported to unit manager on call. Unit manager will pick up resident from Firestone off of (location)...." A nurse's note dated 8/31/18 documented, "Late entry: This RN was contacted by nursing staff of residents (Sic.) failure to return to the facility following his departure for the bank earlier in the afternoon. Nursing staff was advised to make contact with RP to see if they knew where resident was located. This RN was advised that contact was made with residents (Sic.) cousin and friend, neither of which knew of his whereabouts. DON was notified of incident. Nursing staff was advised to call the sheriffs (Sic.) office non emergency number to report the residents (Sic.) failure to return. At approximately 10:30pm, this RN was notified by staff that (resident) had called the facility and stated he was at the Firestone and was unable to get back due to not having enough money for the cab ride. This writer went to pick up resident shortly after. Resident was found in front of the Firestone (location) sitting on the ground. Resident stated he left his bank card (Sic.) back at the facility and was unable to get a ride back. Resident returned to facility. This RN stressed the importance to the resident of returning in a timely manner and the need to be able to take his evening medicine. Resident expressed understanding. Resident was asked where he usually goes when he leaves the facility so if another incident occurs we know where to look. Resident stated that he	F 657		

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F 657	Continued From page 116 goes to the (name of bank) on (location) and is usually in the shopping center above or below the hospital. Resident returned to facility at approximately 11:30pm." A nurse's note dated 10/3/18 documented, "Patient left facility at 2:10p.m., for LOA was supposed to return by 6:10p.m.. Patient called facility at 7:50p.m., to say he was at the Bus Station in (location) with no way back. Patient returned at 9:30p.m. He stated, "Someone from the Bus Station gave me a ride back." Patient education given on Safety and if Patient is going out alone he must have money for Cab fare both ways and he must return back on time." A social services note dated 10/5/18 documented, "Met with patient, (OSM #14 - Other Staff Member - the Ombudsman) CNE (former Center Nurse Executive) to discuss resident's community visits. He has had two instances where he was out in the community and unable to get a ride home after 10pm. Discussed safety and need to be in building when he is scheduled to get his meds. Resident does not have a cell phone at this time. SW (social worker) is working to get him a Medicaid phone. After discussion (resident) is willing to agree to the following. Until he has a cell phone he will not leave the property of (the facility). An exception will be to attend church on Sunday as they will provide transportation both ways. Once he has a phone we will reopen the discussion of his trips into the community. Discussed changing his check to come to (facility) therefore eliminating his need to go to the bank. This would also allow him to have access to his money daily if he wants to purchase a snack. He was agreeable to do this. (Resident) was able to state what the outcome of	F 657		

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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 657	Continued From page 117 the meeting was in his own words. He will contact social work and the ombudsman as needed." A review of the care plan failed to reveal any evidence that the resident's community visits unsupervised, or his non-compliance with returning timely was care planned. On 2/7/19 at 1:24 p.m., in an interview with LPN (licensed practical nurse) #4, when asked if the resident's activity of leaving the facility unsupervised, and noncompliance with returning timely should be care planned, LPN #4stated it should have been. On 2/7/19 at 2:20 p.m., an interview was conducted with the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2). When asked about the resident's unsupervised outings into the community and issues he had of returning to the facility timely, ASM #1 stated that he was alert and oriented, his BIMS (Brief Interview for Mental Status exam) was a 15 (cognitively intact). She stated the physician was aware of the resident's outings and that it was his right to go out if he wanted to. When asked about the lack of care planning of his unsupervised outings and noncompliance with returning timely, ASM #1 stated it should have been care planned. No further information was provided. {1} CBC - "A CBC (complete blood count) is a commonly performed lab test. It can be used to detect or monitor many different health conditions. Your health care provider may order this test:	F 657		

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F 657	Continued From page 118 · As part of a routine check-up · If you are having symptoms, such as fatigue, weight loss, fever or other signs of an infection, weakness, bruising, bleeding, or any signs of cancer · When you are receiving treatments (medicines or radiation) that may change your blood count results · To monitor a long-term (chronic) health problem that may change your blood count results, such as chronic kidney disease." Information obtained from https://medlineplus.gov/ency/article/003642.htm {2} BMP - "The basic metabolic panel (BMP) is a frequently ordered panel of 8 tests that gives a healthcare practitioner important information about the current status of a person's metabolism, including health of the kidneys, blood glucose level, and electrolyte and acid/base balance. Abnormal results, and especially combinations of abnormal results, can indicate a problem that needs to be addressed." Information obtained from https://labtestsonline.org/tests/basic-metabolic-panel-bmp 5. The facility staff failed to review and revise Resident #1's care plan to include oxygen administration. Resident #1 was admitted to the facility on 4/23/18. Resident #1's diagnoses included but were not limited to low back pain, bladder cancer and high blood pressure. Resident #1's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/1/19, coded the resident as being cognitively intact. Section G coded Resident #1 as requiring extensive assistance of one staff with	F 657		

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F 657	Continued From page 119 bed mobility, transfers and personal hygiene. Section O coded the resident as receiving oxygen therapy during the last 14 days. Review of Resident #1's clinical record revealed a physician's order dated 1/25/19 for continuous oxygen, at two liters per minute via nasal cannula. Resident #1's care plan dated 1/29/19 failed to reveal documentation regarding oxygen administration. On 2/5/19 at 9:24 a.m. and 10:58 a.m., Resident #1 was observed sitting up in bed receiving oxygen via a nasal cannula. On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the purpose of a care plan. LPN #3 stated, "So the nursing staff can know how to really care for the resident and if they require any equipment or anything really." When asked if an oxygen dependent resident's care plan should be reviewed and revised to include oxygen administration, LPN #3 stated, "Yes." When asked why, LPN #3 stated, "That's what he is being treated with here and he has it; so what he has should be care planned." On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was obtained prior to exit.	F 657		

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F 657	Continued From page 120 6. The facility staff failed to review and/or revise Resident # 309's care plan to reflect the physician's order to discontinue a Foley catheter. Resident # 309 was admitted to the facility on 01/23/2019 with diagnoses that included but were not limited to: edema (2), respiratory failure (3), hypertension (4) and anxiety (5). Resident # 309's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/30/19, coded Resident # 309 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 309 was coded as requiring limited assistance of one staff member for activities of daily living. Under section "H Bladder and Bowel" Resident # 309 was coded for "Indwelling catheter." On 02/05/19 at 9:45 a.m., an observation of Resident 309 revealed she was lying in her bed receiving oxygen by nasal cannula. Further observation failed to evidence a catheter. When asked if she had a catheter Resident # 309 stated no. The "Physician Telephone Order" dated 02/01/19 for Resident # 309 documented, "D/C (discontinue Foley." The comprehensive care plan for Resident # 309 dated 02/04/2019 with a revision date of 02/04/2019 documented, "Focus. Resident requires indwelling catheter due to: neurogenic bladder." Under "Interventions" it documented, "Assess continued need of catheter. Date Initiated: 02/04/2019."	F 657		

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F 657	Continued From page 121 On 02/06/19 at 2:56 p.m., an interview was conducted with RN (registered nurse) # 6, MDS coordinator and LPN (licensed practical nurse) # 6, MDS nurse. After reviewing the "Physician Telephone Order" dated 02/01/19 for Resident # 309 and the comprehensive care plan dated 02/04/2019 for a Foley catheter, RN # 6 and LPN # 6 stated, "When the catheter was discontinued nursing should have revised or updated the care plan. When there is a change in the resident's status or there are new, orders nursing should revise/update the care plan. It wasn't done." On 02/06/19 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm. (2) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (3) 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. (4) High blood pressure. This information was	F 657		

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F 657	Continued From page 122 obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of facility documentation the facility staff failed to ensure professional standards for the administration of medications for one resident (Resident #35) in the survey sample of 55 residents. The facility staff failed to evidence the physician was notified, consulted and that orders were obtained to administer two medications late to Resident #35, when the resident returned to the facility late, over an hour past the scheduled time for administering two prescribed medications. The facility staff initialed/documented two 8:00 p.m., schedule medications as administered when the clinical record documented the resident was out of the facility on 8/30 and 10/3/18. The findings include:	F 658	F658 1. Resident #35, ADON notified the physician on 2/6/19 of the medications being administered late. 2. All residents are at risk for Physician not being notified of medication being administered late. 100% audit of current residents Medication Administration Records for the last 30 days were audited by Center Nurse Executive, ADON and or Designee, to ensure that any missed or late medication administration was notified to the physician 3. Nurse Practice Educator or, ADON or designee to in-service 100% of licensed nursing staff on proper physician notification when medications are administered late.	

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F 658	Continued From page 123 Resident #35 was admitted to the facility on 5/22/18 with the diagnoses of but not limited to hip fracture, atrial fibrillation, high blood pressure, falls, inguinal hernia, and cardiomyopathy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/23/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for transfers, locomotion, dressing, eating, toileting and as requiring supervision for hygiene. A review of the clinical record revealed a physician's order dated 8/22/18 that documented the resident may go on LOA (leave of absence) for 4 hours daily. A review of the nurse's notes revealed the following: A nurse's note dated 8/30/18 documented, "Resident signed out at 1:30pm, today and stated that he was going to (name of bank) and not going to church tonight. Cousin and friend were contacted at 10pm today because resident was not back at facility. Unit manager on call was contacted. Resident made contact with facility soon after and was reported to unit manager on call. Unit manager will pick up resident from Firestone off of (location)...." A nurse's note dated 8/31/18 documented, "Late entry: This RN was contacted by nursing staff of residents (Sic.) failure to return to the facility following his departure for the bank earlier in the afternoon. Nursing staff was advised to make contact with RP to see if they knew where resident was located. This RN was advised that	F 658	4. Audit of 10 random MARS/Tars to be complete by ADON or designee 5 X week for 4 weeks, and randomly thereafter, to review for medications delivered late to ensure that Physician was notified appropriately. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19	

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F 658	Continued From page 124	F 658		

contact was made with residents (Sic.) cousin and friend, neither of which knew of his whereabouts. DON was notified of incident. Nursing staff was advised to call the sheriffs (Sic.) office non emergency number to report the residents (Sic.) failure to return. At approximately 10:30pm, this RN was notified by staff that (resident) had called the facility and stated he was at the Firestone and was unable to get back due to not having enough money for the cab ride. This writer went to pick up resident shortly after. Resident was found in front of the Firestone (location) sitting on the ground. Resident stated he left his bank card (Sic.) back at the facility and was unable to get a ride back. Resident returned to facility. This RN stressed the importance to the resident of returning in a timely manner and the need to be able to take his evening medicine. Resident expressed understanding. Resident was asked where he usually goes when he leaves the facility so if another incident occurs we know where to look. Resident stated that he goes to the (name of bank) on (location) and is usually in the shopping center above or below the hospital. Resident returned to facility at approximately 11:30pm."

A nurse's note dated 10/3/18 documented, "Patient left facility at 2:10 p.m., for LOA was supposed to return by 6:10 p.m. Patient called facility at 7:50 p.m., to say he was at the Bus Station in (location) with no way back. Patient returned at 9:30p.m., He stated, "Someone from the Bus Station gave me a ride back." Patient education given on Safety and if Patient is going out alone he must have money for Cab fare both ways and he must return back on time."

A review of the clinical record revealed an order

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F 658	Continued From page 125 dated 5/23/18 for Cal-Gest {1}, 1 tab (tablet) twice daily for calcium supplement; and a Metoprolol {2} 50 mg (milligrams) twice daily for high blood pressure. A review of the August 2018 MAR (Medication Administration Record) documented that the resident was to receive the above medications at 8:00 p.m. On 8/30/18, these medications were documented as administered at 8:00 p.m., when the resident was documented in nurses' notes, as not present in the building between 1:30 p.m., and 11:30 p.m. There was no evidence that the physician was notified, consulted and orders were obtained to administer the medications late. A review of the October 2018 MAR documented that the resident was to receive the same two medications above at 8:00 p.m. On 10/3/18, these medications were documented as administered at 8:00 p.m., when the resident was documented in nurses' notes as not being in the building between 2:10 p.m. and 9:30 p.m. There was no evidence that the physician was notified, consulted and orders were obtained to administer the medications late. On 2/7/19 at 1:24 p.m., in an interview with LPN #4, was asked about the process staff follows when a resident is out on leave long enough to miss medications. LPN #4 stated the physician should be called to verify if the medications can be given or not. On 2/7/19 at 2:20 p.m., in an interview with the Executive Director (ASM [administrative staff member] #1) and Nurse Executive, ASM #2. When asked about the resident's unsupervised outings into the community and issues he had of	F 658		

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F 658	Continued From page 126	F 658		

returning to the facility timely, ASM #1 stated that he was alert and oriented, his BIMS (Brief Interview for Mental Status exam) was a 15 (cognitively intact). She stated the physician was aware of the resident's outings and that it was his right to go out if he wanted to. When asked about the resident's missed medications when he was late returning to the facility, ASM #1 stated that the doctor should have been notified and direction provided whether or not to administer them (medications) late. When asked what standard of practice the facility follows, she stated the facility policies and procedures.

A review of the facility policy, "Leave of Absence/Therapeutic Leave" did not include direction on procedures if the resident was out past a medication time and missed medications.

A review of the facility policy, "Leave of Absence, Resident Discharge with Medication or Other Change of Status" documented, "When a Facility physician/prescriber provides an order for the resident to take a leave of absence, the physician/prescriber should specify the medications the resident is to take with them while on leave....If the resident is taking a leave of absence for less than 24 hours, consider a change in the time for administration of a medication, if appropriate, to avoid the need to send that dose of medication with the resident...." The policy did not address what the procedure should be if the resident's leave was to be brief, but the resident missed the medications due to a late return.

The facility policy titled, "Medication Administration: General" documented, "A licensed nurse, Med Tech, or medication aide, per state

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F 658	Continued From page 127 regulations, will administer medications to patients...If discrepancies, ... notify physician/advanced practice provider (APP) and/or pharmacy as indicated..." No further information was provided. {1} Cal-Gest Antacid - "Calcium carbonate is a dietary supplement used when the amount of calcium taken in the diet is not enough. Calcium is needed by the body for healthy bones, muscles, nervous system, and heart. Calcium carbonate also is used as an antacid to relieve heartburn, acid indigestion, and upset stomach. It is available with or without a prescription." Information obtained from https://medlineplus.gov/druginfo/meds/a601032.html {2} Metoprolol - "Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure." Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html	F 658		
F 684 SS=E	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	F 684		

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F 684	Continued From page 128 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 resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow physician's orders and professional standards of practice for one of 55 residents in the survey sample, Residents #71. The facility staff failed to administer the medication Advair to Resident #71 per physician's order on multiple dates in November 2018 and January 2019. The findings include: The facility staff failed to administer the medication Advair (1) to Resident #71 per physician's order on multiple dates in November 2018 and January 2019. Resident #71 was admitted to the facility on 10/1/18. Resident #71's diagnoses included but were not limited to chronic obstructive pulmonary disease (2), low back pain and anxiety disorder. Resident #71's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/8/19, coded the resident as being cognitively intact. Review of Resident #71's clinical record revealed a physician's order dated 10/17/18 for Advair 500	F 684	F684: 1. Resident #71 staff failed to administer Advair in November 2018 and January 2019. 2. All residents have potential to be affected. 100% audit of Medication Administration Records for current resident for the last 30 days was completed to ensure that medications were administered according to physician's order, any deviations noted were corrected by completion of Medication Error Report and Physician notification. 3. Nurse Practice Educator, ADON and or designee to in-service 100% of licensed nursing staff on administration of medication, to include documentation of medication delivery.	

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F 684	Continued From page 129 mcg (micrograms)/50 mcg and to inhale one puff every 12 hours. Review of Resident #71's November 2018 and January 2019 MARs (medication administration records) failed to reveal Advair was administered to the resident (as evidenced by blank spaces with no documented nurses' initials) on 11/1/18 at 9:00 p.m., 11/3/18 at 9:00 a.m., 11/30/18 at 9:00 p.m., 1/9/19 at 9:00 p.m., and 1/23/19 at 9:00 p.m. Nurses' notes for those dates failed to reveal the medication was administered. Further review of Resident #71's January 2019 MAR revealed Advair was not administered to the resident on 1/6/19 at 9:00 a.m. and 9:00 p.m., 1/18/19 at 9:00 a.m. and 9:00 p.m., 1/19/19 at 9:00 a.m. and on 1/29/19 at 9:00 a.m. On these dates, the nurses circled their initials and documented the medication was not available on the back of the MAR. Resident #71's comprehensive care plan dated 10/2/18 documented, "Resident exhibits or is at risk for respiratory complications related to Asthma, COPD...Medicate as ordered..." On 2/5/19 at 12:20 p.m., an interview was conducted with Resident #71. The resident stated he was not getting his Advair as he was supposed to "for a while" but that had "straightened itself out." On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how nurses evidence the medications and treatments they administer. LPN #3 stated, "They sign off on the MAR (medication administration record) and TAR." When asked what is meant if there are blank spaces on the MAR, or TAR and the nurses did	F 684	4. ADON and or designee will audit 10 random Mediation Administration Records 5 X week for 4 weeks then randomly thereafter to ensure medications are administered per order. 5. Date of Compliance: 3/15/19	

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not sign off, LPN #3 stated, "In reality it means that they didn't do it." LPN #3 was asked what is meant if nurses sign and circle their initials on the MAR. LPN #3 stated, "Usually if signed and circled, either they held it, or couldn't give it, they are supposed to explain on the back of the MAR." LPN #3 was asked if Advair is contained in the facility STAT (Immediate) box (a box containing various medications that can be accessed for any resident if needed). LPN #3 stated Advair is contained in the facility omnicell (a machine provided by that pharmacy, containing many various medications that can be accessed for each resident). LPN #3 was asked about the facility process for ensuring Advair is available for administration, if not in the medication cart. LPN #3 stated, "They can check the omnicell. If it's the right dose, the omnicell will let you pull it. If not, let the physician know it's not here, let the patient know, call the pharmacy and ask to send (the medication) from backup (a backup pharmacy) and let the rp (responsible party) know that you didn't give it." At this time, LPN #3 was made aware of this surveyor's concern regarding Resident #71's Advair. LPN #3 stated in the past, nurses would run out of Resident #71's Advair "really quick" because the disk device containing the medication only contained 14 doses as opposed to a typical device that contains 60 doses. LPN #3 stated nurses used to attempt to get the Advair out of the omnicell but the omnicell would not release the medication because it was too soon for a refill (except for one time when someone maintaining the omnicell was in the building). LPN #3 stated nurses would have to call the pharmacy, and authorize the pharmacy to bill the facility and send the medication. When asked if Resident #71 missed doses of his Advair, LPN #3 stated, "Yes. He would tell us he got it

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(the disk) and it was empty; then I further investigated." LPN #3 was asked if the Advair disk displays how many doses are left in the device. LPN #3 confirmed it did. LPN #3 was asked if nurses should have addressed a pharmacy refill for the medication before the medication ran out and stated nurses should have addressed the refill when there were four doses left.

On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern.

The facility policy titled, "Medication Administration: General" documented, "A licensed nurse, Med Tech, or medication aide, per state regulations, will administer medications to patients...If discrepancies, including medication not available, notify physician/advanced practice provider (APP) and/or pharmacy as indicated..."

No further information was obtained prior to exit.

(1) Advair is used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a699063.html

(2) "COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. 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

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F 684	Continued From page 132 smoke. Air pollution, chemical fumes, or dust can also cause it." 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=copd&_ga=2.95971676.178186840.1550160688-1667741437.1550160688	F 684		
F 686 SS=E	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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services for the treatment of a pressure injury for one of 55 residents in the survey sample, Resident #29. The facility staff failed to provide Resident #29's pressure injury treatment as prescribed by the physician on multiple dates in October 2018 and November 2018.	F 686	F686 1. Resident #29 staff failed to provide pressure injury treatment as prescribed. 2. Residents' requiring pressure injury treatment are at risk. 100% audit of treatment administration records for current residents with wounds was completed to ensure that ordered treatments were administered according to order. 3. Nurse Practice Educator, ADON and or designee to in-service 100% of licensed nursing staff on providing pressure injury treatment as prescribed by physician.	

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F 686	Continued From page 133 The findings include: Resident #29 was admitted to the facility on 8/11/18. Resident #29's diagnoses included but were not limited to urinary tract infection, arthritis and abnormal posture. Resident #29's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/21/18, coded the resident's cognition as moderately impaired. Section G coded Resident #29 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene. Section M coded Resident #29 as having one stage three pressure injury (1) that was present upon admission. Review of a skin integrity report dated 10/29/18 revealed Resident #29 presented with a stage three-pressure injury. A physician's order dated 10/29/18 documented, "Cleanse open area L (left) buttock (with) NS (normal saline), apply skin prep to wound edges, santyl (2) to wound bed & cover (with) dry dressing QD (every day) & PRN (as needed) (illegible word)." Review of Resident #29's October 2018, and November 2018, TARs (treatment administration records) failed to reveal evidence that the treatment ordered on 10/29/18 was provided for Resident #29 on 10/30/18, 11/4/18, 11/10/18, 11/11/18, 11/12/18, 11/24/18, 11/25/18, 11/26/18, 11/27/18, 11/28/18, 11/29/18 and 11/30/18. This was evidenced by blank spaces on the TARs. No nurses' initials were signed off to indicate the treatment had been performed. Review of nurses' notes for the above dates failed to reveal Resident #29's pressure injury treatment was administered except for a note dated 11/4/18 that documented treatments were administered as ordered.	F 686	4. ADON and or designee to audit 10 Treatment Administration Records 5 X week for four weeks then randomly thereafter to ensure treatments are provided per order. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19	

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Further review of Resident #29's skin integrity report for October 2018 and November 2018 revealed the resident's pressure injury did not deteriorate during those months.

Resident #29's comprehensive care plan dated 11/8/18 documented, "Resident has actual skin breakdown related to limited mobility, stage 3 pressure wound to left buttock...Provide wound treatment as ordered..."

On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how nurses evidence the medications and treatments they administer. LPN #3 stated, "They sign off on the MAR (medication administration record) and TAR." When asked what is meant if there are blank spaces on the MAR, or TAR and the nurses did not sign off, LPN #3 stated, "In reality it means that they didn't do it."

On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern.

The facility policy titled, "Skin Integrity Management" documented, "4.7 Implement Special Wound Care treatments/techniques, as indicated and ordered."

No further information was presented prior to exit.

(1) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other

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F 686	Continued From page 135 device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information was obtained from the website: https://www.santyl.com/	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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F 689	Continued From page 136 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that four of 55 residents in the survey sample (Resident #35, 31, #15 and #39) were provided a safe enviorment and adequate supervision to prevent potential accidents, injuries, or harm. 1. The facility staff failed to ensure Resident #35 was assessed to determine if the resident was able to go out into the community unsupervised safely, and allowed the resident to have unsupervised, unmonitored leaves of absences, alone, without a friend of family with him, putting him at risk of potential accidents, injuries. Resident #35 was documented as being excessively late returning to the facility at times and did not have a cell phone so the facility could contact him to check on his safety, and was documented as contacting the facility on 2 occasions in which he did not have a ride or money to return to the facility late at night. 2. Resident #31 sustained a fall on 1/18/19. The facility staff failed to implement interventions identified at the time of the fall to prevent further falls for Resident #31. 3. Resident #15 sustained a fall on 1/28/19. The facility staff failed to implement interventions identified at the time of each fall to prevent further falls for Resident #15. 4. Resident #39 sustained falls on 11/8/18,	F 689	F689 1. Resident #35 a plan was created to allow him leave of absences with a friend present, Resident #31, 15 and 39 have had fall interventions implemented and added to plan of care. 2. Residents' requiring leave of absence without chaperone and residents who fall are at risk. 100% audit of current residents who have had falls in the last 30 days was completed to ensure that interventions were implemented and added to care plan accordingly. Social Services/Activities Director reviewed current residents that sign themselves out LOA to ensure that appropriate interventions are in place to ensure their safety on their outings.	

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F 689	Continued From page 137 12/24/18, 1/1/19, 1/6/19, and 2/3/19. The facility staff failed to implement interventions identified at the time of each fall to prevent further falls for Resident #39. The findings include: 1. Resident #35 was admitted to the facility on 5/22/18 with the diagnoses of but not limited to hip fracture, atrial fibrillation, high blood pressure, falls, inguinal hernia, and cardiomyopathy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/23/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for transfers, locomotion, dressing, eating, toileting; and required supervision for hygiene. A review of the clinical record revealed the following: A physician's order dated 8/2/18 that the resident may go on LOA (leave of absence) for 4 hours on 8/3/18 to go to the bank. A physician's order dated 8/13/18 that the resident may go on LOA for 4 hours on 8/13/18. A physician's order dated 8/15/18 that the resident may go on LOA for 4 hours on 8/15/18. A physician's order dated 8/21/18 that the resident may go on LOA for 2 hours on 8/21/18. A physician's order dated 8/22/18 that the resident may go on LOA for 4 hours daily. A review of the nurse's notes revealed the following: A nurse's note dated 8/15/18 that documented,	F 689	3. Nurse Practice Educator, ADON and or designee to in-service 100% of licensed nursing staff on leave of absences including evaluation for supervision versus unsupervised visit and implementing interventions post falls. 4. ADON and or designee to audit plan for leave of absence request prior to leave. ADON and or designee to audit all falls 5X a week x 4 weeks and weekly thereafter to ensure that care plans are updated with new interventions post falls to prevent further falls. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee meeting monthly with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19	

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"Resident has order for LOA for 4 hrs, resident left the facility at 99:45 {sic} but not back at 3pm. Safety maintained will continue to monitor."

A nurse's note dated 8/15/18, that documented, "A change in condition has been noted. The symptoms include: Behavioral symptoms (e.g. agitation, psychosis) 8/15/18 in this afternoon...." No further information was documented.

A nurse's note dated 8/16/18, documented, "Late Entry for 8-15-18 resident was observe by this writer and other staff news paper (Sic.) on the floor resident pouring A-Jax / urine on the news paper (Sic.) and pouring A Jax in urinal full of urine. This writer ask why and resident stated I wanted to see what dish detergent works the best. Call NP (nurse practitioner) to make aware of the altered mental status N.O. (new order) CBC {1} and BMP {2} in the AM resident own RP [responsible party]."

A nurse's note dated 8/30/18 documented, "Resident signed out at 1:30pm, today and stated that he was going to (name of bank) and not going to church tonight. Cousin and friend were contacted at 10pm today because resident was not back at facility. Unit manager on call was contacted. Resident made contact with facility soon after and was reported to unit manager on call. Unit manager will pick up resident from Firestone off of (location)...."

A nurse's note dated 8/31/18 documented, "Late entry: This RN [registered nurse] was contacted by nursing staff of residents (Sic.) failure to return to the facility following his departure for the bank earlier in the afternoon. Nursing staff was advised to make contact with RP to see if they

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knew where resident was located. This RN was advised that contact was made with residents (Sic.) cousin and friend, neither of which knew of his whereabouts. DON was notified of incident. Nursing staff was advised to call the sheriffs (Sic.) office non emergency number to report the residents (Sic.) failure to return. At approximately 10:30pm, this RN was notified by staff that (resident) had called the facility and stated he was at the Firestone and was unable to get back due to not having enough money for the cab ride. This writer went to pick up resident shortly after. Resident was found in front of the Firestone (location) sitting on the ground. Resident stated he left his bank card (Sic.) back at the facility and was unable to get a ride back. Resident returned to facility. This RN stressed the importance to the resident of returning in a timely manner and the need to be able to take his evening medicine. Resident expressed understanding. Resident was asked where he usually goes when he leaves the facility so if another incident occurs we know where to look. Resident stated that he goes to the (name of bank) on (location) and is usually in the shopping center above or below the hospital. Resident returned to facility at approximately 11:30pm."

A nurse's note dated 10/3/18 documented, "Patient left facility at 2:10p.m., for LOA was supposed to return by 6:10p.m. Patient called facility at 7:50p.m., to say he was at the Bus Station in (location) with no way back. Patient returned at 9:30p.m., He stated, "Someone from the Bus Station gave me a ride back." Patient education given on Safety and if Patient is going out alone he must have money for Cab fare both ways and he must return back on time."

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F 689	Continued From page 140 A social services note dated 10/5/18 documented, "Met with patient, (OSM #14 - Other Staff Member - the Ombudsman) CNE (former Center Nurse Executive) to discuss resident's community visits. He has had two instances where he was out in the community and unable to get a ride home after 10pm. Discussed safety and need to be in building when he is scheduled to get his meds (medication). Resident does not have a cell phone at this time. SW (social worker) is working to get him a Medicaid phone. After discussion (resident) is willing to agree to the following. Until he has a cell phone he will not leave the property of (the facility). An exception will be to attend church on Sunday as they will provide transportation both ways. Once he has a phone we will reopen the discussion of his trips into the community. Discussed changing his check to come to (facility) therefore eliminating his need to go to the bank. This would also allow him to have access to his money daily if he wants to purchase a snack. He was agreeable to do this. (Resident) was able to state what the outcome of the meeting was in his own words. He will contact social work and the ombudsman as needed." A review of the care plan failed to reveal any evidence that the resident's community visits unsupervised, or his non-compliance with returning timely was care planned. On 2/6/19 at approximately 2:00 p.m., in an interview with RN #1 (Registered Nurse) she stated that she was not aware of the "Ajax" incident. She stated that the resident used to go out of the facility but has not in a long time unless a friend is with him. She did not recall anything else about the resident's incidents about being	F 689		

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WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(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 689	Continued From page 141 away from the facility and unable to get back. On 2/7/19 at 1:05 p.m., in an interview with LPN #3 (Licensed Practical Nurse) when asked about the resident going out unsupervised, LPN #3 stated, "He would just call a cab or a friend would take him out. He would either have cab money to come back or he wouldn't and would call the facility to let them know where he was at so he could get back." When asked what assessment was done to ensure the resident was safe to leave the facility unsupervised, LPN #3 stated, "I don't know what, if any assessment was done to ensure he was safe to go unsupervised." When asked process is followed if Resident #35 called and said he could not get back, LPN #3 stated, "The Facility finds him a way to get back" When asked about the incident as documented in the 8/31/18 nurse's note, LPN #3 stated, "We could not get in contact with the bus station. We called the cab to get him. I'm not sure why he didn't get the cab. The cab would not go in (the bus station) to find him and the bus station would not go looking for him to notify him of a cab." When asked what the facility did to ensure Resident #35's safety outside the facility, LPN #3 stated, "I don't know. He no longer goes out without a friend." LPN #3 stated she did not know anything about the "AJax" incident. On 2/7/19 at 1:24 p.m., in an interview with LPN #4, when asked how the resident was assessed to determine that, he was safe to leave the facility unsupervised, LPN #4 stated, "I don't recall how or if he was assessed as being safe to go out unsupervised." When asked about the incidents of the resident leaving and then being unable to get back to the facility, LPN #4 stated, "I know that it was discussed about him having issues	F 689		

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F 689	Continued From page 142	F 689		

getting back but I don't know what happened." When asked if the resident's activity of leaving the facility unsupervised, and noncompliance with returning timely should be care planned, LPN #4 stated it should have been. When asked about the process followed when the resident is out long enough to miss medications, LPN #4 stated that the physician should be called and verify if the medications can be given or not. When asked about the "AJax" incident, LPN #4 stated she did not know anything about it.

On 2/7/19 at 2:20 p.m., an interview was conducted with the Executive Director (ASM [administrative staff member] #1) and Nurse Executive, ASM #2. When asked about the resident's unsupervised outings into the community and the issues he had of returning to the facility timely, ASM #1 stated that he was alert and oriented, his BIMS (Brief Interview for Mental Status exam) was a 15 (cognitively intact). She stated the physician was aware of the resident's outings and that it was his right to go out if he wanted to. When asked what assessment was done to ensure that the resident was safe to go out unsupervised, ASM #1 stated that if the IDT (Interdisciplinary team) felt he was safe to do so that is what they chose to do. ASM #1 was not employed at the facility at the time of the incidents when the resident came back late to the facility and was unable to provide any documented evidence of an assessment of the resident or discussions of his unsupervised activities by the IDT team.

When asked about the A-Jax incident ASM #1 stated the facility does not use A-Jax and presumed he brought the cleaner in with him from one of his outings, but she was unable to find any

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F 689	Continued From page 143 administrative documentation or soft file of the incident. When asked about the lack of care planning of his unsupervised outings and noncompliance with returning timely, ASM #1 stated it should have been care planned. When asked about the resident's missed medications when he was late returning to the facility, ASM #1 stated that the doctor should have been notified and provided direction whether to administer them late. ASM #1 was informed that it was documented in the clinical record that the resident had an episode of psychosis and behaviors after one outing (the AJax incident dated 8/16/18), bringing question to his mental capacity to be safe when unsupervised. ASM #1 was asked if anything was done after the incidents of Resident #35 being out excessively late without means of transportation or communication with the facility on at least two occasions. ASM #1 again restated it is his (Resident #35's) right to go out if he wanted because he was cognitively intact and made his own decisions. ASM #1 stated that maybe he (Resident #35) brought in the Ajax because he might have thought he could clean his own equipment and property, although, she was unable to locate any information on the incident (administrative file, etc.) and was not employed at the facility at the time of the incident to speak on it. When asked about the assessment criteria that was used to determine Resident #35 was safe unsupervised, ASM #1 stated she did not know. She stated that it may have been an informal conversation and was not documented and a formal assessment tool used. ASM #1 stated that the facility apparently determined that he was mentally able to leave unsupervised and that he did not have a diagnoses to prevent him from	F 689		

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F 689	Continued From page 144 making decisions and that the facility felt he was safe to do so. ASM #1 stated that she was not employed at the facility at that time, but that he (Resident #35) has since had a physical decline in health and no longer went out of the facility without supervision of friend or family. On 2/7/19 at 2:49 p.m., a phone interview was conducted with RN #12, (who the facility called to speak with the survey team, because she worked at the facility but was not on duty at the time of the resident's leave when he was late returning and no longer worked at the facility at the time of survey). RN #12 stated that regarding the night of 8/31/18, that when the resident called and stated he was at the bus station and was unable to return, an Uber was called for the resident to return to center, arrived at the bus station and waited 10 minutes and left. She stated the facility notified the ombudsman next day. RN #12 stated that the resident did not have cell phone with him and the facility was not able to let him know that the Uber was called and waiting for him. On 2/7/19 at 3:21 p.m., in an interview with OSM #14, the Ombudsman, she stated that she has worked with the resident since before he ever came to this facility. She stated she met with the facility and talked about his history because he was calling her saying the facility would not let him leave. OSM #14 stated he had a high BIMS to make decisions to go out into the community. She stated that he likes to go out into the community, even when at prior facilities, to go shopping, and that there is a community area, where he has friends he liked to go to and would come back. OSM #14 stated he knew he had to be back and could not stay out over night. OSM #14 stated that when he initially came to the	F 689		

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F 689	Continued From page 145	F 689		

facility, it was a concern for the facility. However, measures were put in place for him to go out with a friend, so it would be safe and he would not need money for cabs (this was after 2 incidents of being away from the facility without a means to return). She stated it was addressed with the resident to have funds for cab or transportation. OSM #14 stated the facility does have the responsibility to keep him safe, and that "I know that him (Resident #35) not having a ride a couple of times looks bad and there is no way to excuse that." OSM #14 stated that she is working with him now for discharge to a subsidized housing setting. She stated that his friend says there is a house available and have been looking at it to ensure a safe discharge and that this just happened today (2/7/19). She stated that since has he been at the facility, she had been helping with placement. She stated, "We put things in place to ensure if he wanted to leave he was safe to do so."

The social worker who was at the facility during the above incidents was no longer at the facility as of a few days before the survey and therefore could not be interviewed.

No further information could be provided, and staff who were employed at the time either, no longer were at the facility, or did not recall there being concerns with his safety. During the days of the survey the resident was not observed going out of the facility unsupervised.

{1} CBC - "A CBC (complete blood count) is a commonly performed lab test. It can be used to detect or monitor many different health conditions. Your health care provider may order this test:

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F 689	Continued From page 146 · As part of a routine check-up · If you are having symptoms, such as fatigue, weight loss, fever or other signs of an infection, weakness, bruising, bleeding, or any signs of cancer · When you are receiving treatments (medicines or radiation) that may change your blood count results · To monitor a long-term (chronic) health problem that may change your blood count results, such as chronic kidney disease." Information obtained from https://medlineplus.gov/ency/article/003642.htm {2} BMP - "The basic metabolic panel (BMP) is a frequently ordered panel of 8 tests that gives a healthcare practitioner important information about the current status of a person's metabolism, including health of the kidneys, blood glucose level, and electrolyte and acid/base balance. Abnormal results, and especially combinations of abnormal results, can indicate a problem that needs to be addressed." Information obtained from https://labtestsonline.org/tests/basic-metabolic-panel-bmp 2. Resident #31 sustained a fall on 1/18/19. The facility staff failed to implement interventions identified at the time of the fall to prevent further falls for Resident #31. Resident #31 was admitted to the facility on 5/26/18 with the diagnoses of but not limited to high blood pressure, cardiomyopathy, stroke, atrial fibrillation, pacemaker, dementia, contracture, seizures, chronic kidney disease and acute kidney failure. The most recent MDS	F 689		

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F 689	Continued From page 147 (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/5/18. 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; extensive care for transfers, dressing, toileting and hygiene; and limited assistance for eating. On 2/5/19 at 10:07 a.m., and on 2/6/19 at 1:14 p.m., a observations were made of Resident #31. There were no concerns identified. A review of the nurse's notes revealed one dated 1/18/19, which documented, "A change in condition has been noted. The symptoms include: Falls 1/18/19 at night....Change reported to Primary Care Clinician...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/18/19 documented, "Resident was found face down beside his bed with no injuries, tolerated ROM well, res stated "I am trying to grab something from the floor" denies any pain/discomfort....Interventions added immediately after fall and care plan updated: Educated resident to use call bell at all times." A review of the comprehensive care plan failed to reveal any evidence Resident # 31's care plan was reviewed and/or updated following this fall to prevent further falls. The intervention documented in the "Event Summary Report"	F 689		

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F 689	Continued From page 148 above was not included/documented and implemented on the care plan. The resident's care plan documented as follows: "Resident is at risk for falls: CVA (stroke), Impaired mobility, cognitive loss, lack of safety awareness, syncopal episode." This care plan was dated 10/13/15, and most recently revised on 12/10/18. The interventions were as follows: "12/17/18 - Offer/assist resident with urinal/commode as requested/needed." (Created on 12/10/18). "Place bedside table within reach on left side." (Created on 12/9/15 and revised on 3/9/18). "Medication evaluation as needed." (Created on 9/20/17). "8/10/18 Provide resident/caregiver education for safe techniques." (Created on 8/13/18). "Place call light within reach at all times." (Created on 10/13/15). "Remind resident to use call light when attempting to ambulate or transfer." (Created on 10/13/15). "When resident is in bed, place all necessary personal items within reach." (Created on 10/13/15). "Monitor for and assist toileting needs." (Created on 10/13/15). There was no evidence that after the fall on 1/18/19, that the effectiveness of the above interventions were reviewed and modifications made if necessary to include interventions implemented to prevent further falls for Resident #31. On 2/06/19 at 1:47 p.m., an interview was conducted with CNA #1 (Certified Nursing Assistant). When asked what a care plan is, CNA	F 689		

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F 689	Continued From page 149 #1 stated, "All the basic information about how to care for a resident." When asked if she has access to the residents care plan, CNA #1 stated, "Yes, its on our tablet." On 2/06/19 at 2:17 p.m., in an interview with LPN #2 (Licensed Practical Nurse), when asked what the purpose of a care plan, LPN #2 stated, "It has all you need so you know what to do for a particular resident." When asked what information is on a care plan, LPN #2 stated, "diagnoses, skin integrity, UTI (urinary tract infection)." When asked who has access to the care plan, LPN #2 stated, "nursing and administration." When asked who can review and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, adl (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, ASM #2 was notified that the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any injuries, and if there were any care plan reviews	F 689		

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F 689	Continued From page 150 or revisions and any interventions implemented to prevent further falls.. A review of the facility policy, "Person-Centered Care Plan" documented, "A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments....7. Care plans will be:...7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals...." No further information was provided by the end of the survey. 3. Resident #15 sustained a fall on 1/28/19. The facility staff failed to implement interventions identified at the time of each fall to prevent further falls for Resident #15. Resident #15 was admitted to the facility on 7/9/15 with the diagnoses of but not limited to atrial fibrillation, high blood pressure, hypothyroidism, acute kidney injury, pacemaker, and congestive heart failure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/18/18. The resident was coded as mildly cognitively impaired in ability to make daily life decisions. The resident was	F 689		

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F 689	Continued From page 151 coded as requiring extensive care for bathing; supervision for transfers and toileting; and was independent for dressing, eating, and hygiene. On 2/5/19 at 9:15 a.m., and at 11:26 a.m., observations were made of Resident #15. There were no concerns identified. A review of the clinical record revealed a nurse's note dated 1/28/19, which documented, "A change in condition has been noted. The symptoms include: Fall on 1/28/19 at night....Change reported to Primary Care Clinician....Orders obtained include: Have PT (physical therapy) eval (evaluate) for functional status." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/28/19 documented, "heard res (resident) calling help, entered res room and observed her sitting on the floor between w/c [wheelchair] and bed., holding on to bed and w/c, on neuro [neurological] checks, abrasion to upper mid-back, no bleeding. NP (nurse practitioner) made aware and ordered PT to eval, res rp (responsible party) made aware of fall with abrasion and res need for more assist with ADLs (activities of daily living)....Interventions added immediately after fall and care plan updated: Refer to PT [physical therapy], enc (encourage) res to call for assist before getting oob (out of bed)." A review of the comprehensive care plan failed to	F 689		

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F 689	Continued From page 152 reveal any evidence Resident # 15's care plan was reviewed and/or updated following this fall to prevent further falls. The interventions documented in the "Event Summary Report" above, were not included/documented and implemented on the care plan. The resident's care plan documented as follows: "Resident is at risk for falls R/T (related to) Diagnosis of vertigo, Impaired mobility, cognitive loss, lack of safety awareness, history of falls and requires assistance with transfers." This care plan was dated 1/26/15, and most recently revised on 3/15/18. The interventions were as follows: "3/15/18 OT (occupational therapy) evaluation for w/c (wheel chair) positioning." (Created 3/15/18). "Assist resident in getting in and out of bed per lift assessment." (Created 2/4/15, revised on 3/9/18). "Place call light within reach at all times." (Created on 1/26/15, revised on 7/11/15). "Remind resident to use call light when attempting to ambulate or transfer." (Created on 1/26/15, revised on 7/11/15). "Monitor for and assist toileting needs." (Created on 1/26/15, revised on 7/11/15). "1/2 side rails x 2 for functional mobility." (Created on 2/4/15, revised on 3/7/18). There was no evidence that after the fall on 1/28/19, that the effectiveness of the above interventions were reviewed and modifications made if necessary to include interventions implemented to prevent further falls for Resident #15. On 2/06/19 at 1:47 p.m., an interview was conducted with CNA #1 (Certified Nursing	F 689		

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F 689	Continued From page 153 Assistant). When asked what a care plan is, CNA #1 stated, "All the basic information about how to care for a resident." When asked if she has access to the residents care plan, CNA #1 stated, "Yes, it's on our tablet." On 2/06/19 at 2:17 p.m., in an interview with LPN #2 (Licensed Practical Nurse), when asked what the purpose of a care plan, LPN #2 stated, "It has all you need so you know what to do for a particular resident." When asked what information is on a care plan, LPN #2 stated, "diagnoses, skin integrity, UTI (urinary tract infection)." When asked who has access to the care plan, LPN #2 stated, "nursing and administration." When asked who can review and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, adl (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, ASM #2 was notified that the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any	F 689		

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F 689	Continued From page 154 injuries, and if there were any care plan reviews or revisions, including any interventions implemented to prevent further falls. No further information was provided by the end of the survey. 4. Resident #39 sustained falls on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19. The facility staff failed to implement interventions identified at the time of each fall to prevent further falls for Resident #39. Resident #39 was most recently readmitted to the facility on 12/6/18 with the diagnoses of but not limited to dementia, diabetes, chronic back pain, high blood pressure, history of femur fracture, overactive bladder, adjustment disorder with anxiety, and osteoarthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/3/18. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for eating; and supervision for hygiene, toileting, dressing, and transfers. On 2/5/19 at 9:25 a.m., and on 2/6/19 at 2:11 p.m., observations were made of Resident #39. There were no concerns identified. A review of the nurse's notes revealed one dated 11/8/18, which documented, "A change in condition has been noted. The symptoms include: Falls 11/8/18 in the afternoon...Orders obtained include: NNO (no new orders)..." This	F 689		

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F 689	Continued From page 155	F 689		

note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall.

A review of the "Event Summary Report" dated 11/8/18 documented, "Resident feel {sic} in dining room trying to reach across the table to get her stuffed cats. Resident fell to floor and hit her head. Resident stated that her head no long {sic} hurt after a few mins (minutes) and was able to get up from the floor with assistance. Resident was assessed for any injuries and none were found....Interventions added immediately after fall and care plan updated: Resident was educated on not leaning while in chair."

A review of the comprehensive care plan failed to reveal any evidence that the resident's care plan was reviewed, updated to reflect the above intervention, following this fall on 11/8/18.

A review of the nurse's notes revealed one dated 12/24/18, which documented, "A change in condition has been noted. The symptoms include: Falls 12/24/18 in the morning....Change reported to Primary Care Clinician...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall.

A review of the "Event Summary Report" dated 12/24/18 documented, "Resident was found on the floor beside her bed with no injuries, tolerated

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F 689	Continued From page 156 ROM (range of motion) well with no difficulty, vital signs were taken and neuro (neurological) checks initiated....Interventions added immediately after fall and care plan updated: Resident had disabled alarm prior to fall, alarm was replaced." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed updated to reflect the above intervention, following this fall on 12/24/18. A review of the nurse's notes revealed one dated 1/1/19, which documented, "A change in condition has been noted. The symptoms include: Falls....Change reported to Primary Care Clinician....Orders obtained included: Continue to monitor aware of the complaints of buttocks pain no bruising present" This note did not document the circumstances surrounding the fall and if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/1/19 documented, "The resident was toileted by the CNA (Certified Nursing Assistant) was instructed to pull call bell when she was done. The resident did not was noted to be lying on the floor near her bed....Interventions added immediately after fall and care plan updated: Staff to remain with the resident while in the bathroom." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed, updated to reflect the above intervention, following this fall on 1/1/19.	F 689		

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F 689	Continued From page 157 A review of the nurse's notes revealed one dated 1/6/19, which documented, "A change in condition has been noted. The symptoms include: Falls 1/6/19 in the morning." A second note dated 1/6/19 documented, "....The resident has no new changes in the ROM, usual complaints of general body ache...." A third note dated 1/6/19 documented, "....NP (nurse practitioner)...aware of the falls this am there are no new orders." There was no incident report related to this fall provided. These notes did not document the circumstances surrounding the fall and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the comprehensive care plan failed to reveal any evidence Resident # 39's care plan was reviewed and/or updated following the resident's falls on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19, to prevent further falls. The interventions documented on the "Event Summary Report" for each fall above, were not included/documented and implemented on the care plan. The resident's care plan documented as follows: "Resident is at risk for falls: cognitive loss, lack of safety awareness." This care plan was dated 5/14/18 and most recently revised on 12/14/18. The interventions were as follows: "Provide verbal cues for safety and sequencing when needed." (Created on 5/14/18)	F 689		

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F 689	Continued From page 158 "6/21/18 Provide resident/caregiver education for safe techniques." (Created on 6/22/18) "Place call light within reach while in bed or close proximity to the bed." (Created on 5/14/18) "12/13/18 - Remind resident to use call light when attempting to ambulate or transfer." (Created on 12/14/18) "When resident is in bed, place all necessary personal items within reach." (Created on 5/14/18) "Implement the following safety precautions resident will wear non-skid socks when ambulating in room." (Created on 10/22/18) There was no evidence that after falls on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19, that the effectiveness of the above interventions were reviewed and modifications made if necessary to include implemented interventions to prevent further falls for Resident #39. On 2/06/19 at 1:47 p.m., an interview was conducted with CNA #1 (Certified Nursing Assistant). When asked what a care plan is, CNA #1 stated, "All the basic information about how to care for a resident." When asked if she has access to the residents care plan, CNA #1 stated, "Yes, it's on our tablet." On 2/06/19 at 2:17 p.m., in an interview with LPN #2 (Licensed Practical Nurse), when asked what the purpose of a care plan, LPN #2 stated, "It has all you need so you know what to do for a particular resident." When asked what information is on a care plan, LPN #2 stated, "diagnoses, skin integrity, UTI (urinary tract infection)." When asked who has access to the care plan, LPN #2 stated, "nursing and administration." When asked who can review	F 689		

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F 689	Continued From page 159 and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, adl (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, ASM #2 was notified that the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any injuries, and if there were any care plan reviews or revisions including interventions implemented to prevent further falls. No further information was provided by the end of the survey.	F 689		
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	F 695		

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F 695	Continued From page 160 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, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services according to physician's order for four of 55 residents in the survey sample, Residents #1, #51, #52 and #309. 1. The facility staff failed to administer oxygen to Resident #1 at two liters per minute, per physician's order. 2. The staff failed to discontinue Resident #51's oxygen per physician's order. 3. The facility staff failed to provide respiratory services according to the physicians order for Resident #52. 4. The facility staff failed to administer Resident # 309's oxygen according to the physician's orders. The findings include: 1. The facility staff failed to administer oxygen to Resident #1 at two liters per minute, per physician's order. Resident #1 was admitted to the facility on 4/23/18. Resident #1's diagnoses included but were not limited to low back pain, bladder cancer and high blood pressure. Resident #1's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/1/19 coded the resident as cognitively	F 695	F695 1. Resident #1 Oxygen was corrected while surveyor was present, Resident #51 oxygen was discontinued while surveyor was present, Resident #52 oxygen was corrected while surveyor was present and Resident #309 oxygen was corrected while surveyor was present. 2. All residents requiring oxygen are at risk. 100% audit was completed by nursing leadership of all current residents with oxygen orders to ensure that flow rates are set at the ordered rate. 100% audit of current residents who have had Oxygen discontinued in the last 30 days were reviewed to ensure that order to discontinue was carried out accordingly.	

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F 695	Continued From page 161 intact. Section G coded Resident #1 as requiring extensive assistance of one staff with bed mobility, transfer and personal hygiene. Section O coded the resident as receiving oxygen therapy during the last 14 days. Review of Resident #1's clinical record revealed a physician's order dated 1/25/19 for continuous oxygen, at two liters per minute via nasal cannula. Resident #1's care plan dated 1/29/19 failed to reveal documentation regarding oxygen administration. On 2/5/19 at 9:24 a.m. and 10:58 a.m., Resident #1 was observed sitting up in bed receiving oxygen via a nasal cannula. During each observation, the oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the ball in the concentrator flowmeter positioned between the two and a half and three-liter lines. On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to describe where the ball in an oxygen concentrator flowmeter should be if a resident has a physician's order for two liters. LPN #3 stated the two-liter line should run through the middle of the ball. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. On 2/7/19 at approximately 4:30 p.m., ASM #3 confirmed the facility did not have a policy regarding oxygen administration.	F 695	3. Nurse Practice Educator and or designee to in-service 100% of licensed nursing staff on correct oxygen administration process, to include how to set oxygen concentrators on the correct setting. Education also includes on following orders to discontinue oxygen per orders. 4. ADON and or designee to audit 100% of patients receiving oxygen weekly for 4 weeks, then weekly thereafter, to ensure oxygen delivery is done per physician order. Variances will be corrected immediately and brought to Quality Assurance and Performance Improvement Committee monthly, with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19	

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F 695	Continued From page 162 The oxygen concentrator manufacturer's manual documented, "Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed." No further information was obtained prior to exit. 2. The staff failed to discontinue Resident #51's oxygen per physician's order. Resident #51 was admitted to the facility on 6/28/18. Resident #51's diagnoses included but were not limited to diabetes, high blood pressure and pneumonia. Resident #51's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 12/13/18, coded the resident's cognition as severely impaired. Section G coded Resident #51 as requiring extensive assistance of two or more staff with bed mobility and extensive assistance of one staff with personal hygiene. Section O did not coded the resident as receiving oxygen during the last 14 days. Review of Resident #51's clinical record revealed a physician's order form signed by the physician on 1/15/19 that documented an order for oxygen, at two liters per minute as needed. On 2/5/19 at 9:21 a.m., Resident #51 was observed sitting up in bed receiving oxygen via a nasal cannula. On 2/5/19 at 4:43 p.m., Resident #51 was observed lying in bed receiving oxygen via a nasal cannula. During each observation, the oxygen concentrator was set at a rate between one and a half and two liters as	F 695		

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F 695	Continued From page 163 evidenced by the ball in the concentrator flowmeter positioned between the one and a half and two-liter lines. On 2/6/19 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to describe where the ball in an oxygen concentrator flowmeter should be if a resident has a physician's order for two liters. LPN #3 stated the two-liter line should run through the middle of the ball. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. On 2/7/19 at 4:25 p.m., ASM #2 and ASM #3 presented a copy of a separate physician's order for Resident #51 that was dated 2/4/19. The order documented to discontinue the resident's oxygen. ASM #2 and ASM #3 also presented a copy of Resident #51's resolved oxygen care plan. ASM #2 and ASM #3 confirmed oxygen was administered to Resident #51 on 2/5/19 when it should not have been administered because the physician's order had been discontinued. No further information was presented prior to exit. 3. The facility staff failed to provide oxygen to Resident #52, according to the physicians order. Resident #52 was admitted to the facility on 2/7/2013. Diagnoses included but were not limited to: chronic obstructive pulmonary disease (COPD) (1), myelodysplastic syndrome (2), anemia (3), depression and shortness of breath.	F 695		

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F 695	Continued From page 164 The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 12/15/18 coded the resident as having a score of 14 of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Section O-Special Treatment, documented that Resident #52 receives oxygen therapy. The physician order sheet dated January 2019 documented "Oxygen at 2 liters per minute via nasal cannula (A plastic tube with two prongs that inserts in the nose) continuously." Resident #52's comprehensive care plan dated 7/13/18 documented, "O2 (oxygen) as ordered." Review of the MAR (medication administration record) dated January 2019, for Resident #52 documented, "Oxygen at 2 liters per minute via nasal cannula continuously." The oxygen was signed off as administered to Resident #52 as evidenced by staff initials. On 2/5/19 at approximately 8:34 a.m., an observation was made of Resident #52. Resident #52 was observed receiving oxygen via a nasal cannula connect to an oxygen concentrator. Observation of the flowmeter on Resident #52's oxygen concentrator revealed the oxygen flow rate was set with the ball between the 2.0L/min (liters per minute) and 2.5L/min lines. On 2/5/19 at approximately 3:30 p.m., a second observation was made of Resident #52's oxygen concentrator. Observation of the flowmeter on Resident #52's oxygen concentrator revealed the	F 695		

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F 695	Continued From page 165	F 695		

oxygen flow rate was set with the ball between the 2.0L/min (liters per minute) and 2.5L/min lines.

On 2/5/19 at approximately 3:40 p.m., a third observation was made with of Resident 52's oxygen concentrator flowmeter with LPN (licensed practical nurse) #1. LPN #1 was asked to read the flowmeter on Resident #52's oxygen concentrator. After observing Resident #52's oxygen concentrator flowmeter, LPN #1 stated, "its set at 2.5L (liters)."

On 2/5/19 at approximately 3:41 p.m., an interview was conducted with LPN #1. When asked was asked how an oxygen flowmeter is read, LPN #1 replied, "The top of the ball is supposed to be on the line."

On 2/5/19 at approximately 3:45 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked how the rate on an oxygen flowmeter is set. RN #2 replied, "You turn the dial until the line is in the middle of the ball."

The manufacturer's instructions for Resident #52's oxygen concentrator documented on page 19, "Center the ball on the L/min (liters per minute) line prescribed."

On 2/07/19 at approximately 4:30 p.m., ASM (administrative staff member) # 3, Clinical Quality Specialist, provided copies of requested facility polices. ASM # 3 informed this surveyor the facility did have a policy for oxygen administration.

On 2/7/18 at approximately 5:45 p.m., ASM #1, the Executive Director and ASM #2, the Nurse

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F 695	Continued From page 166 Executive, and ASM #3 were made aware of the findings. No further information was provided prior to exit. 1. 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. 2. Your bone marrow is the spongy tissue inside some of your bones, such as your hip and thigh bones. It contains immature cells, called stem cells. The stem cells can develop into the red blood cells that carry oxygen through your body, the white blood cells that fight infections, and the platelets that help with blood clotting. If you have a myelodysplastic syndrome, the stem cells do not mature into healthy blood cells. Many of them die in the bone marrow. This means that you do not have enough healthy cells, which can lead to infection, anemia, or easy bleeding. This information was obtained from the website: https://medlineplus.gov/myelodysplasticsyndromes.html 3. 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:	F 695		

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F 695	Continued From page 167 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 4. The facility staff failed to administer Resident # 309's oxygen according to the physician's orders. Resident # 309 was admitted to the facility on 01/23/2019 with diagnoses that included but were not limited to: edema (1), respiratory failure (2), hypertension (3) and anxiety (4). Resident # 309's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/30/19, coded Resident # 309 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 309 was coded as requiring limited assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 309 was coded for "C. Oxygen therapy." On 02/05/19 at 9:45 a.m., an observation of Resident 309 revealed she was lying in her bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flowmeter on the oxygen concentrator revealed an oxygen flow rate between three-and-a-half liters and four liters per minute. The POS (physician's order sheet) for Resident # 309 dated "01/23 2019"documented, "O2 (oxygen) at 2/L (two liters) via (by) N/C (nasal cannula) continuous."	F 695		

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F 695	Continued From page 168 The comprehensive care plan for Resident # 309 dated 01/25/2019 failed to evidence documentation for oxygen use. On 02/05/19 at 4:48 p.m., an observation of Resident 309 was conducted with LPN (licensed practical nurse) # 4. Resident 309 was lying in her bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flowmeter on the oxygen concentrator revealed an oxygen flow rate of two liters per minute. At this time in an interview LPN # 4, LPN #4 stated that she needed to readjust the oxygen for Resident # 309 because it was up at four liters per minute. When asked what time she adjusted the oxygen flow rate, LPN # 4 stated, "I don't remember." When asked how often a resident's oxygen flow rate is checked, LPN # 4 stated, "Every time I go into the room, and at the beginning of the shift." When asked to describe how to read the oxygen flow rate on the oxygen concentrator LPN # 4 stated, "The liter line should go through the middle of the ball." On 02/06/19 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (2) When not enough oxygen passes from your	F 695		

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F 695	Continued From page 169 lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 695		
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 the facility staff failed to conduct annual performance reviews for 10 of 23 CNAs (certified nursing assistants) who were employed for at least one year. The facility staff failed to complete annual performance reviews for CNA #1, CNA #2, CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8. CNA #9, and CNA #10. The findings include:	F 730	F730 1. Annual performance reviews were not completed for CNA #1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. 2. All CNA's in the facility are at risk for incomplete annual performance reviews. 100% audit was complete by Human Resources to determine current staff members that have not had a performance review in the past year, and performance reviews were completed accordingly.	

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F 730	Continued From page 170 On 2/6/19 at approximately 9:00a.m., a request for the annual performance reviews and associated training's for the CNAs was made to ASM (administrative staff member) #2, the nurse executive. On 2/6/19 at 5:30 p.m., a second request made for the annual performance reviews and associated training's for the CNAs to ASM #2, ASM #1, the executive director, and ASM #3, the clinical quality specialist. On 2/7/19 at 9:41 a.m., ASM #2 informed this surveyor that the facility could not find any performance reviews. When asked where they would be located, ASM #2 stated in the HR (human resources) files. ASM #2 stated, "We searched the files last night and can't find anything." CNA #1 was hired on 9/6/17 CNA #2 was hired on 5/28/15 CNA #3 was hired on 8/21/17 CNA #4 was hired on 3/5/12 CNA #5 was hired on 3/14/16 CNA #6 was hired on 8/11/11 CNA #7 was hired on 5/12/14 CNA #8 was hired on 7/22/08 CNA #9 was hired on 4/2/15 CNA #10 was hired on 2/1/18. The facility policy, "Performance Appraisal Program: Employee" documented in part, "Policy: Managers will meet with their regular full-time, regular part-time and regular casual employees at least annually to conduct a performance appraisal. In-service education will be provided based on the outcome of these reviews."	F 730	3. Education provide to Facility Leadership by the Regional Human Resource Director on policy and regulation for completing annual performance reviews for staff. 4. Human Resources to complete monthly audit to assess for staff requiring annual performance review based on their hire date. Variances will be corrected when observed and brought to Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/19	

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F 730	Continued From page 171 ASM #1, ASM #2 and ASM #3 were made aware of the above concern on 2/7/19 at 3:46 p.m. No further information was provided prior to exit.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732	F732 1. Staff Posting was corrected on 2/07/19 to reflect actual hours worked per regulation. 2. All patients are at risk for incomplete staff posting information. 3. Center Executive Director, Director of Nursing, Nurse Practice Educator, or designee will educate scheduler and shift supervisors on regulation for required daily posting, to include recording the actual hours worked.	

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F 732	Continued From page 172 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to post the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. The facility staff failed to post the total number and the actual hours worked by the licensed and unlicensed nursing staff each day. The finding include: Observation was made during the initial tour on 2/5/19 at approximately 8:30 a.m., of the staff posting in the lobby of the facility. The form documented the facility name, the census of the building -103, the date - 2/5/19. The form further documented the following: Shift - Day, Evening, Night Licensed nursing staff - Day - 5, Evening - 5, Night - 3. Unlicensed nursing staff - Day - 9, Evening - 8, Night - 5. Observation was made of the staff posting on 2/6/19 at 3:41 p.m. of the staff posting in the lobby of the facility. The form documented the facility name, the census of the building -104, the date - 2/6/19. The form further documented the following:	F 732	4. Staff posting will be audited 5 X week by CED or designee, then weekly thereafter , to ensure all information according to regulation is included. Variances will be corrected immediately and brought to monthly Quality Assurance and Performance Improvement Committee monthly with the QAPI committee responsible for ongoing compliance. 5. Date of compliance: 3/15/2019	

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F 732	Continued From page 173 Shift - Day, Evening, Night Licensed nursing staff - Day - 5, Evening - 4, Night - 3. Unlicensed nursing staff - Day - 8, Evening - 8, Night - 5. An interview was conducted with other staff member (OSM) #5, the staffing coordinator, on 2/6/19 at 3:41 p.m. When asked about the process for posting the staffing, OSM #5 stated, "I usually put up a week's worth, I do it on Monday. I write down the staffing number. I change it daily if staff members picked up extra shifts. It's updated once a day unless there are changes." When asked if this is the form she has always used, OSM #5 stated she had used another form over a year ago but was instructed to use this form about one year ago. A request was made of OSM #5 at this time for the copies of the last two weeks of staff postings. The last two weeks of staff postings were received from OSM #5 at approximately 4:00 p.m. All of the papers were documented as the other two above. There was no documentation of total number of hours worked. An interview was conducted with administrative staff member (ASM) #3, the clinical quality specialist, on 2/6/19 at 3:49 p.m. When asked who is responsible for posting the staff posting daily, ASM #3 stated, "In this building, it's the scheduler (staffing coordinator)." When asked what is supposed to documented on the form, ASM #3 stated, "The name of the facility, the date, the census, the breakdown of nursing staff for the day by licensed and unlicensed staff." The above forms were shown to ASM #3. When asked if the form was properly filled out, ASM #3	F 732		

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F 732	Continued From page 174 stated, "No, it's should be broken down by RN's (registered nurses), LPN's (licensed practical nurses) and CNA's (certified nursing assistants) and it should be updated each shift. When asked if the number of staff is supposed to be documented, ASM #3 stated, "No, it is supposed to be the number of hours, not staff members." The facility policy, "Posting Staffing" documented in part, "Policy: In accordance with federal and state regulations, (Name of Corporation) will post the census, shift hours, number of staff and total actual hours worked by licensed and unlicensed nursing staff who are directly responsible for patient care for each shift and on a daily basis....2. The posting should include the: a. center name, current date, patient census at the beginning of each shift, center specific shifts, the number and actual hours worked per shift of nursing staff directly responsible for the care of patients. The posting should be: completed on a daily basis at the beginning of each shift and adjusted either upward or downward if staffing changes." Administrative staff member (ASM) #1, the executive director, ASM #2, the nurse executive and ASM #3, were made aware of the above concern on 2/6/19 at 5:32 p.m. No further information was provided prior to exit.	F 732		
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,	F 758		

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F 758	Continued From page 175 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 §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	F 758	F758 1. Resident #61 PRN Lorazepam was re-assessed by Nurse Practioner on 2/11/2019 and discontinued. 2. 100% audit of all current residents on antianxiety medications was completed by Nursing Leadership to ensure that there were no other residents with as needed anxiolytic medications for a duration longer than 14 days. 3. Nurse Practice Educator, ADON and or designee to in-service 100% of licensed nursing staff on use of unnecessary psychotropic medications, to include that anxiolytic medications may not be administrated/ordered for longer than 14 days without evaluation by Physician for necessity of ongoing use.	

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F 758	Continued From page 176 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, clinical record review, and facility documentation review, facility staff failed to ensure one resident, Resident #61, was free of unnecessary psychotropic medications. Resident #61 had a PRN (as-needed) order for Lorazepam (1) more than 14 days old and with no stop date. The Findings Included: Resident #61 was admitted on 12/18/2018. Her diagnoses included Hyperlipidemia (high levels of fat/cholesterol in the blood), Anxiety, Alzheimer's disease (2), and Dementia. Resident #61's most recent Minimum Data Set (MDS) Assessment was a 14-Day Assessment with an Assessment Reference Date (ARD) of 01/01/2019. Resident #61 was scored as a 5 on the Brief Interview for Mental Status (BIMS), indicating severe impairment. Resident #61 was coded as requiring total assistance of two or more people for transfers and toileting; total assistance of one person for ambulation; extensive assistance of two or more people for dressing, and as requiring extensive assistance of one person for eating, bed mobility, and hygiene. A review of the Physician Order Sheet dated 02/01/2019 revealed the following under PRN (as needed) Medications: "Lorazepam 0.5MG tablet (WF: Ativan) 1 tab [tablet] by mouth every day as needed." To the left of that order, in the column	F 758	4. Director of Nursing and or designee to complete 100% audit of new orders 5X week for four weeks, and weekly thereafter, for orders for "prn" as needed anxiolytic medications to ensure that a stop date/evaluation date of 14 days or less included in the order. Variances will be provided to Physician/Nurse Practioner for correction and brought to Quality Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/19	

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F 758	Continued From page 177 labeled "date", 01/20/19 was typed. To the right of the order, the column labeled "Discontinue by" was left blank. A review of Resident #61's Medication Administration Record (MAR) revealed that she received the PRN dose of Ativan on February 2nd, 2019. On 02/07/2019 at 1:55p.m., an interview was conducted with ASM (Administrative Staff Member) #5, the Nurse Practitioner. ASM #5 was asked to describe why a resident might be prescribed Ativan. She stated that it is a drug used to treat anxiety. ASM #5 also stated that it is sometimes used in people with dementia "for behaviors", but that that is not an approved use. When asked about what restrictions might be in place when prescribing Ativan for a resident, ASM #5 stated that, aside from considering things like the resident's allergies, orders for drugs like Ativan are usually written to be given on a schedule. She stated that when writing an order for one to be given "as needed", it cannot be written for greater than 14 days. She went on to state that if the prescriber believes that the resident needs the medication to be given "as needed" for more than 14 days, he or she must re-assess the patient, as well as document the justification for extending the order. A resident on Hospice care, for example, might be one who would benefit from a greater than 14 day course. On 02/07/2019 at 2:02p.m., an interview was conducted with ASM #3, the Facility Medical Director. When asked why a resident might be taking Ativan, ASM #3 stated that very often they would get patients from the Hospital who already have an "as-needed" order for Ativan in place. He	F 758		

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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 758	Continued From page 178 stated that in many cases, the hospital does this to treat agitation or disruptive behaviors. ASM #3 went on to state that for these residents arriving from the hospital with a PRN order already in place, he usually leaves it in place at the facility because many residents have difficulty adjusting to their new environment and can benefit from anti-anxiety medication. ASM #3 stated that the maximum time he uses the as-needed order is 14 days. After that, he will either discontinue the medication or ask Psychiatric services to see the resident and decide if the medication should be extended. When asked, if, in either case, described the initial order should only be 14 days, ASM #3 responded, "yes, that is correct." A review of the facility policy "3.9 Psychotheraputic Medication Use" revealed the following under the heading "Purpose": "To ensure patients are prescribed psychotherapeutic drugs for appropriate indications, dosages, lengths of treatment, and duration." No further information in the policy elaborated on "lengths of treatment, and duration." The Executive Director, ASM #1and Center Nurse Executive, ASM #2, were informed of the findings at the End of Day Meeting on 02/07/2019. No further information was provided. 1. Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. - https://medlineplus.gov/druginfo/meds/a682053.html	F 758		

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F 758	Continued From page 179 2. Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. AD begins slowly. It first involves the parts of the brain that control thought, memory and language. People with AD may have trouble remembering things that happened recently or names of people they know. - https://medlineplus.gov/alzheimersdisease.html	F 758		
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, staff interview, facility document review, it was determined that the facility staff failed to ensure food was palatable on one of four units during the lunch meal on 2/5/19. On 2/5/19, the facility staff failed to serve food at a palatable taste and temperature on the Martin Unit. The findings include: On 02/05/19 at 11:00 a.m., a group interview was conducted with four residents. Three residents	F 804		

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F 804	Continued From page 180 voiced complaints that the food "is not always hot." On 02/05/19 at 11:55 a.m., observation was made of the tray line in the kitchen based on a complaint investigation that the food "is not always hot." At approximately 1:35 p.m., a test tray consisting of a grilled cheese sandwich, tater tots, mash potatoes, tomato soup and pureed grilled cheese sandwich was placed in the food cart with the lunch trays for residents' and was sent to the Martin Unit. This surveyor and OSM (other staff member) #7, dining services manager, followed the food cart. At approximately 1:55 p.m., the last lunch tray was served to a resident on the Martin Unit and OSM # 7 was asked to remove the test tray from the food cart, placed it on top of the cart and proceeded to take the temperatures of the food. OSM #7 was observed obtaining the test, tray food temperatures using a facility thermometer. The grilled cheese sandwich was 148 degrees F (Fahrenheit), tater tots were 122 degrees F, mash potatoes were 114 degrees F, tomato soup was 140 degrees F and pureed grilled cheese sandwich was 116 degrees F. Two surveyors and OSM # 7 sampled the test tray for appropriate holding temperatures and palatable taste. When asked to describe the taste of the pureed grilled cheese sandwich OSM # 7 stated, "It's a doughy taste." When asked if he taste samples any of the food before it is served to the residents OSM # 7 stated no. On 02/06/19 at 1:32 p.m., an interview was conducted with OSM # 7, dining service manager. When asked about the temperature of the food on the test tray sampled on 02/05/19 during lunch OSM # 7 stated, "Should be at 130 degrees at the	F 804	F804 1. Dietary staff in serviced on Food Quality and Palatability by Dietary Services Manager focusing on appropriate tray line temps and tasting food before serving, to include appropriate consistency of pureed diets by 3/1/2019. 2. All patients are at risk for foods not at appropriate temperatures. 3. Dietary Manager/Designee to complete test trays 5x per week for 4 weeks, then 2x per week for 6 weeks to ensure appropriate temperatures/ and palatability at point of service. Administrator or designee will audit a test tray of regular diet and pureed diet 3 X week for four weeks then randomly thereafter to ensure palatability. 4. Variances will be corrected immediately, documented and brought to monthly Quality	

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F 804	Continued From page 181 point of service." When asked to describe the taste and flavor of the pureed grilled cheese OSM # 7 stated, "I could tell it wasn't at the correct temperature, it tasted gummy." When asked if he thought it was appealing to the residents OSM # 7 stated, "Most likely not. It could be improved upon." The facility policy, "Food: Quality and Palatability"" documented in part, "Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature."	F 804	Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/2019	
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:	F 812		

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F 812	Continued From page 182 Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store, prepare and serve food in a sanitary manner. 1. The facility staff failed to label containers of tartar sauce and sour cream with a use-by date. 2. The facility staff failed to maintain a mixer and meat slicer in a clean and sanitary manner. 3. The facility staff failed to keep used alcohol swabs off the food-preparation sheet pan and place clean soup bowls on a clean surface before serving. The findings include: 1. The facility staff failed to label containers of tartar sauce and sour cream with a use-by date. On 02/05/19 at 9:15 a.m., an observation of the kitchen was conducted with OSM (other staff member) # 7, dining services manager. Observation of the inside of the reach-in refrigerator revealed a tray with 12 small plastic containers with approximately two ounces of tartar sauce in each container and three plastic containers with approximately two ounces of sour cream in each one. Further observation of the tray of containers failed to evidence a use-by-date. When asked about the missing date, OSM # 7 stated, "They were prepared and used for dinner last night. There should be a date on them." OSM # 7 then removed the tray of containers from the reach in refrigerator. The facility's policy "Food and Nutrition Services Policies and Procedures" documented in part,	F 812	F812 1. The slicer and mixer were cleaned immediately prior to use. The items not labeled properly were disposed of immediately by Dining Services Director. All Dietary Staff was inserviced by Dining Services Director on how to clean and sanitizer slicer and mixer properly and store to keep clean, dating & labeling open items, proper use and disposal of alcohol swabs, and proper use soup bowls ensuring clean bowls on clean surface before serving on 2/7/2019. 2. All patients are at risk for food safety requirements not met.	

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F 812	Continued From page 183 "25. Use-By Dating Guidelines. Foods that are marked with the manufacturer's 'use-by' date that are properly stored can be used until that date as long as the product has not been combined with any other food or prepared in any way including proportioning. Once a product has been prepared or portioned, a new 'use-by' date is established." On 02/06/19 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit. 2. The facility staff failed to maintain a mixer and meat slicer in a clean and sanitary manner. On 02/05/19 at 9:15 a.m., an observation of the kitchen was conducted with OSM (other staff member) # 7, dining services manager. Observation of the mixer revealed it was covered with a plastic bag. When asked if the mixer was clean and ready for use OSM # 7 stated, "Yes." OSM # 7 then removed the bag covering the mixer. Further observation of the mixer revealed food debris splattered on the splashguard of the mixer above the mixing bowl and food debris around the mounting pins for the cage. OSM # 7 agreed the mixer was not clean. Observation of the meat slicer revealed it was covered with a plastic bag. When asked if the meat slicer was clean and ready for use, OSM # 7 stated, "Yes." OSM # 7 then removed the bag covering the meat slicer. Further observation of the meat slicer revealed debris on the surface of	F 812	3. Dietary Manager to complete daily audits of kitchen sanitation 5 x per week for 6 weeks to ensure slicer and mixer cleaned and stored properly, proper dating and labeling, proper use and disposal of alcohol swabs, and soup bowls being used properly on clean surfaces. 4. Administrator and Registered Dietician to audit the kitchen weekly for Sanitation requirements to ensure in compliance with regulation. Variances will be corrected immediately and brought to monthly Quality Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/2019	

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F 812	Continued From page 184	F 812		

the base under the gauge plate and under the slice deflector. OSM # 7 was asked to observe the debris on the meat slicer. When asked if the debris was food debris, OSM # 7 stated he could not be sure if it was food debris or debris from the surrounding environment where work had been done in the kitchen. OSM # 7 agreed the meat slicer was not clean.

On 02/06/19 at 1:32 p.m., an interview was conducted with OSM # 7. When asked how often the meal slicer and mixer should be cleaned, OSM # 7 stated, "It should be washed and sanitized after each use."

The facility policy "Equipment" documented in part, "Procedures: 3. All food contact equipment will be cleaned and sanitized after every use."

On 02/06/19 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings.

No further information was provided prior to exit.

3. The facility staff failed to keep used alcohol swabs off the food-preparation sheet pan and place clean soup bowls on a clean surface before serving.

On 02/05/19 at 11:55 a.m., an observation was made of the holding temperatures of the food on the steam table in the kitchen. An observation of steam table revealed a food preparation table at the end and in line with the steam table. Observation of the food preparation table revealed a sheet pan sitting on top of the food preparation table. Observation of the sheet pan

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F 812	Continued From page 185 revealed the bottom of the pan was covered with parchment paper. On top of the parchment paper was a stack of sliced cheese, 12 slices of bread, and a small stack of 4 grilled cheese sandwiches ready for grilling. Observation of OSM (other staff member) # 11, the cook taking the food temperatures revealed that she would open an alcohol swab package, clean the thermometer after taking the temperature of each food item and set the used alcohol swabs on the sheet pan that contained the cheese, bread and prepped grilled cheese sandwiches. Further observation of the tray line revealed a kitchen staff member placing six clean soup bowls, upside down on the food preparation table above the sheet pan. Further observation of the area on the food preparation table above the sheet pan revealed it was not cleaned before the soup bowls were placed there and there was food debris under the bowls. Further observation of the food line service revealed OSM # 11, the cook, picking up the six soup bowls, one at a time, fill them with soup, and placing a plastic cover over the bowl and then placing them on the resident's lunch trays." On 02/05/19 at 2:20 p.m., an interview was conducted with OSM # 7, dining services manager. When informed of the observation of the placement of the used alcohol swabs and the clean soup bowls, OSM # 7 stated, "The swabs should have been placed in the trash and not on the food prep (preparation) sheet pan and the clean soup bowls should have been placed on a clean serving tray." The facility policy "Food: Preparation" documented in part, "2. Dining Services staff will be responsible for food preparation that avoid	F 812		

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F 812	Continued From page 186 contamination by potentially physical, biological and chemical contamination." On 02/06/19 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit.	F 812	F842 1. Dumpster area was cleaned immediately by Environmental Services Director and staff on 2/5/19. 2. Environmental Service, Dietary and Maintenance Staff along with center management team Members were in serviced by CED, Nurse Practice Educator, Maintenance Director, Environmental Services Manager and Dining Services Director on cleaning around entire dumpster and keeping doors closed according to regulation on 2/5 and 2/6/2019. 3. All patients are at risk for garbage not being disposed of properly. 4. Housekeeping and Dietary Manager or designee to monitor dumpster 5x week for 6 weeks and weekly thereafter to ensure no debris surrounding dumpster and	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster area in a sanitary manner. The facility staff failed to close the sliding doors on the facility's two dumpsters and maintain the area behind the dumpsters free of trash. The findings include: On 02/05/19 at 2:27 p.m., an observation of the facility's dumpsters was conducted with OSM (other staff member) # 7, dining services manager and OSM # 1, director of environmental services. The facility had two dumpsters located behind the facility on a concrete pad. Behind the dumpsters was a lawn area with small shrubs. Observation of both dumpsters revealed one sliding door	F 814		

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F 814	Continued From page 187 located on the side was open on each dumpster. Further observation of the lawn area behind the two dumpsters revealed the following: approximately three old clear plastic trash bags, approximately four soda cans and bottles, a clear old plastic trash bag hanging from a branch in one of the shrubs. Approximately 24 plastic bowl covers, numerous pieces of paper, several Styrofoam cups, several plastic spoons and plastic cups, approximately four pairs of used plastic gloves and several plastic straws. An interview was then conducted with OSM # 1 and # 7. When asked who was responsible for keeping the dumpster's door closed and maintaining the dumpsters in a clean and sanitary manner, OSM # 1 and # 7 stated they were. When asked to describe the procedure for maintaining the dumpsters, OSM # 1 stated, "Environmental services is responsible for checking the dumpsters on Tuesdays and dietary on Thursdays and both department monitor it during the rest of the week." When asked about all the debris and trash observed behind the dumpsters, OSM # 1 stated, "I was going to take care of it the other day but there were some animals around it and I didn't want to deal with them." OSM # 7 stated, "I always check the front and the sides of the dumpsters." When asked about the sliding doors being open on the sides of the dumpster, OSM # 1 and # 7 stated that the doors should be kept closed." On 02/06/19 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit.	F 814	doors closed. Administrator or designee to monitor dumpster for debris and doors closed 3 x week for 4 weeks then weekly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19	

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F 842 SS=E	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, 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	F 842	F842 1. Resident #312 comprehensive care plan for incorrect diagnosis of dementia was discontinued, Resident #35 medications were administered late on 8/30/18 and 10/3/18, Resident #39 and 31 clinical record did not demonstrate details of falls. Late entry documentation were made to resident # 39 and # 31 for the falls that had occurred. 2. All residents are at risk for inaccurate medical records. 100% residents who sign themselves out on leave of absence have been reviewed to ensure that measures are taken to administer their medications according to order. All residents who have had falls in the last 30 days were reviewed to ensure documentation in place regarding the actual fall and follow up to the event. 100% of care plans for residents currently in the facility were audited including ensuring the diagnosis used are accurate.	

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

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F 842	Continued From page 189 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, and 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 four of 55 residents in the survey sample, Residents #312, # 35, #39 and #31. 1. The facility staff inaccurately documented Resident 312's comprehensive care plan with a diagnosis of dementia.	F 842	3. Nurse Practice Educator, ADON and or designee to in-service licensed nursing staff on accurate care plan documentation, late administration of medication and complete documentation of clinical record in reference to falls. 4. ADON and or designee to audit 20% of care plans weekly for 4 weeks to ensure accuracy, 20% of Mars/Tars daily for 4 weeks to ensure proper documentation for late administration and audit residents who fall 5 X week for four weeks, to ensure complete clinical record documentation. All audits will be continued weekly thereafter. Results of audits will be reviewed at Quality Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 3/15/2019	

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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 842	Continued From page 190 2. The facility staff failed to ensure an accurate clinical record for the administration of medications to Resident #35. The facility staff documented two medications were administered to Resident #35 at 8:00 p.m., on 8/30/18 and 10/3/18, when the clinical record documented the resident was out of the facility. 3. The facility staff failed to evidence that the clinical record documented the details of Resident #39's fall on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19. 4. The facility staff failed to evidence that the clinical record documented the details of Resident #31's falls on 12/7/18 and 1/18/19. The findings include: 1. The facility staff inaccurately documented Resident 312's comprehensive care plan with a diagnosis of dementia. Resident # 312 was admitted to the facility on 07/30/18 with diagnoses that included but were not limited to pneumonia, fracture (break) of right humerus (1) urinary tract infection (2), dysphagia, (3), and hypokalemia (4). Resident # 312's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 08/06/18, coded Resident # 312 as scoring an (11) eleven on the brief interview for mental status (BIMS) of a score of 0 - 15, (11) eleven - being moderately impaired of cognition for making daily decisions. Resident # 312 was coded as requiring limited assistance of one staff member for activities of daily living.	F 842		

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F 842	Continued From page 191 The comprehensive care plan for Resident # 312 dated 07/30/2018, documented, "Focus: Resident/patient has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: Dementia (other than Alzheimer's disease). Date initiated: 07/30/2018." The "Assessment & Plan" dated 07/25/18 from (Name of Hospital) for Resident # 312 documented, "(Resident # 312) is a 93 y.o. (year old) female admitted under the hospitalist service with Pneumonia. Patient Active Problem List: Diagnosis: Pneumonia, Diarrhea, UTI (urinary tract infection), Failure to Thrive, CAD (coronary artery disease), Diabetes mellitus, Hypertension, Hyperlipidemia, and recent right humerus fracture." The "Assessment & Plan" dated 07/28/18 from (Name of Hospital) for Resident # 312 documented, "(Internal Medicine Daily Progress Note. Principal Problem" Pneumonia. Active Problems: Diarrhea, Pneumonia left lower lobe due to infectious organism. "(Resident # 312) is a 93 y.o. (year old) female with a PM Hx (past medical history) of coronary artery disease, diabetes mellitus, hypertension, hyperlipidemia who presents here from assisted living facility accompanied by multiple family members secondary to fever." The facility's POS (physician order sheet) dated "7/30/18" for Resident # 312 documented, "PNA (pneumonia), UTI (urinary tract infection), CAD (coronary artery disease), HTN (hypertension), HLD (high-lipid disorder), FTT (failure to thrive), DM II (type two diabetes), HX (history of): C-Diff	F 842		

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F 842	Continued From page 192 (clostridium difficile), hyperkalemia, hx: fall, R (right) humerus fx (fracture)." Further review of the clinical record for Resident # 312 failed to evidence documentation of a diagnosis of dementia. On 02/07/19 at 11:21 a.m., an interview was conducted with RN (registered nurse) # 6, MDS coordinator and LPN (licensed practical nurse) # 6, MDS nurse. LPN #6 was asked where the diagnosis of dementia documented on the comprehensive care plan for Resident # 312 came from. RN # 6 and LPN # 6 reviewed the clinical for Resident # 312. RN # 6 stated, "It is not documented anywhere else, then the care plan is inaccurate in terms of the diagnosis of dementia. When the assistant director of nursing (who was no long employed with the facility) did the initial care plan, she put the diagnosis of dementia on the care plan. I don't know where she got that diagnosis from." When asked to describe the process for obtaining a resident's diagnosis, RN # 6 and LPN # 6 stated, "We get the diagnoses from the hospital discharge summary and any other information from the hospital." On 02/07/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, executive nurse, were made aware of the above findings. No further information was provided prior to exit. Complaint Deficiency References: (1) The humerus is the long bone in the upper	F 842		

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F 842	Continued From page 193 arm. It is located between the elbow joint and the shoulder. This information was obtained from the website: https://www.healthline.com/human-body-maps/humerus-bone#1. (2) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000479.htm. 2. The facility staff failed to ensure an accurate clinical record for the administration of medications to Resident #35. The facility staff documented two medications were administered to Resident #35 at 8:00 p.m., on 8/30/18 and 10/3/18, when the clinical record documented the resident was out of the facility. Resident #35 was admitted to the facility on 5/22/18 with the diagnoses of but not limited to hip fracture, atrial fibrillation, high blood pressure, falls, inguinal hernia, and cardiomyopathy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/23/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for transfers, locomotion,	F 842		

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F 842	Continued From page 194 dressing, eating, and toileting and as requiring supervision for hygiene. A review of the clinical record revealed a physician's order dated 8/22/18 that documented the resident may go on LOA [leave of absence] for 4 hours daily. A review of the nurse's notes revealed the following: A nurse's note dated 8/30/18 documented, "Resident signed out at 1:30pm, today and stated that he was going to (name of bank) and not going to church tonight. Cousin and friend were contacted at 10pm today because resident was not back at facility. Unit manager on call was contacted. Resident made contact with facility soon after and was reported to unit manager on call. Unit manager will pick up resident from Firestone off of (location)...." A nurse's note dated 8/31/18 documented, "Late entry: This RN was contacted by nursing staff of residents failure to return to the facility following his departure for the bank earlier in the afternoon. Nursing staff was advised to make contact with RP to see if they knew where resident was located. This RN was advised that contact was made with residents cousin and friend, neither of which knew of his whereabouts. DON was notified of incident. Nursing staff was advised to call the sheriffs office non emergency number to report the residents failure to return. At approximately 10:30pm, this RN was notified by staff that (resident) had called the facility and stated he was at the Firestone and was unable to get back due to not having enough money for the cab ride. This writer went to pick up resident	F 842		

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F 842	Continued From page 195	F 842		

shortly after. Resident was found in front of the Firestone (location) sitting on the ground. Resident stated he left his bank card back at the facility and was unable to get a ride back. Resident returned to facility. This RN stressed the importance to the resident of returning in a timely manner and the need to be able to take his evening medicine. Resident expressed understanding. Resident was asked where he usually goes when he leaves the facility so if another incident occurs we know where to look. Resident stated that he goes to the (name of bank) on (location) and is usually in the shopping center above or below the hospital. Resident returned to facility at approximately 11:30pm."

A nurse's note dated 10/3/18 documented, "Patient left facility at 2:10 p.m., for LOA was supposed to return by 6:10 p.m. Patient called facility at 7:50 p.m., to say he was at the Bus Station in (location) with no way back. Patient returned at 9:30 p.m. He stated, "Someone from the Bus Station gave me a ride back." Patient education given on Safety and if Patient is going out alone he must have money for Cab fare both ways and he must return back on time."

A review of the clinical record revealed an order dated 5/23/18 for Cal-Gest {1}, 1 tab (tablet) twice daily for calcium supplement; and a Metoprolol {2} 50 mg (milligrams) twice daily for high blood pressure.

A review of the August 2018 MAR (Medication Administration Record) documented that the resident was to receive the above medications at 8:00 p.m. On 8/30/18, these medications were initialed and documented as administered at 8:00 p.m., when the nurses' notes, documented the

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F 842	Continued From page 196	F 842		

resident was not present in the building between 1:30 p.m., and 11:30 p.m. There was no evidence that the physician was notified, consulted for orders to administer the medications late.

A review of the October 2018 MAR documented that the resident was to receive the same two medications above at 8:00 p.m. On 10/3/18, these medications were initialed and documented as administered at 8:00 p.m., when the nurses' notes, documented the resident was not present in the building between 2:10 p.m. and 9:30 p.m. There was no evidence that the physician was notified, consulted for orders to administer the medications late.

On 2/7/19 at 1:24 p.m., in an interview with LPN #4, was asked about the process staff follows when a resident is out on leave long enough to miss medications. LPN #4 stated the physician should be called to verify if the medications could be given or not.

On 2/7/19 at 2:20 p.m., an interview was conducted with the Executive Director (ASM [administrative staff member] #1) and Nurse Executive, ASM #2. When asked about the resident's unsupervised outings into the community and issues he had of returning to the facility timely, ASM #1 stated that he was alert and oriented, his BIMS (Brief Interview for Mental Status exam) was a 15 (cognitively intact). She stated the physician was aware of the resident's outings and that it was his right to go out if he wanted to. When asked about the resident's missed medications when he was late returning to the facility, ASM #1 stated that the doctor should have been notified and direction provided

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F 842	Continued From page 197 whether or not to administer them (medications) late. No further information was provided. {1} Cal-Gest Antacid - "Calcium carbonate is a dietary supplement used when the amount of calcium taken in the diet is not enough. Calcium is needed by the body for healthy bones, muscles, nervous system, and heart. Calcium carbonate also is used as an antacid to relieve heartburn, acid indigestion, and upset stomach. It is available with or without a prescription." Information obtained from https://medlineplus.gov/druginfo/meds/a601032.html {2} Metoprolol - "Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure." Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html 3. The facility staff failed to evidence that the clinical record documented the details of Resident #39's fall on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19. Resident #39 was most recently readmitted to the	F 842		

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F 842	Continued From page 198	F 842		

facility on 12/6/18 with the diagnoses of but not limited to dementia, diabetes, chronic back pain, high blood pressure, history of femur fracture, overactive bladder, adjustment disorder with anxiety, and osteoarthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/3/18. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for eating; and supervision for hygiene, toileting, dressing, and transfers.

A review of the nurse's notes revealed one dated 11/8/18, which documented, "A change in condition has been noted. The symptoms include: Falls 11/8/18 in the afternoon...Orders obtained include: NNO (no new orders)..." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall.

A review of the "Event Summary Report" dated 11/8/18 documented, "Resident feel {sic} in dining room trying to reach across the table to get her stuffed cats. Resident fell to floor and hit her head. Resident stated that her head no long {sic} hurt after a few mins (minutes) and was able to get up from the floor with assistance. Resident was assessed for any injuries and none were found....Interventions added immediately after fall and care plan updated: Resident was educated on not leaning while in chair."

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F 842	Continued From page 199 A review of the nurse's notes revealed one dated 12/24/18, which documented, "A change in condition has been noted. The symptoms include: Falls 12/24/18 in the morning....Change reported to Primary Care Clinician...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 12/24/18 documented, "Resident was found on the floor beside her bed with no injuries, tolerated ROM (range of motion) well with no difficulty, vital signs were taken and neuro checks initiated....Interventions added immediately after fall and care plan updated: Resident had disabled alarm prior to fall, alarm was replaced." A review of the nurse's notes revealed one dated 1/1/19, which documented, "A change in condition has been noted. The symptoms include: Falls....Change reported to Primary Care Clinician....Orders obtained included: Continue to monitor aware of the complaints of buttocks pain no bruising present" This note did not document the circumstances surrounding the fall and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/1/19 documented, "The resident was toileted by the CNA (Certified Nursing Assistant) was instructed to pull call bell when she was done.	F 842		

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F 842	Continued From page 200 The resident did not was noted to be lying on the floor near her bed....Interventions added immediately after fall and care plan updated: Staff to remain with the resident while in the bathroom." A review of the nurse's notes revealed one dated 1/6/19, which documented, "A change in condition has been noted. The symptoms include: Falls 1/6/19 in the morning." A second note dated 1/6/19 documented, "....The resident has no new changes in the ROM, usual complaints of general body ache...." A third note dated 1/6/19 documented, "....NP (nurse practitioner)...aware of the falls this am there are no new orders." These notes did not document the circumstances surrounding the fall and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. There was no incident report related to this fall provided. A review of the nurse's notes revealed one dated 2/3/19, which documented, "A change in condition has been noted. The symptoms include: Falls in the morning....Change reported to Primary Care Clinician....Orders obtained included: Continued observation...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall.	F 842		

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F 842	Continued From page 201 A review of the "Event Summary Report" dated 2/3/19 documented, "The resident had just been toileted and wanted to make her bed which was already done by the CNA (Certified Nursing Assistant). She wanted to place her blankets and had taken her shoes off and her feet slipped and she was found in a kneeling position next to her bed. The residents shoes were placed on and she was assisted via a gait belt which she pushed herself up and placed into her w/c (wheelchair). Neuro [neurological] checks were initiated....Interventions added immediately after fall and care plan updated: Continued education and encouragement to be compliant." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [administrative staff member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, she was notified that the legal clinical record did not reflect the above data regarding how these falls occurred, if there were any injuries, and if there were any care plan reviews or revisions. No further information was provided by the end of the survey. 4. The facility staff failed to evidence that the clinical record documented the details of Resident #31's falls on 12/7/18 and 1/18/19. Resident #31 was admitted to the facility on 5/26/18 with the diagnoses of but not limited to	F 842		

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F 842	Continued From page 202	F 842		

high blood pressure, cardiomyopathy, stroke, atrial fibrillation, pacemaker, dementia, contracture, seizures, chronic kidney disease and acute kidney failure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/5/18. 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; extensive care for transfers, dressing, toileting and hygiene; and limited assistance for eating.

A review of the nurse's notes revealed one dated 1/18/19, which documented, "A change in condition has been noted. The symptoms include: Falls 1/18/19 at night....Change reported to Primary Care Clinician...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall.

A review of the "Event Summary Report" dated 1/18/19 documented, "Resident was found face down beside his bed with no injuries, tolerated ROM well, res stated "I am trying to grab something from the floor" denies any pain/discomfort....Interventions added immediately after fall and care plan updated: Educated resident to use call bell at all times."

On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [administrative staff member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal

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F 842	Continued From page 203 document and is not part of the legal clinical record. At this time, she was notified that the legal clinical record did not reflect the above data regarding how this fall occurred, if there were any injuries, and if there were any care plan reviews or revisions. No further information was provided by the end of the survey.	F 842		
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 the facility staff failed to provide the required annual in-service training's for 10 CNAs (certified nursing assistants) who	F 947	F947 1. Facility failed to provide required annual 12 hours of mandatory Dementia Training for CNA #1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. Dementia Training being provided for all current Certified Nurses Aids. 2. All nursing staff will receive the required Dementia Training according to regulation. 3. Nurse Practice Educator and or designee will provide scheduled mandatory education on Dementia training, on hire, monthly and quarterly according to regulations. 4. Director of Nursing will audit training monthly for 4 months then randomly thereafter to ensure required dementia training is occurring. Variances	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

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F 947	Continued From page 204 were employed for at least one year. The facility staff failed to provide the required annual 12 hours and/or dementia management training's for CNA #1, CNA #2, CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, CNA #9, and CNA #10. The findings include: On 2/6/19 at approximately 9:00 a.m., a request was made to administrative staff member (ASM) #2, the nurse executive, for the training transcripts, for all CNAs who were employed at the facility for at least one year. For six of the above listed CNAs, an "In-service Record" was provided. The following was documented: CNA #2 - last training's completed - 1/5/18 CNA # 3 - last training's completed - 1/5/18 CNA # 1 - last training's completed - 1/8/18 CNA #6 - last training's completed - 1/5/18 CNA # 7 - last training's completed - 1/8/18 CNA # 9 - last training's completed - 1/8/18. There were no training records for CNA #4, CNA #5, CNA #8 and CNA #10. An interview was conducted with RN (registered nurse) #5, the nurse practice educator, on 2/7/19 at 11:36 a.m. When asked if she had any other documentation of training's provided to the above listed CNAs, RN #5 stated, "I have reviewed all the files in my office and I haven't been able to find any other documented training's since January 2018." ASM #1, the executive director, ASM #2 and ASM	F 947	and brought to monthly Quality Assurance and Performance Improvement Committee monthly with QAPI committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19	

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F 947	Continued From page 205 #3, the clinical quality specialist, were made aware of the above concern on 2/7/19 at 3:46 p.m. No further information was provided prior to exit.	F 947		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0279	A. BUILDING _____ B. WING _____	02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 2/5/19 through 2/7/19. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 118 certified bed facility was 103 at the time of the survey. The survey sample consisted of 45 current resident reviews and 10 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 250 A - cross references to Federal deficiency 641 12 VAC 5 - 371 - 360 E 11 - cross references to Federal deficiency 661 12 VAC 5 - 371 - 200 B 3 and B 9 - cross references to Federal deficiency 730 12 VAC 5 - 371 - 210 D - cross references to Federal Deficiency 732 12VAC5-371-140. Policies and Procedures. Cross reference to F622, F695 12VAC5-371-150. Resident Rights. Cross reference to F622 12VAC5-371-220. Nursing Services. Cross reference to F676, F695 12VAC5-371-250. Resident Assessment and Care	F 001	See F-641 See F661 SeeF730 See F732 See F622, F695 See F622 See F676, F695 See F-656,695 See F622 See F580 See F684 See F695 See F583 See F656	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Regional Center Executive Director | TITLE | (X6) DATE: 2/28/19

VDH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 001	Continued From Page 1 Planning. Cross reference to F656, F695 12VAC5-371-360. Clinical Records. Cross reference to F622 12VAC5-371-220. Nursing Services cross reference to F580. 12VAC5-371-220. Nursing Services cross reference to F684. 12VAC5-371-220. Nursing Services cross reference to F695. 12VAC5-371-150. (F) cross references with Federal deficiency 583 12 VAC 5-371-250 (G) cross references with Federal deficiency 656	F 001		