STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495213	A. BUILDING _____ B. WING _____	C 10/04/2018

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BAYSIDE HEALTH & REHABILITATION CENTER	1004 INDEPENDENCE BLVD VIRGINIA BEACH, VA 23455

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/2/18 through 10/4/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 10/02/18 through 10/04/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 54 at the time of the survey. The survey sample consisted of 20 current Resident reviews and 3 closed record reviews.	F 000		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social	F 574		11/4/18

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

Electronically Signed | 10/22/2018

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F 574	Continued From page 1	F 574		

Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
(iii) Information regarding Medicare and Medicaid eligibility and coverage;
(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans

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F 574	Continued From page 2 Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on information obtained during the Resident Council Meeting, observations and interviews, the facility staff failed to display advocacy agencies addresses, and telephone numbers in a manner the residents could utilize. The findings included: A resident council meeting was held in the resident dining hall on 10/03/2018 from 10:00 AM to 10:35 AM. Six residents attended the meeting. The residents were not aware of how to obtain or utilize the Long-Term Care Ombudsman's contact information or other advocacy agencies. They were also unaware of the role of the Long-Term Care Ombudsman. On 10/03/18 at approximately 3:20 PM an interview was conducted with the Activity Director regarding the residents in the Resident Council Meeting stating that they were not aware of who the Ombudsman was and the role of the Ombudsman. The Activity Directory stated that she would educated the residents to the facility posting and on the role of the Ombudsman.	F 574	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F574 1. A resident council meeting has been held to review advocacy agency addresses and telephone numbers and the role of the Long-Term Care Ombudsman. 2. The Discharge Planner will review advocacy agency contact information with patients during quarterly care plans and	

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F 574	Continued From page 3 The Activity Director stated that the advocacy agencies addresses and phone numbers were displayed on the wall in the hallway. The advocacy posting was in a glass picture frame not at eye level if a resident was sitting in a wheel chair. The print on the display appeared small. The Activity Director was asked if she could get a resident to read the advocacy sign. She said that she would find a good reader to read the posting. The sub headings were typed in bold upper case print. The print had an approximate font size of 16 with the remainder of the wording with an approximate font size of 12: Resident Rights, How To Resolve A concern, How To File A Grievance, How To Contact the following agencies for issues: OLC (Office of Licensure and Certification, LTC Ombudsman, APS.(Adult Protective Services). The first wheel chair bound resident was asked to read the posting in the facility hallway, but stated that the print was too small to read. The posting was lowered on the wall by facility staff. The activity director stated that she could find another resident to read the sign again. On 10/03/18 at approximately 5:00 PM Resident was asked to read the sign once it was lowered on the wall but he stated that the print was too small to read. The Activity Director informed the surveyor at approximately 5 PM that she had started informing most residents where the Resident rights, ombudsman's info were posted including the contact lists as well as where to locate the survey book. No postings were found in the resident rooms.	F 574	document in a progress note. 3. The Admissions Department will review advocacy information with new admissions and the Activity Director will review advocacy information at monthly resident council meetings. 4. The Administrator will monitor posting of advocacy information and resident ability to utilize the information on a random weekly basis. 5. Results of the monitoring will be presented to the QA committee for review and recommendation.	

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F 574	Continued From page 4 The facility's policy titled Prevention/Screening Training dated 06/20/16 states that the Administrator grievance forms are available for the individual and or family to complete. Investigation and resolution of grievances shall be completed the prevention of abuse and neglect and misappropriation of property by performing background checks on all employees and by advocating and enforcing patient rights and providing patients, families, and staff information on how and to whom they may report concerns, incidents, and grievances without fear of retribution. The procedure states that a poster with the current names, addresses, and telephone numbers of all pertinent state client advocacy groups (such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit) is posted in the Center in an area that is readily accessible to patients and their families. The above findings were shared with the Administrator and Director of Nursing on 10/04/2018 at approximately 7:00 PM.	F 574		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		11/4/18

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F 625	Continued From page 5 any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy for 3 of 23 resident's (Resident #2, #30 and #38) in the survey sample. 1. The facility staff failed to provide the resident (Resident #2) and/or resident's representative with a written copy of the bed hold policy upon transfer to the hospital. 2. The facility staff failed to provide the resident (Resident #30) and/or resident's representative with a written copy of the bed hold policy upon transfer to the hospital. 3. The facility staff failed to provide the resident (Resident #38) and/or resident's representative	F 625	F625 1. Residents #2 and 38 are current residents. Resident #30 discharged to home on October 10, 2018. 2. Bed hold policy information will be provided to residents at time of transfer, hospitalization, or therapeutic leave. 3. The Admission Director will inform the resident or resident representative of the bed hold policy at time of transfer, hospitalization, or therapeutic leave and document provision of the information. 4. The Administrator will monitor documentation of provision of the bed hold policy on a random weekly basis. 5. Results of the monitoring will be presented to the QA committee for review	

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with a written copy of the bed hold policy upon transfer to the hospital.

The findings included:

1. Resident #2 was originally admitted to the facility 9/18/18, was discharged return anticipated from the facility to an acute care hospital 9/23/18 due to an acute illness. The resident returned to the facility 9/25/18. The current diagnoses included; a subarachnoid hemorrhage (a brain bleed) with right side weakness.

No Minimum Data Set (MDS) assessments had not been completed which included a Brief Interview for Mental Status (BIMS) score. The Director of Nursing (DON) stated the resident was usually alert and oriented to person, place and time.

The 9/18/18, discharge MDS assessment revealed in section "G" (Physical functioning) the resident was coded as requiring supervision of 1 person with eating, limited assistance of 1 person with locomotion, extensive assistance of 1 people with dressing, and toileting, extensive assistance of 2 people with bed mobility and transfers and total care of 1 person with bathing.

Review of the clinical record revealed a nurse's note dated 9/23/18, which stated Resident #2 complained of numbness and tingling of the right leg and an inability to stop the spasms in the left leg. The note stated the resident insisted on a transfer to the local hospital.

An interview was conducted with Resident #2 on 10/3/18, at approximately 12:20 p.m. The resident stated she didn't remember the facility staff giving

and recommendation.

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her written information the day she was discharged from the facility to the hospital related to reserving her bed while hospitalized.

The hospital's discharge summary revealed the resident was admitted 9/23/18 and discharged 9/25/18.

On 10/04/18 at approximately at 3:20 p.m., an interview was conducted with the Admission Director and the Admission Coordinator. They both stated they were unaware it was a requirement to offer resident's discharged to the hospital a bed-hold for they provided bed-hold information upon admission to the facility.

On 10/4/18, at approximately 6:15 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided.

2. Resident #30 was originally admitted to the facility 8/17/18, was discharged return anticipated from the facility to an acute care hospital 9/17/18 due to an acute illness. The resident returned to the facility 9/23/18. The current diagnoses included; heart failure.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/24/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #30's cognitive abilities for daily decision making were intact.
In section "G" (Physical functioning) the resident was coded as requiring supervision of 1 person

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with eating, limited assistance of 1 person with in room walking and personal hygiene, extensive assistance of 1 person with bed mobility, transfers, locomotion, dressing, toileting, and bathing.

Review of the clinical record revealed a nurse's note dated 9/17/18, which stated Resident #30 was sent to a local acute care hospital per the responsible party's request; for chest pain. The 9/23/18, hospital discharge summary stated the resident was admitted for exacerbation of heart failure.

An interview was conducted with Resident #30 on 10/3/18, at approximately 12:30 p.m. The resident stated the facility staff didn't give her or her daughter written information the day she was discharged from the facility to the hospital related to reserving her bed while hospitalized.

On 10/04/18 at approximately at 3:20 p.m., an interview was conducted with the Admission Director and the Admission Coordinator. They both stated they were unaware it was a requirement to offer resident's discharged to the hospital a bed-hold for they provided bed-hold information upon admission to the facility.

On 10/4/18, at approximately 6:15 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided.

3. Resident #38 was re-admitted to the facility on 09/4/18. Diagnosis for Resident #38 included but not limited to Chronic Respiratory Failure.

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The current Minimum Data Set (MDS), a 14-day assessment with an Assessment Reference Date (ARD) of 9/18/18 coded the resident with a 8 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment.

The Discharge MDS assessments was dated for 08/08/18-discharge return anticipated and re-admitted to the facility on 09/04/18.

On 08/08/18, according to the facility's documentation, Resident #38 was found with labored breathing, lung sounds wet and coarse. Resident #38 had vomited thick brown emesis. Resident's vital signs were; BP (176/102), P (119), R (26), T (97.6), 02 saturations at 74% on 4/Liters. The facility called 911, Resident #38 was transferred to local ER and admitted with a diagnosis of Aspiration Pneumonia.

An interview was conducted with the Admission Coordinator and Admission Director on 10/04/18 at approximately 3:30 p.m. The both stated, "Since they were given the bed hold policy upon admission, they did not know they had to give them a copy of the bed hold policy when they were discharged out to the hospital."

The facility administration was informed of the finding during a briefing on 10/04/18 at approximately 5:10 p.m. The facility did not present any further information about the findings.

The facility's policy titled Bed Reserve (Revision date: 02/05/15).
-Policy: The Admissions Director will ensure the proper documentation is executed for any patient desiring to voluntarily reserve a bed.

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F 625	Continued From page 10 -Procedure: -The admissions Director must establish contact with the patient and/or responsible agent to determine bed retention arrangements once the patient's hospitalization has been confirmed. -The Admission Director will inform the patient/responsible representative of the payment amount necessary for the requested accommodation of days. -The Admissions Director will establish a time for signing of the Voluntary Bed Retention Agreement and the collection of payment.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 23 residents (Resident #17) in the survey sample who were unable to carry out activities of daily living (ADL) receives the necessary services to maintain fingernail care. The facility staff failed to ensure that fingernail care was provided to Resident #17. The findings included: Resident #17 was re-admitted to the facility on 03/14/16. Diagnosis for Resident #17 included but not limited to *Cerebrovascular Accident (CVA-stroke) with left *hemiplegia. *CVA is a medical emergency. Strokes happen	F 677	F677 1. Resident #17 is receiving fingernail care. 2. Resident fingernails were reviewed to ensure that fingernail care has been provided. 3. Nursing staff were educated on provision of fingernail care. 4. A registered nurse will monitor provision of fingernail care on a random weekly basis. 5. Results of the monitoring will be presented to the QA committee for review	11/4/18

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when blood flow to your brain stops. Within minutes, brain cells begin to die (https://medlineplus.gov/stroke.html).
*Hemiplegia is the loss of muscle function on one side of the body (https://medlineplus.gov/druginfo/meds/a682514.html).
The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 08/20/18 coded Resident #17 with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #17 requiring extensive assistance of two with personal hygiene.
Resident #17's comprehensive care plan with a revision date of 03/08/17 under ADL self-care performance deficit related to stroke with dense left hemiplegia did not include the care or maintenance of fingernail care/hand hygiene.
On 10/02/18 at approximately 10:24 a.m., during the initial tour resident #17 voiced concerns that his fingernails needed to be cut and cleaned. Resident #17's fingernails were observed to be long, thick with a dark brown substance under them. On the same day at approximately 1:05 p.m., the resident's fingernails remained unchanged.
On 10/03/18 at approximately 10:20 a.m., the Director of Nursing (DON) assessed Resident #17's fingernail with the surveyor present. The DON stated, "Yes, his fingernails need to be cut, cleaned and trimmed." The DON said all resident's fingernails and toenails should be looked at twice weekly on shower days by the Certified Nursing Assistant (CNA) and they are to inform the nurses when nail care is needed.
An interview was conducted with CNA #1 on 10/03/18 at 4:05 p.m.who was assigned to give

and recommendation.

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F 677	Continued From page 12 Resident #17 his shower on 10/02/18 (3-11 shift). The CNA stated, "I saw that Resident #17 needed his fingernails cut last night but I did not have enough time. She (CNA) stated, "Time ran out; I would have cut them tonight but he was not my resident." On 10/03/18 at approximately 5:40 p.m., Resident #17 was observed with his fingernails cut, trimmed and clean. Resident stated, "Thank you." The facility administration was informed of the finding during a briefing on 10/4/18 at approximately 5:10 p.m. The facility did not present any further information about the findings.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and facility documentation, the facility staff failed to follow physician orders for 1 of 23 (Resident #27) in the survey. The facility staff failed to follow physician orders for a wound care dressing change to Resident #27's right elbow with a diagnosis of *Methicillin Resistant Staphylococcus Aureus (MRSA) infection.	F 684	F684 1. Resident #27 is receiving wound care dressing changes as ordered by the physician. 2. Residents with wounds were reviewed to ensure that wound care dressing changes have been completed as ordered by the physician. 3. Licensed nurses were educated on	11/4/18

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F 684	Continued From page 13 *MRSA is an infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections (https://www.mayoclinic.org/diseases-conditions/mrsa/symptoms-causes/syc). The findings included: Resident #27 was admitted to the facility on 01/18/18. Diagnosis for Resident #27 included but not limited to Methicillin Resistant Staphylococcus Aureus (MRSA) infection. Resident #27 Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 09/11/18 coded Resident #27's Brief Interview for Mental Status (BIMS) scored of 05 out of a possible score of 15 indicating severe cognitive impairment. In addition, the MDS coded Resident #27 total dependence of one with bathing, extensive assistance of two with bed mobility, transfer, toilet use and personal hygiene, extensive assistance of one with dressing and supervision with eating for Activities of Daily Living care. The MDS with an ARD of 09/11/18 under section "M" (Skin Condition - M0100) was coded: Under section (M1040) for other ulcers, wounds and skin problems was coded for surgical wounds and skin tear and under section (M1200) for skin and treatments was coded for surgical wound care and applications of ointments/medications (other than feet). Also, the MDS for active diagnosis under Infections was coded for Multidrug-Resistant Organism (MDRO - MRSA). The comprehensive care plan dated 09/24/14	F 684	completion and documentation of wound care dressing changes as ordered by the physician. 4. A registered nurse will monitor completion of wound care dressing changes as ordered by the physician on a random weekly basis. 5. Results of the monitoring will be presented to the QA committee for review and recommendation.	

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F 684	Continued From page 14	F 684		

with a revision date of 09/25/18 identified Resident #27 with actual impairment to skin integrity to right elbow surgical wound. The goal set for the resident by the staff was that the resident would have no complications related to surgical wound of the right elbow. Some of the interventions/approaches the staff would use to accomplish this goal included to keep skin clean and dry, use lotion on dry skin and change *mepilex (foam dressing) to right elbow as ordered.

On 10/03/18 at approximately 1:00 p.m., a wound care observation was conducted with License Practical Nurse (LPN) #3. Resident #27 was lying in bed, positioned on her left side. Prior to starting wound care to Resident #27, LPN #3 washed her hands x 24 seconds the donned a pair of gloves. The LPN removed the dressing from the surgical wound to Resident #27's right elbow; the dressing was dated 10/02/18; (3-11 shift). The surveyor asked LPN #1, "What is the date and shift written on the dressing being removed from the right elbow, she replied, "10/2/18 (3-11 shift)."

Review of the Resident #27's clinical record evidenced a physician order dated 01/18/18 revealed the following: clean right elbow with *Dermal Wound Cleanser (DWC), cover with gauze and mepilex every shift. This order was also noted on the Treatment Administration Record (TAR) for October 2018.

The review of Resident #27's October 2018 TAR, the nurse had signed off on 10/02/18 (11p-7a shift) that the dressing change was completed to the surgical wound to resident's right elbow.

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F 684	Continued From page 15 A call was placed to LPN #3's cell phone on 10/4/18 at approximately 10:15 a.m. LPN #3 was the nurse assigned to change the surgical wound dressing to Resident #27's right elbow on 10/2/18 (11-7 shift). A message was left to call the surveyor. The LPN returned the call but was missed. Another call was placed to LPN #3 on the same day at 11:05 a.m., with no return call. An interview conducted with Director of Nursing (DON) on 10/04/18 at approximately 2:00 p.m., who stated, "I expect for the nurses to follow the physician orders. Resident #27's dressing change should have been completed as ordered." The facility administration was informed of the finding during a briefing on 10/04/18 at approximately 5:10 p.m. The facility did not present any further information about the findings. The facility's policy titled General Wound Care Dressing Changes (Revision date: 02/01/15). Policy: A license nurse will provide wound care/dressing changes as ordered by physician.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 756		11/4/18

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F 756	Continued From page 16 and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on review of the resident's medical chart, staff interview, and review of the facility's policy the facility staff failed to assure each resident's medication regimen was reviewed monthly for 1 of 23 residents (Resident #3), in the survey sample. The facility staff failed to review Resident #3's medication regimen during the month of April 2018.	F 756	F756 1. Resident #3 has documentation of a current Monthly Medication Regimen review. 2. Residents were reviewed to ensure that there is a current Monthly Medication Review documented in the medical record. 3. The Pharmacy Consultant was educated on the need for documentation	

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F 756	Continued From page 17 The findings included: Resident #3 was originally admitted to the facility 2/26/14 and has never been discharged from the facility. The current diagnoses included; an anxiety disorder, depression and arthritis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/26/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #3 cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring set-up assistance of 1 person with bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. Resident #3 Physician's order summary for 10/1/18 revealed the resident was currently receiving 16 prescribed medications. Clinical record notes revealed, pharmacy review progress notes dated 10/16/17, 11/14/17, 12/9/17, 1/16/18, 2/8/18, 3/9/18, 5/10/18, 6/15/18, 7/23/18, 8/24/18 and 9/28/18. There was no review for April 2018. An interview was conducted with on 10/14/18, with the the Director of Nursing (DON). The DON stated, "it is the facility's expectation for each resident's medication regimen to be reviewed by the pharmacist monthly." On 10/4/18, at approximately 6:15 p.m., the above findings were shared with the Administrator	F 756	of the Monthly Medication Review in the resident□s medical record. 4. A registered nurse will monitor documentation of the Monthly Medication Review in resident medical records on a random monthly basis. 5. Results of the monitoring will be presented to the QA committee for review and recommendation.	

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F 756	Continued From page 18 and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided. The facility's policy titled "Medication Regimen Review", with a revision dated of 12/1/17, read at #10. If an irregularity does require urgent action but should be addressed before the consultant pharmacist's next monthly Medication Regimen Review.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		11/4/18

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F 761	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation review the facility staff failed to ensure one medication cart was stored in a secured location, accessible to designated staff only. The facility staff failed to ensure medication cart containing medication in the hallway was locked when not in direct site of the nurse. The findings included: On 10/03/18 at approximately 6:20 p.m., the medication cart on the back hall was observed to be unlocked when not in direct view of the nurse. The surveyor waited at the medication cart for approximately 4 minutes before the License Practical Nurse (LPN) #4 returned to her med cart. The surveyor asked, "Should your medication cart be locked when not in direct view of the nurse" she replied, "Yes, I should have checked to make sure my cart was locked before I walked away." On the same day at approximately 6:30 p.m., an interview was conducted with Unit Manager (UM) who stated, "The nurse should have made sure her medication cart was locked before she walked away." The facility administration was informed of the finding during a briefing on 10/04/18 at approximately 5:10 p.m. The Director of Nursing (DON) stated, "The nurse should have doubled checked to make sure her medication cart was locked before she left." The facility did not present any further information about the findings.	F 761	F761 1. Medication carts are locked when not in direct sight of the nurse. 2. Medication carts will be locked when not in direct sight of the nurse and keys will be accessible only to authorized personnel. 3. Licensed nurses will be educated on locking of the medication cart when not in direct sight and limitation of access to keys to authorized personnel. 4. A registered nurse will randomly monitor locking of carts on a weekly basis. 5. Results of the monitoring will be presented to the QA committee for review and recommendation.	

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F 761	Continued From page 20 The facility's policy: Medications - 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles (Last revision Date: 10/31/16). Applicability: This Policy 5.3 sets for the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. General Storage Procedures: -3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.	F 761		
F 812 SS=D	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.	F 812		11/4/18

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F 812	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review the facility staff failed to store food in accordance with professional standards for food service safety. The food service staff failed to ensure foods stored in refrigerated units were labeled and dated appropriately when open; and failed to store employee lunch in an area designated for staff use only. The findings included: On 10/02/18 at 7:55 a.m., during the initial inspection of the kitchen with the dietary cook, the following was observed: 1. Inside the walk in refrigerator was a container of raw chicken; not labeled and dated. 2. Inside the walk in freezer was a bag of mixed vegetables, bag of cinnamon rolls and bag of pulled chicken, all items were open; not labeled and dated. 3. Inside the reach in refrigerator were pre-made salads for the residents along with an employee lunch box. On 10/02/18 at approximately 8:00 a.m., the surveyor asked the dietary cook, "Should the raw chicken, mixed vegetables, cinnamon rolls and bag of pulled chicken be labeled and dated" he replied, "Yes" the dietary cook immediately labeled and dated the chicken but discarded the mixed vegetables, cinnamon rolls and pulled chicken from the walk in freezer.	F 812	F812 1. Food stored in refrigerated units are labeled and dated when opened and employee lunches are being stored in a refrigerated unit designated for employee use. 2. Food is being stored in accordance with professional standards for food service safety. 3. Dietary staff were educated on labeling and dating of food when opened and storage of employee food in areas designated for employee use. 4. The Dietary Manager will monitor labeling and dating of opened food and storage of employee food in non-resident storage areas on a random weekly basis. 5. Results of the monitoring will be presented to the QA committee for review and recommendation.	

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F 812	Continued From page 22 An interview was conducted with the Food Service Director on 10/02/18 at approximately 8:40 a.m., who stated, "Yes, all foods should be labeled and dated once opened." An interview was conducted with the Dietary Manager on 10/02/18 at approximately 9:05 a.m., who stated, "All food items should be labeled and dated after they have been opened and employees should not put their personal lunch in the resident's refrigerator in the main kitchen." The facility's policy titled Refrigerated and Frozen Foods (Effective date: 09/14/18). -Policy: Foods stored in the refrigerator or freezer will be stored in a manner which maintains the food so that it is safe to eat, and retains optimal nutrient content and aesthetic quality. -Procedure: All refrigerated and frozen containers will be labeled, indicating the name of the product and use-by-date. The facility's policy titled Outside Food/Microwave Use (Effective date: 09/14/18). -Procedure: Employee foods should only be stored in areas specifically designated for employees.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		11/4/18

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(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 by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 24 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 observation, staff interviews and facility documentation review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 23 residents (Resident #27) in the survey sample. The facility staff failed to ensure Resident #27's Treatment Administration Record (TAR) was accurate for the right elbow surgical wound dressing change. The findings included: Resident #27 was admitted to the facility on 01/18/18. Diagnosis for Resident #27 included but not limited to Methicillin Resistant Staphylococcus Aureus (MRSA) infection. Resident #27's Minimum Data Set (MDS - an	F 842	F842 1. Resident #27□s medical record is currently accurate. 2. Resident TARs were reviewed to ensure that the medical record is accurate and complete. 3. Licensed staff were educated on accurate and complete documentation in the resident medical record. 4. A registered nurse will complete a random weekly review of documentation in the resident medical record to ensure that the documentation is accurate and complete.	

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F 842	Continued From page 25 assessment protocol) with an Assessment Reference Date of 09/11/18 coded Resident #27's Brief Interview for Mental Status (BIMS) scored of 05 out of a possible score of 15 indicating severe cognitive impairment. In addition, the MDS coded Resident #27 total dependence of one with bathing, extensive assistance of two with bed mobility, transfer, toilet use and personal hygiene, extensive assistance of one with dressing and supervision with eating for Activities of Daily Living care. The MDS with an ARD of 09/11/18 under section "M" (Skin Condition - M0100) was coded: Under section (M1040) for other ulcers, wounds and skin problems was coded for surgical wounds and skin tear and under section (M1200) for skin and treatments was coded for surgical wound care and applications of ointments/medications (other than feet). Also, the MDS for active diagnosis under Infections was coded for Multidrug-Resistant Organism (MDRO - MRSA). On 10/03/18 at approximately 1:00 p.m., a wound care observation was conducted with License Practical Nurse (LPN) #3. Resident #27 was lying in bed, positioned on her left side. Prior to starting wound care to the Resident #27, LPN #3 washed her hands x 24 seconds the donned a pair of gloves. The LPN removed the dressing from the surgical wound to Resident #27's right elbow; the dressing was dated 10/02/18; (3-11 shift). The surveyor asked LPN #1, "What is the date and shift written on the dressing being removed from the right elbow, she replied, "10/02/18 (3-11 shift)." Review of the Resident #27's clinical record evidenced a physician order dated 01/18/18 revealed the following: clean right elbow with *Dermal Wound Cleanser (DWC), cover with gauze and *mepilex (foam dressing) every shift.	F 842	5. Results of the monitoring will be presented to the QA committee for review and recommendation.	

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F 842	Continued From page 26 This order was also noted on the Treatment Administration Record (TAR) for October 2018. The review of Resident #27's October 2018 TAR, the nurse had signed off on 10/02/18 (11p-7a shift) that the dressing change was completed to the surgical wound to resident's right elbow. A call was placed to LPN #3's cell phone on 10/4/18 at approximately 10:15 a.m. LPN #3 was the nurse assigned to change the surgical wound dressing to Resident #27's right elbow on 10/02/18 (11-7 shift). A message was left to call the surveyor. The LPN returned the call but was missed. Another call was placed to LPN #3 on the same day at 11:05 a.m., with no return call. An interview conducted with Director of Nursing (DON) on 10/04/18 at approximately 2:00 p.m. The surveyor asked the DON, "When do you expect for the nurses to document a resident's treatment has been completed on the TAR" she stated, "I expect for the nurses to sign off on the TAR only after the treatment has been completed. The facility administration was informed of the finding during a briefing on 10/04/18 at approximately 5:10 p.m. The facility did not present any further information about the findings. The facility's policy titled Nursing Documentation (Revision: 02/01/15). Procedure in part: 3. Entries will be made as soon as possible after an event or observation is made. An entry will never be made in advance.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		11/4/18

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 28 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to maintain effective infection control practices during the provision of care for 2 of 23 residents (Residents #39 and 27), in the survey sample. 1. The facility staff failed to perform hand hygiene during wound care for Resident #39. 2. The facility staff failed to disinfect Resident #27's personal over bed table before after being used to perform a wound care dressing change that was being treated for *Methicillin Resistant Staphylococcus Aureus (MRSA) infection. The findings included:	F 880	F880 1. Proper hand hygiene is being performed during wound care for resident #39. The over bed table is being disinfected during provision of wound care for resident #27. 2. Hand hygiene and disinfection of the over bed table during provision of wound care is being provided to residents receiving wound care. 3. Licensed staff were educated on hand hygiene and disinfection of the over bed table during wound care. 4. A registered nurse will randomly monitor hand hygiene and disinfection of the over bed table during provision of	

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F 880	Continued From page 29 1. Resident #39 was originally admitted to the facility 7/25/18 and has never been discharged from the facility. The current diagnoses included; a stage 4 pressure ulcer of the sacrum and an unstageable pressure ulcer of the left heel. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/1/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #X cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring set-up with eating, supervision of 2 or more with personal hygiene, extensive assistance of 1 person with dressing, extensive assistance of 2 people with bed mobility, and total care of 1 with toileting and bathing. In section "M" (Skin Condition) the resident was coded as having an 1 unstageable pressure and 1 stage 4 pressure ulcer present and a potential for additional skin problems. A physician order dated 9/25/18, read change wound vacuum Monday, Wednesday and Friday every evening shift. Wound vacuum suction at 125 every shift. Another physician order dated 10/3/18, read cleanse left heel with betadine, cover with gauze and Allevyn every evening shift until healed. The current care plan problem revised 9/25/18 read; skin impairment, sacral ulcer stage 4, left heel necrotic deep tissue injury. Has a wound vacuum. The goal read; the resident will have no evidence of skin impairment through next review 10.30/18. the interventions included; moisture barrier cream as needed for protection of skin,	F 880	wound care on a weekly basis. 5. Results of the monitoring will be presented to the QA committee for review and recommendation.	

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pressure reduction mattress, weekly skin assessments. Wound care as ordered was not an intervention.

On 10/3/18 at approximately 2:10 p.m., pressure ulcer care for Resident #39 was observed. Licensed Practical Nurse (LPN) #8 was observed removing the old wound vacuum drainage canister, dressing and tubing. LPN #8 didn't remove the gloves or perform hand hygiene after removal of the soiled dressing. LPN #8 then cleaned the resident's sacral pressure ulcer with 4 by 4 gauze and wound cleanser, afterwards she removed the gloves and again didn't perform hand hygiene with sanitizer or soap and water. LPN #8 attached the new wound vacuum tubing to the new canister, allowing the tubing ends to make contact with the bed linens. LPN #8, cut the foam dressing and placed it on the bed. The biocclusive dressing was prepared, the foam dressing was placed on the pressure ulcer, another sponge dressing was applied and a hole was made in the foam sponge for the canister tubing, the scissors were placed on the bed, the biocclusive dressings was and the tubing was applied. The pump was turned on and the dressings was held to allowed the wound vacuum to seal. LPN #8 changed the gloves, again she did not sanitized or wash her hands. New gloves were applied, a protective barrier was applied around the wound vacuum dressing, and a piece of tape with the date on it was applied the the dressing. LPN #8 put an incontinence brief was on the resident and positioned him in bed. LPN #8 again, removed the gloves, washed her hands and new gloves were donned. The dressing to the left heel was removed. No hand hygiene was performed prior to cleaning the left heel pressure ulcer. The left heel was cleaned with wound

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cleanser and 4 by 4 gauze, betadine was painted on the left heel, followed by 4 by 4 gauze, a dressing and a non-skid sock was applied. The wound care supplies were removed from the table, the table was cleaned and the trash was discarded.

An interview was conducted on 10/3/18, at approximately 6:00 p.m., with the Director of Nursing. The Director of Nursing stated hand hygiene should take place when going from soiled to clean, and after removing gloves and anytime indicated during wound care.

On 10/4/18, at approximately 6:15 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was given for the facility to present additional information but none was provided.

2. Resident #27 was admitted to the facility on 01/18/18. Diagnosis for Resident #27 included but not limited to Methicillin Resistant Staphylococcus Aureus (MRSA) infection. Resident #27 Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 09/11/18 coded Resident #27's Brief Interview for Mental Status (BIMS) scored of 05 out of a possible score of 15 indicating severe cognitive impairment. In addition, the MDS coded Resident #27 total dependence of one with bathing, extensive assistance of two with bed mobility, transfer, toilet use and personal hygiene, extensive assistance of one with dressing and supervision with eating for Activities of Daily Living care.
The MDS with an ARD of 09/11/18 under section "M" (Skin Condition - M0100) was coded: Under section (M1040) for other ulcers, wounds and

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skin problems was coded for surgical wounds and skin tear and under section (M1200) for skin and treatments was coded for surgical wound care and applications of ointments/medications (other than feet). Also, the MDS for active diagnosis under Infections was coded for Multidrug-Resistant Organism (MDRO - MRSA).
The care plan dated 05/21/15 with a revision date of 02/21/18 identified Resident #27 comprehensive care plan with history of chronic MRSA in right elbow surgical wound and takes *Bactrim DS daily prophylactically. The goal set for the resident by the staff was that the resident will be free from complications related to infection through the next review. Some of the interventions/approaches the staff would use to accomplish this goal included to administer medication as ordered, monitor/document/report signs and symptoms of infections to physician and maintain precautions (contact) as ordered.
*Bactrim DS are both antibiotics that treat different types of infections caused by bacteria (drugs.com).
Review of the Resident #27's clinical record evidenced a physician order dated 02/01/18 revealed the following: Bactrim DS tablet 800-160 mg-give 1 tablet by mouth one time a day for MRSA. This order was also noted on the Medication Administration Record (MAR) for October 2018.
On 10/03/18 at approximately 1:00 p.m., a wound care observation was conducted with License Practical Nurse (LPN) #3. Prior to starting wound care to Resident #27, LPN #1 washed her hands x 24 seconds then donned a pair of gloves. The LPN placed a barrier pad covering Resident #27's personal over bed table without disinfecting the table. The LPN did not remove the TV remote or water pitcher from the over bed table. The LPN

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placed all treatment supplies on the barrier which consisted of the following: *Mepilex dressing, 4x4 gauzes and wound cleanser . The LPN placed a small red biohazard bag at the foot of residents bed. The LPN removed her gloves, washed her hands x 21 seconds then donned another pair of gloves. She then removed the dressings from the surgical wounds to the right elbow; two open areas were observed. The soiled dressing removed were placed in biohazard bag. A large amount of serosanquious drainage was noted on the dressing removed but without odor. The proximal wound was cleansed with wound cleaner x 2 in a circular motion, gloves removed, hands washed x 16 seconds, gloves donned then wound bed covered with mepilex dressing. The distal wound was cleansed with wound cleaner x 2 in a circular motion, gloves removed, hands washed x 23 seconds, gloves donned then wound covered with mepilex dressing. The LPN removed all wound care supplies from the over bed table then placed the over bed table at resident's bedside without disinfecting it.
An interview was conducted with LPN #1 on 10/03/18 at approximately 2:55 p.m., who stated, "I should have disinfected the over bed table before and after treatment and also I should have removed the TV remote and the resident's water pitcher before starting wound care."
An interview was conducted with Staff Development Coordinator on 10/04/18 at approximately 11:59 a.m., who stated, "All personal items should have been removed prior to starting wound care treatment." The table should have been wiped down with antibacterial wipes; let the table dry completely, cover the over bed table with a barrier, place items on the barrier, complete treatment, remove barrier, wipe table again with antibacterial wipes let the table

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F 880	Continued From page 34 dry completely then replace personal belongings. The facility administration was informed of the finding during a briefing on 10/04/18 at approximately 5:10 p.m. The facility did not present any further information about the findings. 1. The facility's policy titled "Infection Prevention and Control Policies and Procedures" Handwashing Requirements was dated 12/26/17. The policy read at procedure A1t; after any contact with potentially contaminated materials (used wound/treatment/dressings), procedure D3; change gloves during patient care when moving from a contaminated body site to a clean body site. 2. The facility's Treatment Observation Non-Sterile Treatment Technique (Last revision: 1/18). Observations to read in part: Clean and sanitize surface before placing waterproof barrier on table.	F 880		