STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 3/1/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 196 certified bed facility was 138 at the time of the survey. The survey sample consisted of 11 resident record reviews.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561	1. Resident # 2 was interviewed regarding shower preference and residents shower schedule was adjusted per her preference. 2. All residents have potential to not have shower preferences honored. An interview was conducted on all residents by the DCS or designee to assure residents shower preferences have been met. 3. All nursing staff (RN, LPN, and CNA) were educated by the DCS or Designee completed by date regarding resident's rights and ensuring residents shower preference is honored.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 4/9/2019

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F 561	Continued From page 1 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility documentation the facility failed to ensure Resident right to self determination for one Resident (#2) in a survey sample of 11 Residents. 1. For Resident #2 the facility failed to allow Resident to determine when she can shower and upon refusal of a shower at 4:15 AM they labeled the refusal as a "behavior." The Findings Include: Resident #2, a 59 year old woman admitted to the facility on 12/4/18 with diagnoses of but not limited to muscle weakness fatigue, history of falls, insomnia, stroke, Major depressive disorder diabetes Hemiplegia and Hemiparesis following stroke. Resident #2's most recent (Minimum Data Set) MDS (screening tool) coded as an admission assessment dated 2/22/19 coded the Resident as having a (Brief Interview of Mental Status) BIMS of 13 indicating mild cognitive impairment. On 3/1/19 at 10:45 a family member approached this surveyor and expressed concern over Resident #1's care. She stated she was the Resident's family member and she was concerned about her getting showered and cleaned up. She stated that Resident said she was expected to take showers in the middle of the night.	F 561	4. QI monitoring will be done by the DCS/Designee to ensure residents shower preferences are honored three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3months for further compliance and/or revision. 5. Date of Compliance: 4/2/19	

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F 561	Continued From page 2 An interview with Resident #2 was then conducted. Resident #2 stated, "They come in here in the middle the night and tell me I need a shower because it's my shower day." She went on to say that she told them she would not be showering at that time that she would like her showers between 7:00 and 8:00 in the morning. She also stated she didn't get her meds on time. On 2/28/19 a clinical record review revealed Progress Note stated: 3/1/19 4:15 AM- Behavior Note: Resident advised that tonight was her shower day. Resident asked if they had to have a shower in the middle of the night. Staff explained to the she is on the 11 pm-7 am shower schedule so she's able to take a shower in between the hours. Resident also advised that showers usually start as early as 4 AM along with morning rounds. Resident stated "I'll Skip it". Staff reminded resident that skipping her shower was not conducive to proper care. Charge nurse attempted to reason with resident that she would be able to get back in bed and that she didn't have to stay up. Residents denied shower again. Staff asked when would be a better time for her to get up and shower. Resident states that she prefers some time between 7 am and 8 am. Staff reminded resident that her shower schedule was on 11-7 shift and that would be too late. Resident again stated that she did not want to take a shower in the early morning hours. Resident also stated "Y'all are going to have to figure out a schedule that works for me" Advised resident that we would have to document her refusing the shower and Notify her RP and MD. Resident stated that was fine and again stated " I'm not	F 561		

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F 561	Continued From page 3 going to take a shower this early"'MD/RP notified." 3/1/19 4:26 AM- Behavior Note Addendum: Documentation correction that resident is own RP and aware. MD aware. On 3/1/19 an interview was conducted with the Administrator and the DON When asked are showers given on any particular shift the DON responded that they were given on all shifts. When asked what time the night shift starts their showers she responded between 500 and 530 am. When asked was she aware of showers being given at 4 am the Administrator stated yes I know who that is and they get up that early that's why. When he was informed of who this Resident was he stated no that's not the same person I was thinking about. The DON and Administrator read the progress note dated 3/1/19 at 4:15 am. The Administrator stated that's not right they should have told her we can see about getting your time changed. DON stated we can always move her to dayshift showers. When asked if a Resident who has a who is her own Responsible Party should be allowed to refuse a shower at 4:15 AM without it being labeled a "BEHAVIOR" the Administrator stated it should not be written as a behavior note she has the right to refuse care at any time. On 3/1/19 an interview was conducted with Employee O (Social Worker). Employee O stated that she felt this was wrong for them to expect a Resident to get up at 4:00 am and shower and it should not be labeled as a behavior. She stated that the resident is alert and oriented she is her own RP she should be allowed to choose when	F 561		

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F 561	Continued From page 4 she gets a shower. She further stated "I will be meeting with her to fix this issue with the shower schedule." On 3/1/19 at the end of day conference the Administration was made aware and offered no new information.	F 561	1. Resident # 10 was placed in another room pending the replacement bed from hospice. Resident #4, #5, #6 and #7 nurse was immediately educated and residents medical information was secured. 2. All residents have potential to be affected. An audit was completed to ensure no other observations of failure to maintain privacy of medical records and residents. No other residents were affected. 3. All clinically licensed staff was educated on HIPAA requirements related to privacy screens when passing medications and on resident rights related to dignity and privacy completed on March 25, 2019 by the Director of Clinical Services and the Staff Development Coordinator.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		

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F 583	Continued From page 5 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure privacy for 1 Resident (Resident # 10) and failed to maintain privacy of clinical records for 4 residents (Residents # 4, 5, 6, and 7) in a survey sample of 11 residents. 1. For Resident # 10 the Resident was observed in the hallway sleeping in a hospital bed for an hour and half. 2. For Resident # 4, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour. 3. For Resident # 5, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour. 4.For Resident # 6, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour. 5. For Resident # 7, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour. The Findings Include: 1. For Resident # 10 the Resident was observed in the hallway sleeping in a hospital bed for an	F 583	4. QI monitoring to ensure privacy of medical records and residents will be done by the DCS/Designee three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3months for further compliance and/or revision. 5. Date of Compliance: 4/2/19	

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F 583	Continued From page 6 hour and half. Resident # 10 a 76 year old man was admitted to the 4/29/18 with diagnoses of but not limited to Parkinson Disease, Atrial Fibrillation (irregular heart beat), Major Depressive Disorder, Dysphagia, and Cognitive Communication Deficit. On 3/1/19 at 10:00 AM, during initial tour, Resident # 10 was observed in the North Hallway asleep in a hospital bed. On 3/1/19 at 10:10 AM, a Vendor was observed near elevator. Vendor stated that he was in the facility to install a "Hospice Bed." When asked in which room he was installing the bed, the Vendor pointed to the Resident in the hallway and said I am not sure of the room number but it is his room. On 3/1/19 at 11:30 AM, staff returned Resident # 10 to his room and transferred him to his new bed. On 3/1/19, an interview was conducted with the DON. When the DON was asked if she was aware of Resident being left in the hallway while his 'Hospice Bed" was being installed, she stated that she was not aware of this. The DON was notified of amount of time Resident was in the hallway and the fact there were several empty rooms. The DON stated that was unacceptable they should have put him in an empty room until his room was ready. When asked why he should not be left in the hall, the DON stated there is no privacy in the hall, anyone can see him and watch him while he is asleep.	F 583		

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F 583	Continued From page 7 On 3/1/19 during end of day conference, the Administrator was made aware of issue and no further information was provided. 2. For Resident # 4, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour. Resident # 4 was an 82-year-old male admitted to the facility on 10/10/2018 with the diagnoses of, but not limited to:Cerebral Infarct, Diabetes, Hypoglycemia, Dementia, Hypertension, and Polyneuropathy. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/23/2019. The MDS coded Resident # 4 with a BIMS (Brief Interview for Mental Status) score of 8/15, indicating severe cognitive impairment. Resident # 4 required limited assistance of one staff person with activities of daily living except for eating and bathing. Resident # 4 required supervision with set up only for eating and total assistance of one staff person for bathing. Resident # 4 was coded as occasionally continent of bowel and bladder. On 3/1/2019 at 11:39 AM, Registered Nurse (RN) C was observed to prepare medications and leave the medication cart. Surveyor A walked past the medication cart. The screen was available for view. Resident # 4's name and list of medications were seen on the screen. On 3/1/2019 at 12:21 PM, an interview was conducted with Staff Development Nurse, Registered Nurse (RN) A. RN A was informed	F 583		

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F 583	Continued From page 8 that the nurse, RN C, was observed to walk away from the medication cart several times while passing medications while leaving the computer screen visible. RN A stated that it was not acceptable for the nurse to leave the medication cart with the Medication Record screen available for view. RN A stated the screen should be hidden any time the nurse walked away. During the end of day debriefing, the facility administrator and Director of Nursing were informed of the findings. No further information was provided. 3. For Resident # 5, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour. Resident # 5 was a 79-year-old female admitted to the facility on 1/3/2019 with the diagnoses of, but not limited to, Diabetes, Schizophrenia with extrapyramidal and movement disorder, Gastroesophageal Reflux Disorder, Hypertension, Major Depressive Disorder, Pacemaker, Anemia. and Vitamin Deficiency. The most recent Minimum Data Set (MDS) was a 30 day assessment with an Assessment Reference Date (ARD) of 1/31/2019. The MDS coded Resident # 5 with a BIMS (Brief Interview for Mental Status) score of 15/15, indicating no cognitive impairment. Resident # 5 required extensive assistance of one staff person with activities of daily living. On 3/1/2019 at 12:04 PM, Registered Nurse (RN) C was observed walking away from the	F 583		

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F 583	Continued From page 9 medication cart with a medication cup in her hand. Surveyor A walked past the medication cart and saw the screen was open to Resident # 5 profile displaying identifying information and a list of medications. On 3/1/2019 at 12:21 PM, an interview was conducted with Staff Development Nurse, Registered Nurse (RN) A. RN A was informed that the nurse, RN C, was observed to walk away from the medication cart several times while passing medications while leaving the computer screen visible. RN A stated that it was not acceptable for the nurse to leave the medication cart with the Medication Record screen available for view. RN A stated the screen should be hidden any time the nurse walked away. During the end of day debriefing, the facility administrator and Director of Nursing were informed of the findings. No further information was provided. 4. For Resident # 6, the facility staff left the Medication Administration Record open for view and unattended during medication pass and pour. Resident # 6 was an 83-year-old female admitted to the facility on 1/25/2019 with the diagnoses of, but not limited to, Atherosclerotic Heart Disease, Contractures of left elbow and left hand, Diabetes, Hemiplegia, Tinea Corporis, Pressure Ulcer of Left Heel, and Hypertension. The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 2/1/2019. The MDS	F 583		

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F 583	Continued From page 10 coded Resident # 6 with a BIMS (Brief Interview for Mental Status) score of 13/15, indicating no cognitive impairment. Resident # 6 required extensive to total assistance of one staff person with activities of daily living except she required total assistance of two staff persons for transfers and limited assistance of one staff person for eating; Resident #6 was coded as always continent of bowel and bladder. On 3/1/2019 at 11:26 AM, three residents were observed standing at the medication cart. The nurse was not at the medication cart. The computer screen open with the name of a resident (Resident # 6) openly displayed. Demographic information and a list of medications was noted on the screen. On 3/1/2019 at 11:29 AM, observed nurse, Registered Nurse (RN) C, returned to the medication cart. On 3/1/2019 at 12:21 PM, an interview was conducted with Staff Development Nurse, Registered Nurse (RN) A. RN A was informed that the nurse, RN C, was observed to walk away from the medication cart several times while passing medications while leaving the computer screen visible. RN A stated that it was not acceptable for the nurse to leave the medication cart with the Medication Record screen available for view. RN A stated the screen should be hidden any time the nurse walked away. During the end of day debriefing, the facility administrator and Director of Nursing were informed of the findings. No further information was provided.	F 583		

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F 604	Continued From page 11	F 604		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility failed to ensure freedom from restraints for 1 Resident (Resident #1) in a survey sample of 11	F 604	Past noncompliance: no plan of correction required.	

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F 604	Continued From page 12 Residents. For Resident #1 the facility reported in a (Facility Reported Incident) FRI that the resident was found restrained in the bed with a bed sheet tied on both side rails. The findings included: Resident #1 a 75 year old man admitted to the facility on 12/4/18 with diagnoses of but not limited to muscle weakness fatigue and repeated falls, Dementia without behavioral disturbances, anemia, insomnia, Dementia in other diseases classified elsewhere with behavioral disturbances. Resident #1's most recent (Minimum Data Set) MDS (screening tool) coded as an admission assessment dated 12/21/18 coded the Resident as having a (Brief Interview of Mental Status) BIMS of 2 indicating severe cognitive impairment. On 3/1/2019 an interview was conducted with LPN D (the nurse who discovered Resident #1 restrained). She stated that on 2/15/2019 she arrived at work and counted narcotics and got report with the off going nurse. She stated she went down the north hall because Resident #1 had fallen a few days prior and she wanted to check on him as he was a fall risk. LPN D stated that she went down the hall and saw his door was open and the bed was in the lowest position with fall mats at either side of the bed. Resident #1 was in bed but sitting on the side facing the window, trying to get up. She stated she then yelled "Hey [CNA C] help me he's going to fall!" She said she and CNA C went to	F 604		

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F 604	Continued From page 13	F 604		

the bed and saw the bed sheet was tied on both bedrails, trapping him in the bed with the sheet at the waist level.

LPN D stated she had then untied him and called the Unit manager the on call manager and the DON. She stated that she then asked which CNA was assigned to his care and was told it was CNA E. She stated that she then questioned CNA E and CNA E stated that CNA D was assisting her with her assignment and she put him to bed. CNA D had already left for the evening as she was only scheduled until 7:00 PM.

LPN D further questioned CNA E and she admitted that she and CNA D both tied him to the bed.

On 3/1/19 at 2:00 PM, an interview was conducted with the DON and the Administrator who stated that he (the Administrator) reported the incident to the State Agency as a (Facility Reported Incident) FRI via fax and phone call as required. The facility investigation included an interview with both CNA's involved and CNA D admitted to tying him to the bed with the sheet with the assistance of CNA E however she stated that she did not do it out of intent to harm she did it because she couldn't get her work done because he was wandering. The CNA's involved were terminated and the State Board of Nursing was notified.

The DON submitted in-service documents dated prior to incident 1/23/19 on Abuse and Neglect. She also submitted in-service sheets dated 2/16/19 on Abuse Neglect and Physical Restraint showing all staff had been in-serviced.

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F 604	Continued From page 14 On 3/1/19 during end of day conference this issue was discussed and no further information was provided. The facility submitted the following Plan of Correction: 1. Resident #1 was immediately assessed and no physical or psychological changes were noted. The facility immediately suspended both CNA's pending investigation. A review of personnel records for both employees identified were completed. No other performance issues were noted in the file. Additionally both employees had received education regarding abuse and neglect prior to this allegation. Both employees have been terminated and reported to the Virginia Department of Health. Allegation reported to OLC, APS and ombudsman within two hours of allegation. 2. The facility has identified that all residents are at risk of abuse. An immediate observation was done on all residents to ensure no other residents had bedsheets tied to the side rails. No other incidents were noted. Skin assessments and resident and staff interviews were completed for the entire facility roster of residents and staff. No additional allegations of abuse were noted. 3. Education was initiated immediately to all staff regarding identifying and reporting abuse and neglect. 4. The facility will conduct ongoing training on abuse/neglect with all staff. All additional allegations of abuse will be reported as required. Management will be present on various shifts for patient observation two times per week for the next four weeks to validate education on abuse and neglect, as well as conduct resident interviews with all interviewable residents and observation for signs and symptoms of abuse.	F 604		

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F 604	Continued From page 15 Information will be reported to the QAPI committee monthly for further compliance and or revision. 5. Date of Compliance: 02/22/2019 Past Non-Compliance.	F 604	1. Resident #2, # 3, #4, #5, #6, #7, #9 provider and responsible representative were notified regarding medications not being administered within the standard parameters of medication administration. No new orders were received. Residents were assessed for adverse reactions. No adverse reactions were identified. 2. All residents have potential to be affected. An audit was completed to ensure no other residents were affected by this deficiency. No other residents were identified. 3. All clinically licensed staff was educated on ensuring medications are administered within the standard parameters of time completed on March 25, 2019 by the Director of Clinical Services.	
F 658 SS=E	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 observation, resident interview, family interview, staff interview, and clinical record review, the facility staff failed to follow the professional standards of medication administration for 6 residents (Residents # 3, # 4, # 5, # 6, # 7, 9, and # 2) in a survey of 11 residents. 1. For Resident # 3, the facility staff failed to administer medications within the standard parameters of time regarding medication administration. 2. For Resident # 4, the facility staff failed to administer medications within the standard parameters of time regarding medication administration. 3. For Resident # 5, the facility staff failed to administer medications within the standard parameters of time regarding medication administration.	F 658		

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F 658	Continued From page 16 4. For Resident # 6, the facility staff failed to administer medications within the standard parameters of time regarding medication administration. 5. For Resident # 7, the facility staff failed to administer medications within the standard parameters of time regarding medication administration. 6. For Resident # 9, the facility staff failed to administer medications within the standard parameters of time regarding medication administration. 7. For Resident #2, the facility failed to administer medications within the standard parameters of medication administration. Findings included: 1. For Resident # 3, the facility staff failed to administer medications within the standard parameters of medication administration. Resident # 3 was a 61-year-old male admitted to the facility on 10/25/2017 with the diagnoses of, but not limited to, Severe Chronic Obstructive Pulmonary Disease, Sarcoidosis, Hypertension, Chronic Pain Syndrome following multiple car accidents, depression and anxiety, Major Depressive disorder. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 3 with a BIMS (Brief Interview	F 658	4. QI monitoring will be done by the DCS/Designee to ensure medications are administered within the standard parameters of time three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3months for further compliance and/or revision. 5. Date of Compliance: 4/2/2019	

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F 658	Continued From page 17 for Mental Status) score of 15/15, indicating no cognitive impairment. Resident # 3 required supervision and set up only assistance with activities of daily living for ambulation, dressing, eating, bathing and toileting and required supervision with assistance of one staff person for transfer and bed mobility; Resident # 3 was coded as always continent of bowel and bladder. On 3/1/2019 at 10:20 AM, an interview was conducted with Resident # 3 who stated the facility was always working short of staff. Resident # 3 stated he received his medications late the night before (2/28/2019). Resident # 3 stated he did not get his medication until 11 PM but was supposed to get it at 9 PM. Resident # 3 stated he was upset because he needed to get his breathing medications on time. Resident # 3 stated he had 4 liters of oxygen per minute and still was short of breath because of COPD. Resident # 3 stated "I need my medicines on time so I can breathe." Review of the clinical record was conducted on 3/1/2019 at 11:30 AM. Review of the February 2019 Medication Administration Record revealed documentation of medications being administered at 9 PM on 2/28/2019. There was no documentation of late administration of medications for Resident # 3. Review of the Nurses Notes from 2/1/2019 to 3/1/2019 revealed no documentation of late administration of medications. Thorough review of the clinical record revealed no documentation of late administration of medications on 2/28/2019.	F 658		

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F 658	Continued From page 18 On 3/1/2019 at 1:10 PM, an interview was conducted with the Staff Development Director, Registered Nurse (RN) A who stated medications should be passed within an hour before and an hour after the scheduled time of administration. RNA A stated RN C was a new employee of approximately 3 weeks at the time of the survey. RN A stated "the 6 rights of Medication Administration" was stressed during orientation with all new nurses. RN A stated new nurses receive 3 days of classroom instruction and 3 days on the floor with a nurse, then any questions should be directed to the Unit Manager or Staff Development Nurse or any other nurse on the floor. RN A stated RN C received the information about medication administration during her orientation. RNA A stated the professional nursing standard was for nurses to administer medications within one hour before and one hour after the scheduled time of administration and that "all nurses should know that." RN A was asked to provide a copy of the orientation topics covered with Registered Nurse C. The list of topics covered during RN C's orientation was not provided to the surveyor prior to the end of the survey. On 3/1/2019 at 1:35 PM, an interview was conducted with the Director of Nursing who stated the MAR showed the medications were administered at 9 PM as scheduled. The DON was informed that Resident # 3 reported that he received his medications 2 hours late on 2/28/2019. When the DON was asked for a copy of the EMAR (electronic medication administration record) report, she stated she was not sure of how to obtain a copy of the EMAR report. The DON stated she would get a Nurse	F 658		

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F 658	Continued From page 19 who was familiar with giving medications and using the EMAR system to try to retrieve the report. On 3/1/19 at 1:45 PM, an interview was conducted with the unit manager, Licensed Practical Nurse (LPN) E, who looked at the MAR and stated that the medications were given at the time printed on the MAR. When told that Resident # 3 stated he received his medications late on 2/28/2019, LPN E stated she would see if she could print out what the actual times of administration shown on the EMAR (electronic medication administration record). When LPN E was asked if she could access the EMAR information on the computer given to the surveyors to use, LPN E attempted to retrieve the report and got the error message "User does not have access to this screen." LPN E stated she would try one of the facility's computers. LPN E then went to a facility computer and printed he EMAR Report denoting the exact times each medications were administered, signed out and by whom. On 3/1/2019 at 2:02 PM, LPN E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were not correct. They were actually administered at the times noted: Advair Diskus Aerosol Powder Breath Activated 250-50 microgram/dose one puff inhale orally two times a day for Chronic Obstructive Pulmonary Disease Scheduled at 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM)	F 658		

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F 658	Continued From page 20 Gabapentin 600 milligrams give one tablet by mouth two times a day Scheduled at 9 AM and 9 PM for Chronic Pain Syndrome 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Ketotifen Fumarate Solution 0.025 % Instill one drop in both eyes every 12 hours Scheduled at 9 AM and 9 PM related to Hereditary and Idiopathic Neuropathy Scheduled at 9 AM and 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Oxycontin Extended Release 12 hour Abuse-Deterrent 20 milligrams give one tablet by mouth every 12 hours related to Chronic Pain Syndrome Scheduled 9 AM and 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Senna Capsule 8.6 milligrams give one capsule by mouth at bedtime for constipation Scheduled at 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Tylenol 325 milligrams Give 3 tablets every 8 hours for pain Scheduled at 6 AM, 2 PM and 10 PM 2/28/2019 at 23:14 (11:14 PM) documented 2/28/2019 at 23:18 (11:18 PM) On 3/1/2019 at 5 PM, the Director of Nursing reported that Potter and Perry was the standard used by the facility for professional nursing guidance. The DON stated the facility staff was expected to use the six rights of Medication Administration.	F 658		

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Guidance for professional nursing standards for the administration of medication was provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed:
"Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident."

During the end of the day debriefing, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications actually were given over two hours

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F 658	Continued From page 22 later than the scheduled time of 9 PM on 2/28/2019 and appeared to have been given on time according to the MAR. The Director of Nursing stated the expectation was that medications should be administered within one hour before and after the scheduled time. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 20:01 (8:01 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications administered late." signed by LPN B. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 19:56 (7:56 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications administered late." signed by Registered Nurse (RN) B. No further information was provided. 2. For Resident # 4, the facility staff failed to administer medications within the standard parameters of medication administration. Resident # 4 was an 82-year-old male admitted to the facility on 10/10/2018 with the diagnoses of, but not limited to:Cerebral Infarct, Diabetes, Hypoglycemia., Dementia, Hypertension, and Polyneuropathy. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/23/2019. The MDS	F 658		

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F 658	Continued From page 23 coded Resident # 4 with a BIMS (Brief Interview for Mental Status) score of 8/15, indicating severe cognitive impairment. Resident # 4 required limited assistance of one staff person with activities of daily living except for eating and bathing. Resident # 4 required supervision with set up only for eating and total assistance of one staff person for bathing. Resident # 4 was coded as occasionally continent of bowel and bladder. Review of the clinical record was conducted on 3/1/2019 at 1:15 PM. Review of the Medication Administration Record revealed documentation of all medications being administered on time. There were check marks and the initials of the nurses administering the medications in the slots for scheduled times. There was no documentation of late administration of medications on the MAR. Review of the Nurses Notes from 2/1/2019 to 3/1/2019 revealed no documentation of late administration of medications. The last Nurses Note was 2/28/2019 at 17:05 (5:05 PM) stating "Bs (Blood Sugar) was 72." On 3/1/2019 at 1:35 PM, an interview was conducted with the Director of Nursing who stated the MAR showed the medications were administered as scheduled. When the DON was asked for a copy of the EMAR (electronic medication administration record) report, she stated she was not sure of how to obtain a copy of the EMAR report. The DON stated she would get a Nurse who was familiar with giving medications and using the EMAR system to try to retrieve the report.	F 658		

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F 658	Continued From page 24 On 3/1/19 at 1:45 PM, an interview was conducted with the unit manager, Licensed Practical Nurse (LPN) E, who looked at the MAR and stated that the medications were given at the time printed on the MAR. LPN E stated she would see if she could print out what the actual times of administration showed on the EMAR (electronic medication administration record). When LPN E was asked if she could access the EMAR information on the computer given to the surveyors to use, LPN E attempted to retrieve the report and got the error message "User does not have access to this screen." LPN E stated she would try one of the facility's computers. LPN E then went to a facility computer and printed he EMAR Report denoting the exact times the medications were administered, signed out and by whom. On 3/1/2019 at 2:02 PM, LPN E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Ascorbic Acid Tablet 500 milligrams by mouth one time a day Scheduled for 9 AM 3/1/2019 administered at 10:39 AM Aspirin 81 milligrams one tablet by mouth one time a day Scheduled for 9 AM 3/1/2019 administered at 10:39 AM Calcium 600-D 600-400 milligrams one tablet by mouth two times a day for supplement , vitamin D deficiency Scheduled 9 AM and 9 PM 3/1/2019 administered at 10:39 AM (due at 9 AM)	F 658		

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F 658	Continued From page 25 2/27/2019 administered at 11:46 PM (due at 9 PM) Humalog Insulin per sliding scale : If 151-200 = 3 units, 201-250= 6 units, 251-300= 9 units, 301-350= 12 units, 351-400= 15 units, subcutaneously before meals and at bedtime related to Diabetes Scheduled 6 AM, 11 AM, 4 PM and 9 PM 2/27/2019 at 11:47 PM (9 PM dose) Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed: "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." During the end of the day debriefing, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the	F 658		

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F 658	Continued From page 26 nurses notes revealed documentation on 3/1/2019 at 19:56 (7:56 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications were administered late this morning." signed by RN B. No further information was provided. 3. For Resident # 5, the facility staff failed to administer medications within the standard parameters of medication administration. Resident # 5 was a 79-year-old female admitted to the facility on 1/3/2019 with the diagnoses of, but not limited to, Diabetes, Schizophrenia with extrapyramidal and movement disorder, Gastroesophageal Reflux Disorder, Hypertension, Major Depressive Disorder, Pacemaker, Anemia, and Vitamin Deficiency. The most recent Minimum Data Set (MDS) was a 30 day assessment with an Assessment Reference Date (ARD) of 1/31/2019. The MDS coded Resident # 5 with a BIMS (Brief Interview for Mental Status) score of 15/15, indicating no cognitive impairment. Resident # 5 required extensive assistance of one staff person with activities of daily living. Review of the clinical record was conducted on 3/1/2019. Review of the March 2019 Medication Administration Record revealed medications were administered on 3/1/2019 at 9 AM. There was a check mark indicating the medications were administered. There was no documentation of late administration of medications. There was no	F 658		

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F 658	Continued From page 27 documentation of medications scheduled to be administered during the time the nurse, Registered Nurse (RN) C was observed passing medications to Resident # 5 on 3/1/2019. Review of the Nurses Notes from 2/1/2019 to 3/1/2019 revealed no documentation of late administration of medications. The last Progress Note was from Activities on 2/22/2019 at 13:30 (1:30 PM) stating "Participation Note:_____(Resident # 5) does not wish to participate in group programs and enjoys spending time in room watching tv. She likes friendly conversation at times. No concerns. Signed by Activities Director. The note prior to the Activities note was a Skilled Nurse Note dated 2/21/2019 at 1:50 AM. On 3/1/2019 at 1:10 PM. an interview was conducted with the Staff Development Director, Registered Nurse (RN) A who stated medications should be passed within an hour before and an hour after the scheduled time of administration. RNA A stated RN C was a new employee of approximately 3 weeks at the time of the survey. RN A stated the 6 rights of Medication Administration was stressed during orientation with all new nurses. RN A stated new nurses receive 3 days of classroom instruction and 3 days on the floor with a nurse, then any questions should be directed to the Unit Manager or Staff Development Nurse or any other nurse on the floor. RN A stated RN C received the information about medication administration during her orientation. RNA A stated the professional nursing standard was for nurses to administer medications within one hour before and one hour after the scheduled time of administration and that "all nurses should know that."	F 658		

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F 658	Continued From page 28 RN A was asked to provide a copy of the orientation topics covered with Registered Nurse C. The list of topics covered during RN C's orientation was not provided to the surveyor prior to the end of the survey. On 3/1/2019 at 1:35 PM, an interview was conducted with the Director of Nursing who stated the MAR showed the medications were administered as scheduled. When the DON was asked for a copy of the EMAR (electronic medication administration record) report, she stated she was not sure of how to obtain a copy of the EMAR report. The DON stated she would get a Nurse who was familiar with giving medications and using the EMAR system to try to retrieve the report. On 3/1/19 at 1:45 PM, an interview was conducted with the unit manager, Licensed Practical Nurse (LPN) E, who looked at the MAR and stated that the medications were given at the time printed on the MAR. When informed that RN C was observed administering medications to Resident # 5 at times not scheduled, LPN E stated she would see if she could print out what the actual times of administration showed on the EMAR (electronic medication administration record). When LPN E was asked if she could access the EMAR information on the computer given to the surveyors to use, LPN E attempted to retrieve the report and got the error message "User does not have access to this screen." LPN E stated she would try one of the facility's computers. LPN E then went to a facility computer and printed he EMAR Report denoting the exact times the medications were administered, signed out and by whom.	F 658		

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F 658	Continued From page 29 On 3/1/2019 at 2:02 PM, LPN E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Aspirin EC (Enteric Coated) Delayed Release 81 milligrams one tablet by mouth one time a day. Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Atorvastatin 40 milligrams give one tablet by mouth one time a day for Hyperlipidemia Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Buspirone 5 milligrams one tablet by mouth one time a day for major depressive disorder. Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Loratadine 10 milligrams one tablet by mouth one time a day for Allergic Rhinitis Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Miralax 17 grams by mouth two times a day related to constipation Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Tramadol 50 milligrams give 0.5 tablet by mouth every 12 hours for pain Scheduled at 9 AM and 9 PM 3/1/2019- administered at 12:03 PM Zoloft 25 milligrams give one tablet by mouth one time a day. for Major Depressive Disorder Scheduled at 9 AM	F 658		

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F 658	Continued From page 30 3/1/2019- administered at 12:03 PM Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed: "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." On 3/1/2019 at 3:30 PM, an interview was conducted with RN A who stated it was not acceptable for medications to be given 3 hours late. RN A stated she planned to provide education to the nursing staff about proper medication administration. RN A stated she had "talked with the staff on duty now and will educate the other shifts too." RN A stated she would stress medication administration standards during orientation of new employees as well. During the end of the day debriefing, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications listed were given three hours later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the	F 658		

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F 658	Continued From page 31 nurses notes revealed documentation on 3/1/2019 at 19:57 (7:57 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of late administration of morning meds (medications)." signed by RN B. No further information was provided. 4. For Resident # 6, the facility staff failed to administer medications within the standard parameters of medication administration. Resident # 6 was an 83-year-old female admitted to the facility on 1/25/2019 with the diagnoses of, but not limited to, Atherosclerotic Heart Disease, Contractures of left elbow and left hand, Diabetes, Hemiplegia, Tinea Corporis, Pressure Ulcer of Left Heel, and Hypertension. The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 2/1/2019. The MDS coded Resident # 6 with a BIMS (Brief Interview for Mental Status) score of 13/15, indicating no cognitive impairment. Resident # 6 required extensive to total assistance of one staff person with activities of daily living except she required total assistance of two staff persons for transfers and limited assistance of one staff person for eating; Resident # 6 was coded as always continent of bowel and bladder. Review of the clinical record was conducted on 3/1/2019. Review of the March 2019 Medication Administration Record revealed medications were administered on 3/1/2019 at 9 AM. There was a	F 658		

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F 658	Continued From page 32 check mark indicating the medications were administered. There was no documentation of late administration of medications. There was no documentation of medications scheduled to be administered during the time the nurse, Registered Nurse (RN) C was observed passing medications to Resident # 6 on 3/1/2019. Review of the Nurses Notes revealed no documentation of late administration of medications. On 3/1/2019 at 2:02 PM, Licensed Practical Nurse (LPN) E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Amlodipine 10 milligrams give one tablet by mouth one time a day Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Aspirin chewable 81 milligrams give one tablet by mouth one time a day Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Atorvastatin 20 milligrams give one tablet by mouth one time a day Scheduled ay 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Basaglar KwikPen Insulin inject 10 units subcutaneously one time a day for Diabetes Scheduled at 9 AM 3/1/2019 administered at 11:17 AM	F 658		

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F 658	Continued From page 33 2/28/2019 administered at 10:39 AM Lisinopril 10 milligrams give one tablet by mouth one time a day for Hypertension Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Metformin 500 milligrams give one tablet by mouth one time a day for Diabetes Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed: "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." On 3/1/2019 at 3:30 PM, an interview was conducted with RN A who stated it was not acceptable for medications to be given late. RN A stated she planned to provide education to the nursing staff about proper medication administration. RN A stated she had "talked with the staff on duty now and will educate the other shifts too." RN A stated she would stress the importance of adhering to the standards of medication administration during orientation of new employees as well. During the end of the day debriefing, the Administrator and Director of Nursing were informed of the findings of medications being	F 658		

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F 658	Continued From page 34 documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 20:10 (8:10 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications were administered late." signed by RN C. No further information was provided. 5 . For Resident # 7, the facility staff failed to administer medications within the standard parameters of medication administration. For Resident #7, the facility staff failed to administer medications on time within the standard parameters of medication administration. Resident # 7, a 60 year old female, was admitted to the facility 11/28/18. Resident # 7's diagnoses included but were not limited to: Epilepsy, Malignant Neoplasm of the uterus, Vitamin D Deficiency, Anemia, Edema, Bariatric Surgery, Generalized Anxiety Disorder.	F 658		

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F 658	Continued From page 35 Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/5/2018 was coded as an admission assessment. Resident # 7 was coded as having a BIMS (Brief Interview of Memory Status) Score of 15 out of 15 indicating no cognitive impairment and was able to make her own daily life decisions. Resident # 7 was coded as requiring limited to extensive assistance of one staff member to perform her activities of daily living including transfers, toileting, hygiene and bathing. Resident # 7 was coded as independent in eating, and ambulation On 3/1/2019 at 11:55 AM, review of the clinical record for Resident # 7 was conducted. Review of the Medication Administration Record (MAR) for March 2019 revealed documentation of medications that were administered at 9 AM. The MAR revealed that Resident # 7 had only one medication due at the time the nurse was observed to be administering medications to her (Depakote 500 milligrams by mouth at 12 noon). All of the other medications prescribed for Resident # 7 were scheduled for administration as morning (6 AM or 9 AM), afternoon (2 PM) or evening medications (9 PM or 10 PM); and there were PRN (as needed) medications ordered. On 3/1/2019 at 12:20 PM, an interview was conducted with RN C who admitted that she gave the medications late and left the medications with Resident # 7. On 3/1/19 at 12:50 PM, the facility staff provided a copy of the March (Medication Administration Record) MAR as requested. The March 2019 MAR showed that all medications were given on	F 658		

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F 658	Continued From page 36 time. Review of Resident #7's clinical record revealed documentation on the March 2019 Medication Administration Record that medications (Lasix, Levetiracetam, Loratadine, Potassium Chloride) were given on time at 9 AM. There were checkmarks indicating medications were administered on time. There was no missing documentation of medications or any indication of late administration. Further review of the MAR revealed the Clorazepate 7.5 milligrams one tablet every 8 hours was not scheduled for administration at 9 AM. It was scheduled for administration every 8 hours at 6 AM, 2 PM and 10 PM each day. Review of the Progress Notes revealed no nurses notes documenting late administration of medications. The last Progress Note was from Activities on 2/22/2019 at 13:27 (1:27 PM) stating "Participation Note:_____(Resident # 7) participates as tolerated and self directs in room. no concerns.." Signed by Activities Director. The note prior to the Activities Progress Note was an "eMAR-Medication Administration Note" dated 2/16/2019 at 14:42 (2:42 PM) stating that Zofran 4 milligrams was given for nausea and vomiting. On 3/1/2019 at 2:02 PM, Licensed Practical Nurse (LPN) E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted:	F 658		

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F 658	Continued From page 37 Review revealed medications scheduled for 10 PM on 2/28/2019 and 3/1/2019 at 6 AM were both given on 3/1/2019 at 5:52 AM. Documentation showed two doses of these medications were given at the same time on 3/1/2019 at 5:52 PM. Clorazepate 7.5 milligrams one tablet by mouth every 8 hours for Generalized Anxiety Disorder (Scheduled 6 AM, 2 PM, and 10 PM Depakote 500 milligrams one tablet by mouth every 6 hours for every 6 hours for Seizures (Scheduled 6 AM, 12 noon, 6 PM and 12 Midnight) Tegretol 200 milligrams by mouth every 8 hours for Seizures (Scheduled 6 AM, 2 PM, and 10 PM) Medications scheduled to be administered on 3/1/2019 at 9 AM were administered at 11:31 AM Docusate Sodium 100 milligrams one tablet by mouth one time a day scheduled at 9 AM Administered 3/1/2019 at 11:31 AM Lasix 40 milligrams one tablet by mouth one time a day for edema Levetiracetam 750 milligrams one tablet by mouth two times a day for Epilepsy Loratadine 10 milligrams one tablet by mouth one time ad day for seasonal allergies Potassium Chloride Extended Release 10 milliequivalents give two capsule by mouth one time a day Vitamin D 50000 units give one capsule by mouth one time a day every Tuesday and Friday Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed:	F 658		

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F 658	Continued From page 38 "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." On 3/1/2019 at 3:30 PM, an interview was conducted with RN A who stated it was not acceptable for medications to be given late. RN A stated she planned to provide education to the nursing staff about proper medication administration. RN A stated she had "talked with the staff on duty now and will educate the other shifts too." RN A stated she would stress medication administration standards during orientation of newemployees as well. During the end of the day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. The Director of Nursing stated nurses should administer medications as ordered by the physician. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 20:01 (8:01 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications administered late."	F 658		

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F 658	Continued From page 39 signed by RN C. Nurses Note dated 3/1/2019 at 15:02 (3:02 PM) "argumentative about medications and why they should be at other times." signed by RN C. No further information was provided. 6. For Resident # 9, the facility staff failed to administer medications within the standard parameters of time regarding medication administration. Resident # 9, a 72 year old male, was admitted to the facility 10/5/2018. Resident # 9's diagnoses included but were not limited to: Parkinson's Disease, Tremor, Chronic Embolism and Thrombosis, Benign Prostate Hyperplasia without Urinary Tract Symptoms, Hyperlipidemia, Anxiety, Hypertension, Dysarthria, Anarthria, and Abnormalities of Gait and Mobility. Resident # 9's most recent MDS (Minimum Data Set) with an Assessment Review Date of 1/12/2019 was coded as a quarterly assessment. Resident # 9's BIMS (Brief Interview for Mental Status) Score was coded as a 6 out of 15 indicating severe cognitive impairment. Resident # 9 was coded as needing limited to total assistance of one staff member to perform his activities of daily living. Review of the clinical record was conducted on 3/1/2019 at 4:30 PM. Review of the MAR (Medication Administration Record) revealed medications were administered on time on 2/28/2019 and 3/1/2019. There was a check mark indicating the medications were	F 658		

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BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

(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 658	Continued From page 40 administered. There was no documentation of late administration of medications. On 3/1/2019 at 5:10 PM, Registered Nurse (RN) A presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Ativan 0.5 milligrams give 0.5 tablet by mouth every morning and at bedtime for Anxiety-Scheduled at 8 AM and 9 PM Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Atorvastatin 10 milligrams one tablet by mouth at bedtime for Hyperlipidemia Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Carbidopa-Levodopa 25-100 milligrams give four tablets by mouth three times a day for Parkinson's Disease Scheduled 2/28/2019 at 10 PM, administered 3/1/2019 at 1:32 AM Carbidopa-Levodopa ER (Extended Release) 25-100 milligrams one tablet by mouth at bedtime for Parkinson's Disease Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Gabapentin 100 milligrams give one capsule by mouth every 8 hours for Benign Prostatic Hyperplasia Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM	F 658		

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F 658	Continued From page 41 Oxybutynin Chloride 5 milligrams give one tablet by mouth every 8 hours for Benign Prostatic Hyperplasia Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Senna 8.6 milligrams give two tablet by mouth at bedtime for Constipation Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Monitor vital signs every 12 hours Scheduled 2/28/2019 at 9 PM, documented 3/1/2019 at 1:32 AM During the end of the day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. The Director of Nursing stated nurses should administer medications as ordered by the physician. No further information was provided. 7. For Resident #2 the facility failed to administer medications within the accepted standard parameters of medication administration.	F 658		

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F 658	Continued From page 42 Resident #2, a 59 year old woman, was admitted to the facility on 12/4/18 with diagnoses of but not limited to muscle weakness fatigue, history of falls, insomnia, stroke, Major depressive disorder diabetes Hemiplegia and Hemiparesis following stroke. Resident #2's most recent (Minimum Data Set) MDS (screening tool) was coded as an admission assessment dated 2/22/19. The MDS coded the Resident as having a (Brief Interview of Mental Status) BIMS of 13 indicating mild cognitive impairment. On 3/1/19 at 1:45 PM, an observation was made of LPN A passing medications to residents. On 3/1/19, a clinical Record review revealed that Resident # 2 did not have medications due at the time LPN A was observed passing medications. On 3/1/19 at 4:30 PM, the facility provided a (Medication Administration Record) MAR as requested. The MAR showed that all medications were given on time. The MAR revealed this Resident had no afternoon medications all meds were scheduled for morning or evening medications. On 3/1/19 at 4:35 PM, an interview was conducted with the DON. When asked what time medications were administered to this resident, the DON stated that they were given at 8:00 AM and 9:00 AM as printed on the MAR. When advised that the surveyors had observed meds being given at 1:45 PM, the DON stated she wasn't sure how to get the (Electronic Medication Administration Record) EMR printed out. She stated she would get a Nurse, who is used to	F 658		

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F 658	Continued From page 43 giving meds and the EMAR system, to try. On 3/1/19 at 4:45PM, an interview with LPN E, the unit manager. LPN E stated that the medications were giving at the time printed on the MAR. However when told that observations had been made of nurse passing medications at 1:45 pm, LPN E stated well let me see if I can print out what the EMAR shows. When asked if she could do it on the computer given to the surveyors to use, LPN E attempted to do so but got the error message "User does not have access to this screen." LPN E then went to a facility computer and printed out the EMAR Report that showed exactly what time the meds were signed out and by whom. The following was on the EMAR REPORT: Medication - Amlodipine (Cardiac Med) - Give 1 tablet by mouth two times per day scheduled for 8:00 AM and 8:00 PM On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F On 3/1/19 the 08:00 AM dose was signed off at 1:46 PM by LPN A Lantus Solution (Long acting Insulin) Give 50 units subcutaneously at bedtime for Diabetes scheduled for 9:00 PM On 2/28/19 it was signed off by LPN G at 1:07 AM Metformin HCL Tablet 1000 [Milligrams] MG Give 1 Tablet by mouth two times a day for Diabetes. Scheduled for 8:00 AM and 8:00 PM On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F	F 658		

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F 658	Continued From page 44 On 3/1/19 the 08:00 AM dose was signed off at 1:46 PM by LPN A Lisinopril [Cardiac Med] 20 mg give 1 Tablet 2 two times per day for hypertension scheduled at 8:00 AM and 8:00 PM On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F On 3/1/19 the 08:00 AM dose was signed off at 1:46 PM by LPN A Metoprolol Tartrate 50 MG [Cardiac Med] give one tablet by mouth two times per day for hypertension scheduled for 8:00 AM and 8:00 PM On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F On 3/1/19 the 08:00 AM dose was signed off at 1:46 PM by LPN A Spironolactone 50 MG Give 50 MG by mouth one time per day for Hypertension scheduled for 9:00 AM and 9:00 PM On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F On 3/1/19 the 08:00 AM dose was signed off at 1:46 PM by LPN A Valproic Acid [Seizure Med] Give 15 [Milliliters] ML by mouth two times per day related to Unspecified Convulsions scheduled for 9:00 AM and 9:00 PM On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F On 3/1/19 the 08:00 AM dose was signed off at 1:46 PM by LPN A According to Potter & Perry: Fundamentals of Nursing Multi-Media Enhanced Edition, 7th Edition, Chapter 35: Medication Administration,	F 658		

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F 658	Continued From page 45 the five rights of medication administration are: Right client. Right route. Right drug. Right dose. Right time. On 3/1/19, an interview was conducted with LPN A. When asked what time she administered medications that morning. LPN A stated that it was the time indicated on the MAR (8:00 AM and 9:00 AM). When shown the EMAR Report she stated, oh well I gave my medications on time. I just signed them out late. She was then asked about the acceptable time for medication administration and she stated 1 hour before or after the medication is due. When asked when she was supposed to sign off medications, LPN A stated immediately after you see them take the medicine. LPN A said she knew her practice was wrong but it was faster to pull, pass, and then sign. The Administrator and the DON were notified of this issue during the end of day conference and no further information was provided.	F 658	1. The crescent wrench and the socket set were immediately removed form the counter at the nurses' station on March 1, 2019. The wheel chair legs were placed on wheel chair for resident #9 March 1, 2019. 2. All residents have potential to be affected. An audit was completed to ensure no other residents were affected by this deficiency. No other residents were identified. 3. Maintenance staff was educated on ensuring equipment is secure when not in immediate supervision completed on March 1, 2019. All staff was educated on 3/5/2019 regarding resident safety with equipment. All clinical staffs were educated to ensure when transporting a resident wheelchair legs are applied to wheelchair completed on March 22, 2019.	
F 689 SS=D	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		

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F 689	Continued From page 46 by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure a safe environment for the Residents residing on one floor (Second Floor) of three floors and failed to ensure a safe environment for one resident (Resident # 9) in a survey sample of 11 residents. 1. For Residents on the Second Floor, the facility staff failed to secure a Crescent Wrench and Socket Set left unattended on the counter (ledge) of the nurses station, where Residents of various cognitive abilities had access.. 2. Resident #9 was being transferred from Physical Therapy to his room without foot pedals/leg rests on the wheelchair. The findings included: 1. For Residents on the Second Floor, the facility staff failed to secure a Crescent Wrench and Socket Set left unattended on the counter (ledge) of the nurses station, where Residents of various cognitive abilities had access.. On 3/1/2019 at 10:45 AM, during initial tour a Crescent Wrench and a Socket Set was observed sitting on the ledge at the nurses station unattended until 11:55 AM. During this time several staff members (including maintenance, nursing, admissions, dietary and Administration) walked past and did not notice. On 3/1/2019 at 11:55 AM, an interview was conducted with the Staff Development Nurse, Registered Nurse (RN) A who was standing at the	F 689	4. QI monitoring will be done by the DCS/Designee to ensure residents being transported in wheel chair have wheel chair legs applied and ED/Designee will ensure no maintenance equipment is left unsupervised three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3months for further compliance and/or revision. 5. Date of Compliance: 4/2/2019	

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F 689	Continued From page 47 nurses station. RN A was asked if she educated staff members on all topics including recognizing hazards, to which she replied "yes". When RN A was asked if she saw any hazards in the area, RN A looked around the vicinity and stated "no." RN A was asked if a wrench and socket set was considered a hazard and she replied "Yes." RN A said "Oh, Maintenance" and immediately removed the wrench and socket set off the ledge. RN A confirmed that Residents who wander did reside on the second floor. RN A stated the tools should not have been left on the ledge where residents of various cognitive abilities had access to them. At the end of day conference, the DON and Administrator were made aware of the issues and no further information was provided. 2. Resident #9 was being transferred from Physical Therapy to his room without foot pedals/leg rests on the wheelchair. Resident # 9, a 72 year old male, was admitted to the facility 10/5/2018. Resident # 9's diagnoses included but were not limited to: Parkinson's Disease, Tremor, Chronic Embolism and Thrombosis, Benign Prostate Hyperplasia without Urinary Tract Symptoms, Hyperlipidemia, Anxiety, Hypertension, Dysarthria, Anarthria, and Abnormalities of Gait and Mobility. Resident # 9's most recent MDS (Minimum Data Set) with an Assessment Review Date of 1/12/2019 was coded as a quarterly assessment. Resident # 9's BIMS (Brief Interview for Mental Status) Score was coded as a 6 out of 15	F 689		

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F 689	Continued From page 48 indicating severe cognitive impairment. Resident # 9 was coded as needing limited to total assistance of one staff member to perform his activities of daily living. On 3/1/2019 at 3:45 PM, the surveyor (Surveyor A) was walking toward the elevator to go to the second floor when the sound of something dragging on the floor was heard for several seconds. When Surveyor A turned around, a resident was observed being transported by a facility staff person. There were no foot/leg rests on the wheelchair. Surveyor A asked the person pushing the wheelchair (Employee Q) if he could hear Resident # 9's feet dragging the floor. Employee Q stated "oh, okay. I didn't hear it." Surveyor A asked Employee Q in which department he worked and Employee Q replied that he worked for Physical Therapy. Employee Q pressed the button on the elevator for the 3rd floor. There were other facility staff members waiting for the elevator, one person already was on the elevator as the surveyor questioned Employee Q. Employee Q was observed while pushing Resident # 9 off the elevator to his room on the third floor. Resident # 9 was observed raising his feet up slightly while Employee Q wheeled him to his room. Surveyor A waited at the nurse's station until Employee Q came out of Resident # 9's room. On 3/1/2019 at 3:52 PM, an interview was conducted with Employee Q as he walked toward the elevator on the 3rd Floor. Employee Q stated "I know. I know I should have had leg rests on the wheelchair." Employee Q stated he did not hear	F 689		

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F 689	Continued From page 49 the sound of Resident # 9's feet dragging on the floor. Employee Q stated sometimes there could be a bag on the wheelchair that might be rubbing and causing the sound. Surveyor A informed Employee Q that Resident # 9's feet were observed dragging the floor for several seconds. Employee Q stated he did not know for sure if there were supposed to be leg rests on the wheelchair but he would check the Physical Therapy gym to see if the leg rests were left there. Employee Q agreed that Resident # 9's feet were on the floor while being wheeled to the elevator and there was a potential for injury. On 3/1/2019 at 4:15 PM, Employee Q came to the conference room to inform the surveyors that Foot/Leg Rests had been applied to Resident # 9's wheelchair. Employee Q stated the leg rests had been in the Physical Therapy gym. Review of the Clinical Record was conducted on 3/1/2019 at 4:30 PM. Review of the Care Plan revealed documentation of: Focus: Potential for injury/falls related to poor safety awareness, impaired gait. balance, decline in functional activity tolerance. States he throws himself onto the floor. Goal: ___(Resident # 9) will have minimized risk of fall/injury through next review. Interventions included: Assess resident for use of wheelchair-Date initiated 10/15/18, Last review 1/21/2019 Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c	F 689		

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F 689	Continued From page 50 (wheelchair) PT (Physical Therapy) consult for strength and mobility The resident needs activities that minimize the potential for falls while providing diversion and distraction On 3/1/2019 at 4:47 PM, an interview was conducted with the Director of Rehab (Employee P) who stated she had been informed that there had been an issue with the Physical Therapist Assistant (Employee Q) while he was transporting Resident # 9 via wheelchair in the hallway on the first floor without foot/leg rests. Employee P was informed that Employee Q was observed to be transporting Resident # 9 via wheelchair without leg rests on the wheelchair. Resident # 9 was observed to be dragging his feet on the floor while Employee Q was pushing the wheelchair toward the elevator on the first floor. Employee P stated as a part of the Therapy session, some residents were encouraged to use their muscles to hold up their feet. Employee P stated it was not safe to transport residents with their feet dragging on the floor due to potential for injuries and accidents. During the end of day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings regarding Resident # 9 being wheeled in the hallway while his feet were dragging the floor. The Administrator and Director of Nursing stated it was unacceptable for Residents to be wheeled with feet dragging the floor. Both stated there was a potential for injury to the resident. The Administrator stated he was sure the Director of Rehab would handle the situation and provide education to the facility staff	F 689		

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F 689	Continued From page 51 about the necessity for foot/leg rests while wheeling residents who No further information was provided.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview and clinical record review, the facility staff failed to provide oxygen therapy consistent with infection control measures and consistent with standards of practice for 1 Resident (Resident # 3) in a survey sample of 11 Residents. For Resident # 3, the facility staff failed to ensure the portable oxygen tank was not empty and failed to date the nasal cannula tubing on the portable oxygen tank. Findings included: Resident # 3 was a 61-year-old male admitted to the facility on 10/25/2017 with the diagnoses of, but not limited to, Severe Chronic Obstructive Pulmonary Disease, Sarcoidosis, Hypertension,	F 695	1. Resident # 3 oxygen tubing was immediately replaced and a full oxygen tank was placed in residents' room March 1, 2019. 2. All residents receiving oxygen therapy have the potential to be affected. An audit was completed to ensure no other residents were affected by this deficiency. No other residents were identified. 3. All clinically licensed staff was educated on ensuring oxygen tubing is changed weekly and residents have access to portable oxygen as requested completed on March 26, 2019.	

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F 695	Continued From page 52 Chronic Pain Syndrome following multiple car accidents, depression and anxiety, Major Depressive disorder. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 3 with a BIMS (Brief Interview for Mental Status) score of 15/15, indicating no cognitive impairment. Resident # 3 required supervision and set up only assistance with activities of daily living for ambulation, dressing, eating, bathing and toileting and required supervision with assistance of one staff person for transfer and bed mobility; Resident # 3 was coded as always continent of bowel and bladder. On 3/1/2019 at 10:39 a.m., during tour of the facility, as the surveyors were passing in the hallway, Resident # 3 was heard yelling out "Hey nurse, could I please get a refill of my oxygen? My tank is empty." The surveyor walked down the hall toward another room. A nurse, Registered Nurse (RN) C, was observed to be in the hallway two doors down from Resident # 3's room, standing in front of the medication cart and preparing medications. The Surveyor went to Resident # 3's room. Resident # 3 again stated " I need another oxygen tank. This one is empty. I've been asking all night and nobody gave me another one." Resident # 3 was observed to be sitting up on the edge of the bed, oxygen was being infused at 4 liters per minute via nasal cannula from an oxygen concentrator. There was a portable oxygen tank on the left side of the bed sitting on a rolling cart.	F 695	4. QI monitoring will be done by the DCS/Designee to ensure residents oxygen tubing is dated and portable oxygen is available as requested by the resident three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3months for further compliance and/or revision. 5. Date of Compliance: 4/2/2019	

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BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

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F 695	Continued From page 53 Inspection of the portable oxygen tank revealed the gauge was in the zone on the far left at zero indicating it was empty. There was oxygen tubing with a nasal cannula attached to the tank. There was no label with a date on the oxygen tubing. The Surveyor left Resident # 3's room and asked RN C to come to the room. RN C entered the room, talked with Resident # 3 and looked at the oxygen tank's gauge. RN C stated "okay, I will get another tank for you." RN C returned with another portable oxygen tank. The Oxygen tank was replaced by RN C who showed the surveyor the tank gauge was then reading the tank was registering at 1000. RN C removed the tubing from the empty tank and placed it on the new tank. Resident # 3 said "That tank is almost empty too. It doesn't have much oxygen in it." RN C stated "I know. But that's the fullest one I could find." Resident # 3 stated "That's not going to last me very long because I get 4 liters a minute. RN C stated "I know. I will call and get some more tanks delivered." On 3/1/2019 at 10:40 a.m., an interview was conducted with Resident # 3 who stated he had been asking for a full oxygen tank all night long, but the staff did not change the tank. Resident # 3 stated the staff "were busy but I need my oxygen so I can go to the bathroom and move around my room." On 3/1/2019 at 1:30 p.m., observed oxygen tanks being delivered by the Oxygen supply company. During the end of day debriefing, the	F 695		

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F 695	Continued From page 54 Administrator and Director of Nursing were informed of the issues of the empty portable oxygen tank and no date on the oxygen tubing on the portable tank. The Director of Nursing stated she noticed that the oxygen tubing on the portable oxygen tank was not dated when she went to Resident # 3's room. The DON stated she immediately changed the tubing and labeled it with a date. The Administrator stated the facility did have extra oxygen tanks that were full and available for use. The Administrator stated the facility received "delivery of oxygen tanks every Friday and always ordered more tanks" than the facility needed. The DON stated Resident # 3 should have oxygen available in the portable tank and the tubing should be dated. The DON stated the facility's policy was that oxygen tubing was to be changed every Sunday on night shift. No further information was provided.	F 695		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation the facility staff failed to ensure two Residents (Residents # 2 and # 7) in a survey sample of 11 residents were free from significant medication errors. 1. For Resident # 2 the facility staff failed to administer Cardiac, Diabetic and Seizure medications as ordered by physician. The medications were administered late	F 760	1. Resident # 2 and #7 were assessed for adverse reaction none were identified, provider and responsible representative were notified March 1, 2019. 2. All residents have the potential to be affected. An audit was completed to ensure no other residents were affected by this deficiency. No other residents were identified. 3. All clinically licensed staff was educated on medication administration completed on March 25, 2019.	

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F 760	Continued From page 55 2. For Resident # 7, the facility staff gave two doses of anti-seizure medications (Depakote and Tegretol) and two doses of Clorazepate for Anxiety at the same time on 3/1/2019 at 5:52 AM. Findings Included: 1. For Resident # 2 the facility staff failed to administer Cardiac, Diabetic and Seizure medications as ordered by physician. The medications were administered late Resident #2, a 59 year old woman, was admitted to the facility on 12/4/18 with diagnoses of but not limited to muscle weakness fatigue, history of falls, insomnia, stroke, major depressive disorder, diabetes, hemiplegia, and Hemiparesis following stroke. Resident #2's most recent (Minimum Data Set) MDS (screening tool) coded as an admission assessment dated 2/22/19 coded the Resident as having a (Brief Interview of Mental Status) BIMS of 13 indicating mild cognitive impairment. On 3/1/19 at 1:45 PM an observation was of LPN C passing medications to residents. During clinical Record review it was noted that Resident # did not have medications due at that time. On 3/1/19 at 4:30 pm, the facility provided a (Medication Administration Record) MAR as requested. The MAR showed that all medications were given on time. The MAR revealed this Resident had no afternoon medications and that	F 760	4. QI monitoring will be done by the DCS/Designee to ensure proper medication administration three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3months for further compliance and/or revision. 5. Date of Compliance: 4/2/2019	

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F 760	Continued From page 56 all medications were morning or evening medications. On 3/1/19, an interview was conducted with the DON. When asked what time medications were administered to this resident she stated they were given at 8 am and 9 am as printed on the MAR. When advised that the MAR was incorrect as surveyors had observed meds being given at 1:45 PM. The DON stated she wasn't sure how to get the (Electronic Medication Administration Record) EMAR printed out. She stated she would get a Nurse who is used to giving meds and using the EMAR system to try. On 3/1/19 at 1645 an interview with LPN a unit manager, she stated that the meds were giving at the time printed on the MAR however when told that observations had been made of nurse passing medications at 145 pm she stated well let me see if I can print out what the EMAR shows. When asked if she could do it on the computer given to the surveyors to use she attempted to do so and got the error message "User does not have access to this screen." LPN E then went to a facility computer and printed out the EMAR Report has shown exactly what time the meds were signed out and by whom. The following was on the EMAR REPORT: Medication - Amlodipine (Cardiac Medication) - Give 1 tablet by mouth two times per day scheduled for 8:00 AM and 8:00 PM. On 3/1/19 it was signed off by LPN A at 13:46 PM.	F 760		

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F 760	Continued From page 57 On 2/28/19 it was signed off by LPN F at 12:20 PM. Lantus Solution (Long acting Insulin) Give 50 units subcutaneously at bedtime for Diabetes scheduled for 9:00 PM. On 2/28/19 it was signed off by LPN G at 01:07 AM. Metformin HCL Tablet 1000 [Milligrams] MG Give 1 Tablet by mouth two times a day for Diabetes. Scheduled for 8:00 AM and 8:00 PM. On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F. On 3/1/19 the 08:00 AM dose was signed off at 13:46 By LPN A. Lisinopril [Cardiac Medication] 20 mg give 1 Tablet 2 two times per day for hypertension scheduled at 8:00 AM and 8:00 PM. On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F. On 3/1/19 the 08:00 AM dose was signed off at 13:46 By LPN A. Metoprolol Tartrate 50 MG [Cardiac Medication] give one tablet by mouth two times per day for hypertension scheduled for 8:00 AM and 8:00 PM. On 2/28/19 the 08:00 AM dose was signed off at 12:21 PM by LPN F . On 3/1/19 the 08:00 AM dose was signed off at 13:46 By LPN A. Spironolactone 50 MG Give 50 MG by mouth one time per day for Hypertension scheduled for 9:00 AM and 9:00 PM. On 2/28/19 the 09:00 AM dose was signed off at 12:21 PM by LPN F.	F 760		

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F 760	Continued From page 58 On 3/1/19 the 09:00 AM dose was signed off at 13:46 By LPN A. Valproic Acid [Seizure Med] Give 15 [Milliliters] ML by mouth two times per day related to Unspecified Convulsions scheduled for 9:00 AM and 9:00 PM On 2/28/19 the 09:00 AM dose was signed off at 12:21 PM by LPN F. On 3/01/19 the 09:00 AM dose was signed off at 13:46 By LPN A. In an interview with LPN E when asked what was the potential issue with medications given at the wrong time but being signed off as if they were given on time, LPN E stated that some medications have to be given a specific number of hours apart or they could create a problem for the Residents health if they are given too close together. The Administrator and the DON were notified of this issue during the end of day conference and no further information was provided. 2. For Resident # 7, the facility staff gave two doses of anti-seizure medications (Depakote and Tegretol) and two doses of Clorazepate for Anxiety at the same time on 3/1/2019 at 5:52 AM. Resident # 7, a 60 year old female, was admitted to the facility 11/28/18. Resident # 7's diagnoses included but were not limited to: Epilepsy, Malignant Neoplasm of the uterus, Vitamin D Deficiency, Anemia, Edema, Bariatric Surgery, Generalized Anxiety Disorder. Resident #7's most recent MDS (minimum data	F 760		

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F 760	Continued From page 59 set) with an ARD (assessment reference date) of 12/5/2018 was coded as an admission assessment. Resident # 7 was coded as having a BIMS (Brief Interview of Memory Status) Score of 15 out of 15 indicating no cognitive impairment and was able to make her own daily life decisions. Resident # 7 was coded as requiring limited to extensive assistance of one staff member to perform her activities of daily living including transfers, toileting, hygiene and bathing. Resident # 7 was coded as independent in eating, and ambulation On 3/1/2019 at 11:55 AM, review of the clinical record for Resident # 7 was conducted. Review of the Medication Administration Record (MAR) for March 2019 revealed documentation of medications that were administered at 9 AM. The MAR revealed that Resident # 7 had only one medication due at the time the nurse was observed to be administering medications to her (Depakote 500 milligrams by mouth at 12 noon). All of the other medications prescribed for Resident # 7 were scheduled for administration as morning (6 AM or 9 AM), afternoon (2 PM) or evening medications (9 PM or 10 PM); and there were PRN (as needed) medications ordered. On 3/1/2019 at 12:20 PM, an interview was conducted with RN C who stated Resident # 7 did not have a "nerve pill" scheduled for administration with morning medications at 9 AM. RN C stated she gave the medications that were scheduled at 9 AM as ordered. RN C stated the night shift had given the last scheduled "nerve pill" to Resident # 7 at 6 AM. On 3/1/19 at 12:50 PM, the facility staff provided	F 760		

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F 760	Continued From page 60 a copy of the March (Medication Administration Record) MAR as requested. The March 2019 MAR showed that all medications were given on time. Review revealed medications scheduled for 10 PM on 2/28/2019 and 3/1/2019 at 6 AM were both given on 3/1/2019 at 5:52 AM. The two doses of the medications were administered at the same time on 3/1/2019 at 5:52 AM. - Clorazepate 7.5 milligrams one tablet by mouth every 8 hours for Generalized Anxiety Disorder - Depakote 500 milligrams one tablet by mouth every 6 hours for every 6 hours for Seizures - Tegretol 200 milligrams by mouth every 8 hours for Seizures Review of the MAR revealed the scheduled times for administration of Clorazepate, Depakote and Tegretol were: Clorazepate 7.5 milligrams one tablet by mouth every 8 hours for Generalized Anxiety Disorder (Scheduled 6 AM, 2 PM, and 10 PM) Depakote 500 milligrams one tablet by mouth every 6 hours for every 6 hours for Seizures (Scheduled 6 AM, 12 noon, 6 PM and 12 Midnight) Tegretol 200 milligrams by mouth every 8 hours for Seizures (Scheduled 6 AM, 2 PM, and 10 PM) On 3/1/2019 at 3:30 PM, an interview was conducted with RN A who stated it was not acceptable for medications to be given late. RN A stated she planned to provide education to the nursing staff about proper medication administration. RN A stated she had "talked with the staff on duty now and will educate the other shifts too." RN A stated she would stress the	F 760		

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F 760	Continued From page 61 importance of adhering to the standards of medication administration during orientation of new employees as well. During the end of the day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within one hour before or one hour after the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. The Director of Nursing stated nurses should administer medications as ordered by the physician, No further information was provided,	F 760		
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;	F 842	1. Resident # 2, #3, #4, #5, #6 and #7 were assessed for adverse reaction none were identified, provider and responsible representative were notified March 1, 2019. 2. All residents have the potential to be affected. An audit was completed to ensure no other residents were affected by this deficiency. No other residents were identified. 3. All clinically licensed staff was educated on documenting medications as administered on the MAR completed on March 25, 2019.	

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F 842	Continued From page 62 (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 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;	F 842	4. QI monitoring will be done by the DCS/Designee to ensure proper medication administration and documentation are completed three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3months for further compliance and/or revision. 5. Date of Compliance: 4/2/2019	

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F 842	Continued From page 63 (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 interview, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 7 residents (Residents # 2, # 3, # 4, # 5, # 6, # 7, and # 9) in a survey of 11 residents. 1. For Resident #2, the facility failed to accurately record the time of medication administration on the MAR (Medication Administration Record). 2. For Resident # 3, the facility staff failed to document the accurate time medications were administered. 3. For Resident # 4, the facility failed to accurately record the time of medication administration on the MAR (Medication Administration Record). 4. For Resident # 5, the facility failed to accurately record the time of medication administration on the MAR (Medication Administration Record). 5. For Resident # 6, the facility failed to accurately record the time of medication administration on the MAR (Medication Administration Record).	F 842		

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F 842	Continued From page 64 6a. For Resident # 7, the facility failed to accurately record the time of medication administration on the MAR (Medication Administration Record) and; 6b. Resident #7 had Progress Notes for another Resident (Resident # 11) filed in the clinical record. 7. For Resident # 9, the facility failed to accurately record the time of medication administration on the MAR (Medication Administration Record). Findings included: 1. For Resident #2 the facility failed to accurately record the time of medication administration on the (Medication Administration Record). Resident #2 a 59 year old woman admitted to the facility on 12/4/18 with diagnoses of but not limited to muscle weakness fatigue, history of falls, insomnia, stroke, Major depressive disorder diabetes Hemiplegia and Hemiparesis following stroke. Resident #1's most recent (Minimum Data Set) MDS (screening tool) coded as an admission assessment dated 2/22/19 coded the Resident as having a (Brief Interview of Mental Status) BIMS of 13 indicating mild cognitive impairment. On 3/1/19 at 1:45 PM an observation was of LPN C passing medications to residents. During clinical Record review it was noted that Resident # did not have medications due at that time.	F 842		

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F 842	Continued From page 65 On 3/1/19 at 4:30 pm, the facility provided the Medication Administration Record (MAR) as requested. MAR showed that all medications were given on time. MAR revealed this Resident had no afternoon medications all meds were morning or evening medications. On 3/1/19 an interview was conducted with the DON. When asked what time medications were administered to this resident, the DON stated that they were given at 8 am and 9 am as printed on the MAR. When advised that the MAR was incorrect as surveyors had observed meds being given at 1:45 PM, the DON stated she wasn't sure how to get the (Electronic Medication Administration Record) EMAR printed out. The DON stated that she would get a Nurse who is used to giving meds and using the EMAR system, to try. On 3/1/19 at 4:45 pm, an interview with LPN E a unit manager was conducted. LPN E stated that the meds were giving at the time printed on the MAR. However when told that observations had been made of a nurse passing medications at 1:45 pm, LPN E stated, well let me see if I can see in the EMAR what time they were given. When asked if she could do it on the computer given to the surveyors to use, LPN E attempted to do so and got the error message "User does not have access to this screen." LPN E then went to a facility computer and was able to print out the times the Nurse actually signed off the medication. LPN E was then asked if there is a difference in what the print out copy of the MAR and the EMAR REPORT. LPN E stated, yes the MAR states all meds were given	F 842		

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BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

(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 66 at the times ordered however the EMAR REPORT states the actual time the meds were signed out. On 2/1/19 during the end of day meeting the Administrator and DON were made aware of this no further information was provided. 2. For Resident # 3, the facility staff failed to accurately record the time of medication administration on the MAR (Medication Administration Record). Resident # 3 was a 61-year-old male admitted to the facility on 10/25/2017 with the diagnoses of, but not limited to, Severe Chronic Obstructive Pulmonary Disease, Sarcoidosis, Hypertension, Chronic Pain Syndrome following multiple car accidents, depression and anxiety, Major Depressive disorder. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 3 with a BIMS (Brief Interview for Mental Status) score of 15/15, indicating no cognitive impairment. Resident # 3 required supervision and set up only assistance with activities of daily living for ambulation, dressing, eating, bathing and toileting and required supervision with assistance of one staff person for transfer and bed mobility; Resident # 3 was coded as always continent of bowel and bladder. On 3/1/2019 at 10:20 AM, an interview was conducted with Resident # 3 who stated the facility was always working short of staff. Resident # 3 stated he received his medications	F 842		

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late the night before (2/28/2019). Resident # 3 stated he did not get his medication until 11 PM but was supposed to get it at 9 PM. Resident # 3 stated he was upset because he needed to get his breathing medications on time. Resident # 3 stated he had 4 liters of oxygen per minute and still was short of breath because of COPD. Resident # 3 stated "I need my medicines on time so I can breathe."

Review of the clinical record was conducted on 3/1/2019 at 11:30 AM.

Review of the February 2019 Medication Administration Record revealed documentation of medications being administered at 9 PM on 2/28/2019. There was no documentation of late administration of medications for Resident # 3.

Review of the Nurses Notes from 2/1/2019 to 3/1/2019 revealed no documentation of late administration of medications. Thorough review of the clinical record revealed no documentation of late administration of medications on 2/28/2019.

On 3/1/2019 at 1:10 PM. an interview was conducted with the Staff Development Director, Registered Nurse (RN) A who stated medications should be passed within an hour before and an hour after the scheduled time of administration. RNA A stated RN C was a new employee of approximately 3 weeks at the time of the survey. RN A stated "the 6 rights of Medication Administration" was stressed during orientation with all new nurses. RN A stated new nurses receive 3 days of classroom instruction and 3 days on the floor with a nurse, then any questions should be directed to the Unit Manager or Staff

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Development Nurse or any other nurse on the floor. RN A stated RN C received the information about medication administration during her orientation. RNA A stated the professional nursing standard was for nurses to administer medications within one hour before and one hour after the scheduled time of administration and that "all nurses should know that."

RN A was asked to provide a copy of the orientation topics covered with Registered Nurse C. The list of topics covered during RN C's orientation was not provided to the surveyor prior to the end of the survey.

On 3/1/2019 at 1:35 PM, an interview was conducted with the Director of Nursing who stated the MAR showed the medications were administered at 9 PM as scheduled. The DON was informed that Resident # 3 reported that he received his medications 2 hours late on 2/28/2019. When the DON was asked for a copy of the EMAR (Electronic Medication Administration Record) report, she stated she was not sure of how to obtain a copy of the EMAR report. The DON stated she would get a Nurse who was familiar with giving medications and using the EMAR system to try to retrieve the report.

On 3/1/19 at 1:45 PM, an interview was conducted with the unit manager, Licensed Practical Nurse (LPN) E, who looked at the MAR and stated that the medications were given at the time printed on the MAR. When told that Resident # 3 stated he received his medications late on 2/28/2019, LPN E stated she would see if she could print out what the actual times of administration shown on the EMAR (Electronic

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F 842	Continued From page 69 Medication Administration Record). When LPN E was asked if she could access the EMAR information on the computer given to the surveyors to use, LPN E attempted to retrieve the report and got the error message "User does not have access to this screen." LPN E stated she would try one of the facility's computers. LPN E then went to a facility computer and printed he EMAR Report denoting the exact times each medications were administered, signed out and by whom. On 3/1/2019 at 2:02 PM, LPN E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Advair Diskus Aerosol Powder Breath Activated 250-50 microgram/dose one puff inhale orally two times a day for Chronic Obstructive Pulmonary Disease Scheduled at 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Gabapentin 600 milligrams give one tablet by mouth two times a day Scheduled at 9 AM and 9 PM for Chronic Pain Syndrome 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Ketotifen Fumarate Solution 0.025 % Instill one drop in both eyes every 12 hours Scheduled at 9 AM and 9 PM related to Hereditary and Idiopathic Neuropathy Scheduled at 9 AM and 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM)	F 842		

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F 842	Continued From page 70 Oxycontin Extended Release 12 hour Abuse-Deterrent 20 milligrams give one tablet by mouth every 12 hours related to Chronic Pain Syndrome Scheduled 9 AM and 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Senna Capsule 8.6 milligrams give one capsule by mouth at bedtime for constipation Scheduled at 9 PM 2/28/2019 at 22:58 (10:58 PM) documented 2/28/2019 at 23:18 (11:18 PM) Tylenol 325 milligrams Give 3 tablets every 8 hours for pain Scheduled at 6 AM, 2 PM and 10 PM 2/28/2019 at 23:14 (11:14 PM) documented 2/28/2019 at 23:18 (11:18 PM) On 3/1/2019 at 5 PM, the Director of Nursing reported that Potter and Perry was the standard used by the facility for professional nursing guidance. The DON stated the facility staff was expected to use the six rights of Medication Administration. Guidance for professional nursing standards for the administration of medication was provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:	F 842		

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F 842	Continued From page 71 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed: "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." During the end of the day debriefing, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications actually were given over two hours later than the scheduled time of 9 PM on 2/28/2019 and appeared to have been given on time according to the MAR. The Director of Nursing stated the expectation was that medications should be administered within one hour before and after the scheduled time and document the correct time the medication was administered. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 20:01 (8:01 PM) that "MD/RP	F 842		

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F 842	Continued From page 72 (Medical Doctor/Responsible Party) made aware of morning medications administered late." signed by LPN B. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 19:56 (7:56 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications administered late." signed by Registered Nurse (RN) B. No further information was provided. 3. For Resident # 4, the facility staff failed to accurately record the time of medication administration on the MAR (Medication Administration Record). Resident # 4 was an 82-year-old male admitted to the facility on 10/10/2018 with the diagnoses of, but not limited to:Cerebral Infarct, Diabetes, Hypoglycemia., Dementia, Hypertension, and Polyneuropathy. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/23/2019. The MDS coded Resident # 4 with a BIMS (Brief Interview for Mental Status) score of 8/15, indicating severe cognitive impairment. Resident # 4 required limited assistance of one staff person with activities of daily living except for eating and bathing. Resident # 4 required supervision with set up only for eating and total assistance of one staff person for bathing. Resident # 4 was coded as occasionally continent of bowel and bladder.	F 842		

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F 842	Continued From page 73 Review of the clinical record was conducted on 3/1/2019 at 1:15 PM. Review of the Medication Administration Record revealed documentation of all medications being administered on time. There were check marks and the initials of the nurses administering the medications in the slots for scheduled times. There was no documentation of late administration of medications on the MAR. Review of the Nurses Notes from 2/1/2019 to 3/1/2019 revealed no documentation of late administration of medications. The last Nurses Note was 2/28/2019 at 17:05 (5:05 PM) stating "Bs (Blood Sugar) was 72." On 3/1/2019 at 1:35 PM, an interview was conducted with the Director of Nursing who stated the MAR showed the medications were administered as scheduled. When the DON was asked for a copy of the EMAR (Electronic Medication Administration Record) report, she stated she was not sure of how to obtain a copy of the EMAR report. The DON stated she would get a Nurse who was familiar with giving medications and using the EMAR system to try to retrieve the report. On 3/1/19 at 1:45 PM, an interview was conducted with the unit manager, Licensed Practical Nurse (LPN) E, who looked at the MAR and stated that the medications were given at the time printed on the MAR. LPN E stated she would see if she could print out what the actual times of administration showed on the EMAR (Electronic Medication Administration Record). When LPN E was asked if she could access the EMAR information on the computer given to the	F 842		

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F 842	Continued From page 74 surveyors to use, LPN E attempted to retrieve the report and got the error message "User does not have access to this screen." LPN E stated she would try one of the facility's computers. LPN E then went to a facility computer and printed he EMAR Report denoting the exact times the medications were administered, signed out and by whom. On 3/1/2019 at 2:02 PM, LPN E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Ascorbic Acid Tablet 500 milligrams by mouth one time a day Scheduled for 9 AM 3/1/2019 administered at 10:39 AM Aspirin 81 milligrams one tablet by mouth one time a day Scheduled for 9 AM 3/1/2019 administered at 10:39 AM Calcium 600-D 600-400 milligrams one tablet by mouth two times a day for supplement , vitamin D deficiency Scheduled 9 AM and 9 PM 3/1/2019 administered at 10:39 AM (due at 9 AM) 2/27/2019 administered at 11:46 PM (due at 9 PM) Humalog Insulin per sliding scale : If 151-200 = 3 units, 201-250= 6 units, 251-300= 9 units, 301-350= 12 units, 351-400= 15 units, subcutaneously before meals and at bedtime related to Diabetes Scheduled 6 AM, 11 AM, 4 PM and 9 PM 2/27/2019 at 11:47 PM (9 PM dose)	F 842		

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Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed:
"Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident."

During the end of the day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within one hour before or one hour after the scheduled time. The medications listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. The Director of Nursing stated nurses should administer medications as ordered by the physician and should document the correct time the medication was administered.

On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 19:56 (7:56 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications were administered late this morning." signed by RN B.

No further information was provided.

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4. For Resident # 5, the facility staff failed to accurately record the time of medication administration on the MAR (Medication Administration Record).

Resident # 5 was a 79-year-old female admitted to the facility on 1/3/2019 with the diagnoses of, but not limited to, Diabetes, Schizophrenia with extrapyramidal and movement disorder, Gastroesophageal Reflux Disorder, Hypertension, Major Depressive Disorder, Pacemaker, Anemia and Vitamin Deficiency.

The most recent Minimum Data Set (MDS) was a 30 day assessment with an Assessment Reference Date (ARD) of 1/31/2019. The MDS coded Resident # 5 with a BIMS (Brief Interview for Mental Status) score of 15/15, indicating no cognitive impairment. Resident # 5 required extensive assistance of one staff person with activities of daily living.

Review of the clinical record was conducted on 3/1/2019.

Review of the March 2019 Medication Administration Record revealed medications were administered on 3/1/2019 at 9 AM. There was a check mark indicating the medications were administered. There was no documentation of late administration of medications. There was no documentation of medications scheduled to be administered during the time the nurse, Registered Nurse (RN) C was observed passing medications to Resident # 5 on 3/1/2019.

Review of the Nurses Notes from 2/1/2019 to 3/1/2019 revealed no documentation of late

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F 842	Continued From page 77 administration of medications. The last Progress Note was from Activities on 2/22/2019 at 13:30 (1:30 PM) stating "Participation Note:_____(Resident # 5) does not wish to participate in group programs and enjoys spending time in room watching tv. She likes friendly conversation at times. No concerns. Signed by Activities Director. The note prior to the Activities note was a Skilled Nurse Note dated 2/21/2019 at 1:50 AM. On 3/1/2019 at 1:35 PM, an interview was conducted with the Director of Nursing who stated the MAR showed the medications were administered as scheduled. When the DON was asked for a copy of the EMAR (Electronic Medication Administration Record) report, she stated she was not sure of how to obtain a copy of the EMAR report. The DON stated she would get a Nurse who was familiar with giving medications and using the EMAR system to try to retrieve the report. On 3/1/19 at 1:45 PM, an interview was conducted with the unit manager, Licensed Practical Nurse (LPN) E, who looked at the MAR and stated that the medications were given at the time printed on the MAR. When informed that RN C was observed administering medications to Resident # 5 at times not scheduled, LPN E stated she would see if she could print out what the actual times of administration showed on the EMAR (Electronic Medication Administration Record). When LPN E was asked if she could access the EMAR information on the computer given to the surveyors to use, LPN E attempted to retrieve the report and got the error message "User does not have access to this screen." LPN E stated she would try one of the facility's	F 842		

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F 842	Continued From page 78 computers. .LPN E then went to a facility computer and printed he EMAR Report denoting the exact times the medications were administered, signed out and by whom. On 3/1/2019 at 2:02 PM, LPN E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Aspirin EC (Enteric Coated) Delayed Release 81 milligrams one tablet by mouth one time a day. Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Atorvastatin 40 milligrams give one tablet by mouth one time a day for Hyperlipidemia Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Buspirone 5 milligrams one tablet by mouth one time a day for major depressive disorder. Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Loratadine 10 milligrams one tablet by mouth one time a day for Allergic Rhinitis Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Miralax 17 grams by mouth two times a day related to constipation Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Tramadol 50 milligrams give 0.5 tablet by mouth every 12 hours for pain Scheduled at 9 AM and 9 PM 3/1/2019- administered at 12:03 PM	F 842		

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F 842	Continued From page 79 Zoloft 25 milligrams give one tablet by mouth one time a day. for Major Depressive Disorder Scheduled at 9 AM 3/1/2019- administered at 12:03 PM Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed: "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." During the end of the day debriefing, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within the parameters of medication administration of within one hour before or one hour after the scheduled time. The medications listed were given three hours later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time as ordered by the physician. and should document the correct time the medications were administered. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 19:57 (7:57 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of late administration of morning meds (medications)." signed by RN B.	F 842		

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F 842	Continued From page 80	F 842		

No further information was provided.

5. For Resident # 6, the facility staff failed to accurately record the time of medication administration on the MAR (Medication Administration Record).

Resident # 6 was an 83-year-old female admitted to the facility on 1/25/2019 with the diagnoses of, but not limited to, Atherosclerotic Heart Disease, Contractures of left elbow and left hand, Diabetes, Hemiplegia, Tinea Corporis, Pressure Ulcer of Left Heel, and Hypertension.

The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 2/1/2019. The MDS coded Resident # 6 with a BIMS (Brief Interview for Mental Status) score of 13/15, indicating no cognitive impairment. Resident # 6 required extensive to total assistance of one staff person with activities of daily living except she required total assistance of two staff persons for transfers and limited assistance of one staff person for eating; Resident #6 was coded as always continent of bowel and bladder.

Review of the clinical record was conducted on 3/1/2019.

Review of the March 2019 Medication Administration Record revealed medications were administered on 3/1/2019 at 9 AM. There was a check mark indicating the medications were administered. There was no documentation of late administration of medications. There was no documentation of medications scheduled to be

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F 842	Continued From page 81 administered during the time the nurse. Registered Nurse (RN) C was observed passing medications to Resident # 6 on 3/1/2019. Review of the Nurses Notes revealed no documentation of late administration of medications. On 3/1/2019 at 2:02 PM, Licensed Practical Nurse (LPN) E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Amlodipine 10 milligrams give one tablet by mouth one time a day Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Aspirin chewable 81 milligrams give one tablet by mouth one time a day Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Atorvastatin 20 milligrams give one tablet by mouth one time a day Scheduled ay 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Basaglar KwikPen Insulin inject 10 units subcutaneously one time a day for Diabetes Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Lisinopril 10 milligrams give one tablet by mouth one time a day for Hypertension Scheduled at 9	F 842		

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F 842	Continued From page 82 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Metformin 500 milligrams give one tablet by mouth one time a day for Diabetes Scheduled at 9 AM 3/1/2019 administered at 11:17 AM 2/28/2019 administered at 10:39 AM Review of the Facility Documentation on Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed: "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." During the end of the day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within one hour before or one hour after the scheduled time. The medications listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. The Director of Nursing stated nurses should administer medications as ordered by the physician and should document the correct time the medication was administered. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the	F 842		

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F 842	Continued From page 83 nurses notes revealed documentation on 3/1/2019 at 20:10 (8:10 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications were administered late." signed by RN C. No further information was provided. 6a. For Resident # 7, the facility failed to accurately record the time of medication administration on the MAR (Medication Administration Record) and; 6b. Resident #7 had Progress Notes for another Resident (Resident # 11) filed in the clinical record. 6a. Resident # 7, a 60 year old female, was admitted to the facility 11/28/18. Resident # 7's diagnoses included but were not limited to: Epilepsy, Malignant Neoplasm of the uterus, Vitamin D Deficiency, Anemia, Edema, Bariatric Surgery, Generalized Anxiety Disorder. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/5/2018 was coded as an admission assessment. Resident # 7 was coded as having a BIMS (Brief Interview of Memory Status) Score of 15 out of 15 indicating no cognitive impairment and was able to make her own daily life decisions. Resident # 7 was coded as requiring limited to extensive assistance of one staff member to perform her activities of daily living including transfers, toileting, hygiene and bathing. Resident # 7 was coded as independent in eating, and ambulation	F 842		

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F 842	Continued From page 84 On 3/1/2019 at 11:55 AM, review of the clinical record for Resident # 7 was conducted. On 3/1/19 at 12:50 PM, the facility staff provided a copy of the March (Medication Administration Record) MAR as requested. The March 2019 MAR showed that all medications were given on time. Review of Resident #7's clinical record revealed documentation on the March 2019 Medication Administration Record that medications (Lasix, Levetiracetam, Loratadine, Potassium Chloride) were given on time at 9 AM. There were checkmarks indicating medications were administered on time. There was no missing documentation of medications or any indication of late administration. Further review of the MAR revealed the Clorazepate 7.5 milligrams one tablet every 8 hours was not scheduled for administration at 9 AM. It was scheduled for administration every 8 hours at 6 AM, 2 PM and 10 PM each day. Review of the Progress Notes revealed no nurses notes documenting late administration of medications. The last Progress Note was from Activities on 2/22/2019 at 13:27 (1:27 PM) stating "Participation Note:_____(Resident # 7) participates as tolerated and self directs in room. no concerns.." Signed by Activities Director. The note prior to the Activities Progress Note was an "eMAR-Medication Administration Note" dated 2/16/2019 at 14:42 (2:42 PM) stating that Zofran 4 milligrams was given for nausea and vomiting. On 3/1/2019 at 2:02 PM, Licensed Practical	F 842		

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F 842	Continued From page 85 Nurse (LPN) E presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Review revealed medications scheduled for 10 PM on 2/28/2019 and 3/1/2019 at 6 AM were given on 3/1/2019 at 5:52 AM. Documentation showed two doses of these medications were given at the same time on 3/1/2019 at 5:52 PM: Clorazepate 7.5 milligrams one tablet by mouth every 8 hours for Generalized Anxiety Disorder Depakote 500 milligrams one tablet by mouth every 6 hours for every 6 hours for Seizures Tegretol 200 milligrams by mouth every 8 hours for Seizures Medications scheduled to be administered on 3/1/2019 at 9 AM were administered at 11:31 AM Docusate Sodium 100 milligrams one tablet by mouth one time a day scheduled at 9 AM Administered 3/1/2019 at 11:31 AM Lasix 40 milligrams one tablet by mouth one time a day for edema Levetiracetam 750 milligrams one tablet by mouth two times a day for Epilepsy Loratadine 10 milligrams one tablet by mouth one time ad day for seasonal allergies Potassium Chloride Extended Release 10 milliequivalents give two capsule by mouth one time a day Vitamin D 50000 units give one capsule by mouth one time a day every Tuesday and Friday Review of the Facility Documentation on	F 842		

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F 842	Continued From page 86 Medications -Oral Administration Policies and Procedures Effective Date: 11/30/2014 and Revision Date: 9/22/2017 on page 1 of 2 revealed: "Chart on Medication Administration Record (MAR) according immediately [sic] following when medication is given and before proceeding to the next resident." During the end of the day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within one hour before or one hour after the scheduled time. The medications listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. The Director of Nursing stated nurses should administer medications as ordered by the physician and should document the correct time the medication was administered. On 3/1/2019 at 8:15 PM, a copy of the Nurses Progress Notes was presented. Review of the nurses notes revealed documentation on 3/1/2019 at 20:01 (8:01 PM) that "MD/RP (Medical Doctor/Responsible Party) made aware of morning medications administered late." signed by RN C. Nurses Note dated 3/1/2019 at 15:02 (3:02 PM) "argumentative about medications and why they should be at other times." signed by RN C. No further information was provided.	F 842		

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F 842	Continued From page 87	F 842		

6b. After the survey ended, further review of the copies of the Physicians Progress Notes revealed clinical information for another resident was included in the copies from Resident # 7's record.

Review of Physicians Progress Notes for Resident # 7 revealed a two-paged Physicians Progress Note dated 1/29/2019 for another resident that was not in the survey sample. That Resident was assigned a number to be identified (Resident # 11) in this documentation. Review of the Progress Note for Resident # 11 revealed Resident # 11 was a 64 year old female with diagnoses of but not limited to: Hypertension, Diabetes, and End Stage Renal Failure. The Progress Note was signed electronically by the physician on 2/5/2019.

7. For Resident # 9, the facility staff failed to accurately record the time of medication administration on the MAR (Medication Administration Record) .

Resident # 9, a 72 year old male, was admitted to the facility 10/5/2018. Resident # 9's diagnoses included but were not limited to: Parkinson's Disease, Tremor, Chronic Embolism and Thrombosis, Benign Prostate Hyperplasia without Urinary Tract Symptoms, Hyperlipidemia, Anxiety, Hypertension, Dysarthria, Anarthria, and Abnormalities of Gait and Mobility.

Resident # 9's most recent MDS (Minimum Data Set) with an Assessment Review Date of 1/12/2019 was coded as a quarterly assessment. Resident # 9's BIMS (Brief Interview for Mental

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F 842	Continued From page 88 Status) Score was coded as a 6 out of 15 indicating severe cognitive impairment. Resident # 9 was coded as needing limited to total assistance of one staff member to perform his activities of daily living. Review of the clinical record was conducted on 3/1/2019 at 4:30 PM. Review of the MAR (Medication Administration Record) revealed medications were administered on time on 2/28/2019 and 3/1/2019. There was a check mark indicating the medications were administered. There was no documentation of late administration of medications. On 3/1/2019 at 5:10 PM, Registered Nurse (RN) A presented a copy of the EMAR report. Review of the EMAR "Administration History Report" revealed medications documented as administered on time according to the MAR were actually administered at the times noted: Ativan 0.5 milligrams give 0.5 tablet by mouth every morning and at bedtime for Anxiety-Scheduled at 8 AM and 9 PM Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Atorvastatin 10 milligrams one tablet by mouth at bedtime for Hyperlipidemia Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Carbidopa-Levodopa 25-100 milligrams give four tablets by mouth three times a day for Parkinson's Disease Scheduled 2/28/2019 at 10 PM, administered 3/1/2019 at 1:32 AM	F 842		

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F 842	Continued From page 89 Carbidopa-Levodopa ER (Extended Release) 25-100 milligrams one tablet by mouth at bedtime for Parkinson's Disease Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Gabapentin 100 milligrams give one capsule by mouth every 8 hours for Benign Prostatic Hyperplasia Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Oxybutynin Chloride 5 milligrams give one tablet by mouth every 8 hours for Benign Prostatic Hyperplasia Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Senna 8.6 milligrams give two tablet by mouth at bedtime for Constipation Scheduled 2/28/2019 at 9 PM, administered 3/1/2019 at 1:32 AM Monitor vital signs every 12 hours Scheduled 2/28/2019 at 9 PM, documented 3/1/2019 at 1:32 AM The documentation on the MAR did not show the actual time the above medications were administered. During the end of the day debriefing on 3/1/2019, the Administrator and Director of Nursing were informed of the findings of medications being documented on the Medication Administration Record as administered on time but actually not being given on time within one hour before or one hour after the scheduled time. The medications	F 842		

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F 842	Continued From page 90 listed were given more than one hour later than the scheduled time. The Director of Nursing stated the expectation was that medications should be administered within one hour before and one hour after the scheduled time. The Director of Nursing stated nurses should administer medications as ordered by the physician and should document the correct time the medication was administered. No further information was provided.	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 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	F 880	1. The nebulizer was removed from the nurses' station and placed in the soiled utility room March 1, 2019. 2. All residents have the potential to be affected. An audit was completed to ensure no other residents were affected by this deficiency. No other residents were identified. 3. All nursing staff (LPN, RN, and CNA) was educated on ensuring nebulizers are placed in the soiled utility room after use March 1, 2019.	

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F 880	Continued From page 91 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880	4. QI monitoring for residents requiring nebulizers, as well as nebulizer equipment, will be done by the DCS/Designee to ensure nebulizers are placed in the soiled utility room after us three times weekly for one month, then one time per week for two months. QI monitoring will be reported to the RM/QI committee monthly for a period of 3 months for further compliance and/or revision. 5. Date of Compliance: 4/2/2019	

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F 880	Continued From page 92	F 880		

IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to maintain infection control practices for Residents residing on one floor (Second Floor) of three floors

1. For Residents on the Second Floor, the facility staff failed to properly store a used nebulizer machine left unattended on the counter (ledge) of the nurses station, where Residents of various cognitive abilities had access.

The findings include:

1. For Residents on the Second Floor, the facility staff failed to properly store a used nebulizer machine left unattended on the counter (ledge) of the nurses station, where Residents of various cognitive abilities had access.

On 3/1/2019 at 10:45 AM during initial tour noted 2 used nebulizer machines on the counter at the nurses station not covered or placed in plastic bags. Nebulizers were left on counter until 11:55 AM.

On 3/1/19 At 11:55 AM, an interview was conducted with RN A (Infection Control /Staff Education Nurse). When asked if the facility had any Residents on the unit that wandered she answered, yes we have two. She was then asked if the two nebulizers on the counter were dirty or clean and she stated " They look dirty." When asked where the dirty equipment should be stored while awaiting disinfection she stated, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

(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 880	Continued From page 93 dirty utility room. She was asked if staff were aware of where the dirty equipment should be stored she stated, yes. On 3/3/19 the end of day briefing the DON and Administrator were made aware of the issues and no further information was provided.	F 880		