STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING ______ B. WING ______	C 03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT HARRISONBURG TRANSITIONAL CARE & REHAB CT	94 SOUTH AVENUE HARRISONBURG, VA 22801

(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) COMPLETE DATE
E000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/5/19 through 3/7/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F561 Self-Determination CFR(s): 483.10(f)(1)-(3)(8)**	
F000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/05/19 through 03/07/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during this survey. The Life Safey Code will follow. The census in this 117 certified bed facility was 98 at the time of the survey. The survey sample consisted of 20 current resident reviews and 4 closed record reviews.	F000	**Resident Affected:** A new tub stopper was installed. Resident #20 preferences have been updated with immediate delivery of bathing preference. **Residents with Potential to be Affected:** A 100% facility audit on bathing preferences was conducted and resident Kardex was updated. **Systemic Changes:** Nursing staff will be educated on location of resident bathing preferences. Nurse Manager will review shower/ bath point of care documentation three times per week to verify the residents are receiving bathing preference as requested. Nurse Manager will report findings to Director of Nursing weekly for three months.	
F561 SS=E	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	F561	**Monitoring:** The Director of Nursing will immediately initiate intervention if needed. The Director of Nursing or Nursing Manager will bring the audit to be reviewed and discussed by the Monthly Performance Improvement Committee consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimum Data Set Coordinator, and Medical Director to ensure compliance is ongoing and determine the need for further audits/ in-services.	4/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elsie Corley, Interim Adm Electronically Signed — TITLE — (X6) DATE 3/27/19

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

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F561	Continued From page 1 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 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, facility staff failed to ensure one of 24 residents bathing preferences, Resident #20. Facility staff failed to offer Resident #20 a tub/whirlpool bath weekly, stating the tub was broken. Findings included: Resident #20 was admitted to the facility on 08/18/2011 with diagnoses including, but not limited to: Cerebrovascular Accident with left sided hemiplegia, Convulsions, Hypertension, and Psoriasis. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment	F561		

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F561	Continued From page 2 reference date) of 12/11/18. Resident #20 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #20, the Resident Council President, was interviewed on 03/06/2019 at 1:30 p.m. During this interview Resident #20 stated, "The small shower chair is broken. The large chair is too big for us small guys. We are afraid we will fall through the hole in the middle. The bath tub/whirlpool isn't working. I used to get in it at least once a week. It helps with my skin. It has been broken for over a year." At approximately 1:45 p.m. the Maintenance Director was interviewed regarding the whirlpool tub. He stated, "It was working. Let's go check it." The Maintenance Director and this surveyor went to the shower room and inspected the tub. He turned the water on in the tub and everything appeared to be working. Regarding the broken, small shower chair, the Maintenance Director stated, "The wheel broke off on Friday. No, we haven't ordered a new one yet. I am going to order one right now." While in the tub room, CNA #5 (certified nursing assistant), bath aide walked into the room and was interviewed regarding the tub. CNA #5 stated, "They told me when I started it didn't work, so I have never tried it. I have been here since October." While interviewing CNA #5, the Administrator walked into the tub room. The Administrator stated, "There is nothing wrong with it. It just needs a drain plug. I just haven't gotten one." No further information was received by the survey team prior to the exit conference on 03/07/19.	F561		
F625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F625		

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F625	Continued From page 3 483.15(d) Notice of bed-hold policy and return- 483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. 483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of 24 residents in the survey sample (Resident # 83), to offer a written bed-hold notice. Resident # 83, who was her own Responsible Party, was not offered a written bed-hold notice upon discharge to the hospital.	F625	**F625 Notice of Bed Hold Policy Before/Upon Transfer CFR(s): 483.15(d)(1)(2)** *Resident Affected:* Written copy of the bed hold policy was given to Resident #83. *Residents with Potential to be Affected:* All current residents are at risk for this deficiency. All current residents who are their own Responsible Party have received a current bed hold policy and this has been scanned into their Electronic Medical Record. A letter of explanation and copy of bed hold policy was mailed to the Responsible Party of any resident that is not their own Responsible Party. The written bed hold policy was added to the admission packet for all future admissions and re-admissions. The written bed hold policy was added to each resident's transfer packet for immediate provision upon transfer to the hospital. *Systemic Change:* Admission Coordinator and Clinical Liaison, Business Office Manager and Licensed Nursing Staff will be educated on the bed hold policy. The Executive Director will conduct a weekly audit of all new / and readmitted residents to verify written bed hold policy was given to the resident or responsible party for four weeks and monthly for two months. *Monitoring:* The Executive Director will report the findings to the Performance Improvement committee monthly for 3 months. The Performance Improvement committee consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F625	Continued From page 4 The findings were: Resident # 83, was admitted to the facility on 12/17/18, and most recently readmitted on 1/30/19 with diagnoses that included atrial fibrillation, congestive heart failure, hypertension, renal insufficiency, pneumonia, diabetes mellitus, osteoporosis, seizure disorder, chronic obstructive pulmonary disease, and respiratory failure. According to the most recent Minimum Data Set, a Significant Change with an Assessment Reference Date of 2/6/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. According to the resident's Electronic Health Record (EHR), she was her own Responsible Party. On 1/22/19, Resident # 83 was transferred to a local hospital due to an hypoglycemic event. Review of Resident # 83's EHR failed to reveal any documentation of a bed-hold notice being issued. At 8:20 a.m. on 3/7/19, the Admissions Director was asked who takes care of the bed-hold notices. "I do," the Admissions Director said. Asked if Resident # 83 got a bed-hold notice when she was transferred to the hospital on 1/22/19, the Admissions Director said, "I called her and asked about the bed-hold. She (Resident # 83) said she didn't have the money to hold the bed. I told her we would hold the bed for her. I did not do a written notice." Resident # 83 was readmitted to the facility on 1/30/19, although not to the same room she had at the time of discharge.	F625		

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F625	Continued From page 5 The lack of a bed-hold notice was discussed during a meeting at 4:15 p.m. on 3/7/19 the included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F625		
F656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) 483.21(b) Comprehensive Care Plans 483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.24, 483.25 or 483.40; and (ii) Any services that would otherwise be required under 483.24, 483.25 or 483.40 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F656	**F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)** ***Resident Affected:*** Resident #39 activity care plan was updated. ***Residents with Potential to be Affected:*** All residents are at risk for this deficiency. All activities staff was educated on completion of person-centered activity care plan that includes resident preferences. ***Systemic Changes:*** Activities staff will conduct a 100% resident population audit of the activity care plans to ensure that each is resident-centered. Any discrepancies will be immediately corrected. Minimum Data Set Coordinator will audit the activities care plan on new admissions to verify the activities care plan weekly for 3 months. ***Monitoring:*** The Minimum Data Set Coordinator will discuss the audit results during the monthly Performance Improvement Committee consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F656	Continued From page 6 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, facility staff failed to develop a comprehensive care plan (CCP) for one of 24 residents in the survey sample, Resident #39. Facility staff failed to develop an activities care plan for Resident #39. Findings included: Resident #39 was originally admitted to the facility on 07/28/16 and readmitted on 01/03/19 with diagnoses including, but not limited to: Diabetes, End Stage Renal Disease requiring Hemodialysis, Hypertension, Epilepsy, Right BKA (below knee amputation), Left AKA (above knee amputation), Stage 4 Sacral Pressure Ulcer, and Cerebrovascular Disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/08/19. Resident #39 was assessed as cognitively intact with a total cognitive score of 13 out of 15. Resident #39 was interviewed on 03/06/19 at 8:	F656		

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F656	Continued From page 7 15 a.m. Resident #39 was observed lying in bed with his tv on. Resident #39 stated, "I have that wheelchair, but I never get out of this bed, except when I go to dialysis. I like going to dialysis. They never get me out of this bed." This resident's privacy curtain was observed pulled between his and the roommate's bed, obscuring Resident #39's view of the hallway. When asked about this curtain, Resident #39 stated, "I guess they don't want me to see what's going in the hall." Resident #39's clinical record was reviewed on 03/07/19 at 10:00 a.m. All Activities Admission / Readmission notes in the clinical record included only weight warning documentation. There was no mention of activities. The only Activity note located in the clinical record was dated 5/31/18 at 1720 (5:20 p.m.). The note included: "Note Text: Resident is alert, oriented and able to make his needs known to others. Resident does not participate in OOR (out of room) activities. Family is not involved in daily activities. Activities staff will visit and invite to activities with supervision, provide monthly calendars, encourage and monitor in and OOR activity." Resident #39's most recent comprehensive MDS with an ARD of 05/30/18 included the following under "Section F: F0300 - Should interview for daily and activity preferences be conducted? 1. yes...F0500. Interview for Activity Preferences. B. How important is it to you to listen to music you like? 1 = Very important C. ...to be around animals such as pets? 1 = Very important D. ...to keep up with the news? 1 = Very important E. ...to do things with groups of people? 1 = Very important F. ...to do your favorite activities? 1 = Very important. G. ...to go outside, get fresh air	F656		

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F656	Continued From page 8 when the weather is good? 1 = Very important...F0600. Daily and Activity Preferences Primary Respondent 1. Resident..." The CCP was reviewed and included under "Focus: At risk for alteration in comfort r/t (related to) dx (diagnosis) of Neuropathy, pressure areas...Date Initiated: 07/28/2016...Revision on: 02/07/2018...Interventions: ...Offer sensory or diversional activities such as TV or music, crafts as resident requests. Date Initiated: 07/28/2016..." There was no mention of an activities care plan other than as used for diversion from alteration in comfort. The Activities Director (AD) was interviewed on 03/07/19 at 11:20 a.m. Regarding an activities care plan for Resident #39, the AD stated, "Yes, he has a 1:1 (one to one) care plan." A copy of this care plan and documentation to support one to one visits with Resident #39 was requested. At 12:00 p.m. the AD stated, "He doesn't have a 1:1 care plan. We take him to activities as requested. We check on him daily, turn on his tv, music, open his blinds. We invite him to activities." Regarding documentation of activities the AD stated, "It will be documented in the computer." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 03/07/19 at approximately 3:30 p.m. No further information was received by the survey team prior to the exit	F656		
F679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) 483.24(c) Activities. 483.24(c)(1) The facility must provide, based	F679		

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F679	Continued From page 9 on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, facility staff failed to implement an ongoing, individual centered activities program for one of 24 residents in the survey sample, Resident #39. Findings included: Resident #39 was originally admitted to the facility on 07/28/16 and readmitted on 01/03/19 with diagnoses including, but not limited to: Diabetes, End Stage Renal Disease requiring Hemodialysis, Hypertension, Epilepsy, Right BKA (below knee amputation), Left AKA (above knee amputation), Stage 4 Sacral Pressure Ulcer, and Cerebrovascular Disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/08/19. Resident #39 was assessed as cognitively intact with a total cognitive score of 13 out of 15. Resident #39 was interviewed on 03/06/19 at 8:15 a.m. Resident #39 was observed lying in bed with his tv on. Resident #39 stated, "I have that wheelchair, but I never get out of this bed, except when I go to dialysis. I like going to	F679	**F679 Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)** ***Resident Affected:*** Resident #39 was interviewed on activity preferences and the comprehensive activities care plan was updated. ***Residents with Potential to be Affected:*** All residents are at risk for this deficiency. All activities staff was educated on completion of person-centered comprehensive activities care plan that includes resident preferences. ***Systemic Changes:*** Activities staff will conduct a 100% resident population activity preference audit and the comprehensive activities care plans will be updated and incorporated into planned activities. The Minimum Data Set Coordinator will assess new admissions to ensure preferences were obtained and the comprehensive activities care plans are generated for twelve weeks. Activities Staff will review resident preferences and update comprehensive care plans quarterly and as needed. ***Monitoring:*** The Minimum Data Set Coordinator will discuss the audit results monthly with Performance Improvement consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F679	Continued From page 10 dialysis. They never get me out of this bed." This resident's privacy curtain was observed pulled between his and the roommate's bed, obscuring Resident #39's view of the hallway. When asked about this curtain, Resident #39 stated, "I guess they don't want me to see what's going in the hall." Resident #39's clinical record was reviewed on 03/07/19 at 10:00 a.m. All Activities Admission / Readmission notes in the clinical record included only weight warning documentation. There was no mention of activities. The only Activity Note located in the clinical record was dated 5/31/18 at 1720 (5:20 p.m.). The note included: "Note Text: Resident is alert, oriented and able to make his needs known to others. Resident does not participate in OOR (out of room) activities. Family is not involved in daily activities. Activities staff will visit and invite to activities with supervision, provide monthly calendars, encourage and monitor in and OOR activity." Resident #39's most recent comprehensive MDS with an ARD of 05/30/18 included the following under "Section F: F0300 - Should interview for daily and activity preferences be conducted? 1. yes...F0500. Interview for Activity Preferences. B. How important is it to you to listen to music you like? 1 = Very important C. ...to be around animals such as pets? 1 = Very important D. ...to keep up with the news? 1 = Very important E. ...to do things with groups of people? 1 = Very important F. ...to do your favorite activities? 1 = Very important. G. ...to go outside, get fresh air when the weather is good? 1 = Very important...F0600. Daily and Activity Preferences Primary Respondent 1. Resident..."	F679		

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F679	Continued From page 11 The coprehensive care plan was reviewed and included under "Focus: At risk for alteration in comfort r/t (related to) dx (diagnosis) of Neuropathy, pressure areas...Date Initiated: 07/28/2016...Revision on: 02/07/2018...Interventions: ...Offer sensory or diversional activities such as TV or music, crafts as resident requests. Date Initiated: 07/28/2016..." There was no mention of an activities care plan other than as used for diversion from alteration in comfort. The Activities Director (AD) was interviewed on 03/07/19 at 11:20 a.m. Regarding an activities care plan for Resident #39, the AD stated, "Yes, he has a 1:1 (one to one) care plan." A copy of the care plan and documentation to support one to one visits with Resident #39 was requested. At 12:00 p.m. the AD stated, "He doesn't have a 1:1 care plan. We take him to activities as requested. We check on him daily, turn on his tv, music, open his blinds. We invite him to activities." Regarding documentation of activities the AD stated, "It will be documented in the computer." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 03/07/19 at approximately 3:30 p.m. No further information was received by the survey team prior to the exit conference on 03/07/19.	F679		
F684 SS=G	Quality of Care CFR(s): 483.25 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must	F684		

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F684	Continued From page 12 ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of hospital documents, review of facility policy and procedure, and staff interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice to maintain the highest level of practicable well being, for one of 24 residents in the survey sample (Resident # 83). Facility staff failed to monitor blood sugars according to facility hypoglycemic protocol, failed to contact the physician according to facility hypoglycemic protocol and physician orders, and failed to seek emergency help in a timely manner. There was a delay of approximately four hours in sending the resident to the hospital for evaluation and treatment after a second hypoglycemic event within 24 hours. This resulted in harm to the resident who was hospitalized. The findings were: Resident # 83 was admitted to the facility on 12/17/18, and most recently readmitted on 1/30/19 with diagnoses that included atrial fibrillation, congestive heart failure, hypertension, renal insufficiency, pneumonia, diabetes mellitus, osteoporosis, seizure disorder, chronic obstructive pulmonary disease, and respiratory failure. According to the most recent Minimum Data Set, a Significant Change with an Assessment Reference Date of 2/6/19,	F684	**F684 Quality of Care CFR(s): 483.25** ***Resident Affected:*** Resident #83's blood sugar was subsequently checked on 1/22/19 and she was transferred to emergency room. Physician was notified on 1/22/19 prior to being sent out. The insulin was discontinued on 1/30/19 for Resident #83. The resident is no longer on insulin and is being diet controlled. ***Residents with Potential to be Affected:*** All residents with hypoglycemic events have the potential to be affected. All current residents on insulin were reviewed and identified. ***Systemic Changes:*** Licensed nurses will be educated on procedure for monitoring blood sugars and reporting to the Medical Provider according to policy for residents for hypoglycemic episodes with post-test. Licensed Nurses will be educated with post-test on calling 911 in emergency situations instead of medical transport. All hypoglycemic episodes identified in documentation review during the clinical morning meeting will be audited by a Nurse Manger to verify that blood sugars were monitored per policy or physician/provider order, and that medical provider was notified, and transport to emergency room was timely if applicable. ***Monitoring:*** The Director of Nursing will discuss the audit results during the monthly Performance Improvement consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, MDS, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F684	Continued From page 13 the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Review of Resident # 83's Electronic Health Record (EHR) revealed the following Progress (Nurses) Notes entry dated 1/21/2019 at 1523 (3:23 p.m.), "Pt. (Patient) lethargic and diaphoretic, was gurgling some, was not talking, (Name of Physician's Assistant) aware. He ordered d5 ns (5% dextrose in normal saline) at 100 cc/hr (cubic centimeters per hour) times (to equal) 1 liter. This was started at 1355 (1:55 p.m.). Blood sugar was 36. Glutose given in mouth as well. Pox (pulse ox) 96% on 3 liters (of oxygen). (Name of Physician's Assistant) stated to put it on 3 liters this am. She started becoming more awake. Blood sugar was 36 at 1345 (1:45 p.m.). Blood sugar was up to 63 at 1410 (2:10 p.m.). Not gurgling anymore at 1530 (3:30 p.m.). No respiratory distress noted." (NOTE: Glutose is an oral gel that delivers 15 grams of pure glucose (dextrose) for rapid response to hypoglycemia. Ref. MooreMedical [McKesson].com.) Also in the resident's EHR was a Telephone Order dated 1/21/19 at 10:35 a.m., that included the following, "D5 1/2 NS (5 1/2 % dextrose in normal saline) at 100 cc/r per IV (intravenous)/clysis x (times) 2 L (liters) for AKI (Acute Kidney Injury/Failure)." (NOTE: Clysis is the introduction of large amounts of fluid into the body, usually by parenteral injection. Ref. Langenscheidt's Merriam-Webster Medical Dictionary, Copyright 2002, page 124.) At 3:00 p.m. on 3/6/19, RN # 2 (Registered	F684		

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F684	Continued From page 14 Nurse), who wrote the 1/21/19 Progress (Nurses) Notes entry, was interviewed. RN # 2 was first asked why Glutose would be given to someone who was "...lethargic and diaphoretic, was gurgling some, was not talking." RN # 2 said, "We put it under her tongue and in her cheek. She was not totally out of it. We encouraged her to swallow and she could. RN # 2 was then asked if the order for the order for the IV was written at 10:35 a.m., why was it not started until 1:55 p.m., approximately 3 hours and 20 minutes later. RN # 2 questioned the timing of the IV order and said she didn't think the time was right. RN # 2 then said, "If I wrote that time (meaning 1355 or 1:55 p.m.), then that was when it (the IV) was started." Asked if the IV supplies were readily available, RN # 2 said they were all in the medication storage room. An order on Resident #83's January Medication Administration Record (MAR) with a start date of 12/19/2018, documented, bood sugar BID (twice a day), call MD (physician) if < (less than) 60 or > (greater than) 500, two times a day for glucose monitoring. The times for checking blood sugar were documented at 9:00 a.m. and 9:00 p.m. on the MAR. On 1/21/2019, Resident #83's blood sugar was documented as 67 at 9:00 p.m. Resident # 83's EHR contained the following Progress (Nurses) Notes entry related to her hypoglycemic event, dated 1/22/2019 at 0336 (3:36 a.m.). "Resident continued with shakes. BS (Blood Sugar) 28. Given med pass X (times) 2, given half a sandwich, given oral glucagon. BS rechecked and 49. On call MD called, order for D5 1/2 NS ordered. BS rechecked after IV running for 2 hours and BS still at 49. Resident	F684		

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F684	Continued From page 15 pulled IV out. Nursing judgement made to send resident out to (name of hospital)." At approximately 11:50 a.m. on 3/7/19, the survey team met with the Administrator, Director of Nursing (DON), and the Corporate Nurse Consultant. At that time, the surveyor requested the DON to make a timeline of Resident # 83's hypoglycemic episode, starting with the Progress (Nurses) Notes dated 1/21/2019 through 1/22/2019. At 2:40 p.m. on 3/7/19, the DON provided the requested timeline. Together, the surveyor and the DON reviewed the timeline, which noted the resident's BS at 9:00 a.m. on 1/21/19 was 108. The timeline confirmed the 1/21/19 Telephone Order time of 10:35 a.m., but it did not include the IV order. The DON agreed the IV order was on the Telephone Order. Continuing, the timeline noted, "After lunch, resident presented diaphoretic, BS 36, PA (Physician's Assistant) aware, D5 1/2 NS ordered at 100 cc/hr for 1 liter, O2 (oxygen) via NC (Nasal Canula) increased to 3 liters. IV started at 1355 (1:55 p.m.). At 1410 (2:10 p.m.) BS 63." Asked if IV supplies were available, the DON stated they were in the Medication Storage Room. When asked why it took so long for the IV to be started, the DON said, "It should not have taken 3 hours." Moving on to the events of 1/22/19, the timeline noted, "...MD notified and order for D5 1/2 NS ordered (IV was started approximately 0130 {1:30 a.m.]) BS rechecked after IV running for 2 hours and BS was 49, resident pulled IV out, and resident was sent to ED (Emergency Department)."	F684		

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Based on a start time of 1:30 a.m., and a run time of two hours, the surveyor and DON agreed that the IV would have finished at approximately 3:30 a.m. A review of the ED Provider Notes from the hospital placed the resident's hospital arrival time at 7:54 a.m. on 1/22/19. Asked how far away from the facility, time wise, was the hospital, the DON said, "About 10 minutes." The DON and surveyor agreed on another 15 to 20 minutes to get the resident ready and loaded into the ambulance, which placed the time the resident left the facility at approximately 7:30 a.m.

Asked why approximately four hours lapsed between the time Resident # 83's IV finished and the time she was sent to the hospital, the DON had no explanation. Asked about physician involvement in the decision to send the resident to the hospital, the DON indicated that apparently there was none since the resident was sent out based on nursing judgement.

On 3/6/19, the surveyor requested and was provided with the facility's protocol to address Hypoglycemia. Under the "Procedure" portion of the protocol the following was noted at Item 6c. "Check blood glucose every 15 minutes, until blood sugar is over 70 mg/dl (milligrams per deciliter). If blood sugar continues to fall after 15 minutes or continues to be below 70 mg/dl after 30 minutes, call physician."

Item 10 of the protocol documented, "Continue to monitor blood sugars, if the resident has not improved within 20 minutes from initial treatment or the resident's condition worsens, or passes out from hypoglycemia:
a. Contact the physician
b. Follow any new orders

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F684	Continued From page 17 c. DO NOT inject insulin d. DO NOT give food or fluids e. Inject glucagon, if ordered f. Call for Emergency help The :Documentation Guidelines" included the following: 1. Date and time of event 2. Resident's response, as related to the procedure, a. Resident's signs and symptoms, b. Frequency and results of blood testing, c. And change in medication administration, d. Type, time, and amount of oral intake, e. Resident's response to treatment. 2. Date and time of physician notification. The DON was asked if the 15 minute Blood Sugar checks were done according to the protocol on 1/21/19 and 1/22/19. The DON said she talked to staff and "...they said they did them, but they did not document them." The DON also noted there was no documentation of what happened between 3:30 a.m. and 7:30 a.m. on 1/22/19. There was also no documentation to indicate the physician was called on 1/21/19 when the resident's Blood Sugar failed to rise above 70 mg/dl, or on 1/22/19 when her Blood Sugar failed to rise after two hours of an IV. There was no documentation of the resident's signs and symptoms between the Progress (Nurses) Notes of 1/21/19 at 3:23 p.m. and 1/22/19 at 3:36 a.m. There was no documentation indicating the physician was called prior to the resident being send to the hospital based on "nursing judgement." The American Diabetes Association classification of hypoglycemia defines a Level 2	F684		

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F684	Continued From page 18 hypoglycemia as "...a blood glucose concentration < 54 mg/dL [3.0 mmol/L]," which "...is the threshold at which neuroglycopenic symptoms begin to occur and requires immediate action to resolve the hypoglycemic event." A Level 3 event is defined as "...a severe event characterized by altered mental status and/or physical functioning that requires assistance from another person for recovery...Level 3 hypoglycemia may be recognized or unrecognized and can progress to loss of consciousness, seizure, coma, or death. It is reversed by administration of rapid-acting glucose or glycogen. Hypoglycemia can cause acute harm to the person with diabetes...A large cohort study suggested that among older adults with type 2 diabetes, a history of level 3 hypoglycemia was associated with a greater risk of dementia." Ref. American Diabetes Association Standards of Medical Care in Diabetes - 2019, page S67. Resident # 83's hypoglycemic episode was discussed during a meeting at 4:15 p.m. on 3/7/19 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F684		
F692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) 483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- 483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight	F692		

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F692	Continued From page 19	F692		

or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, family interview and clinical record review, the facility staff failed to ensure one of 24 residents maintained acceptable parameters of nutritional status, Resident #70.

Resident #70 had a weight loss of 6.12 % in three months and a significant weight loss of 10.20% in six months. Resident #70 was unable to feed herself, and facility staff did not offer assistance at meal time per Resident #70's care plan. This was identified as harm by the survey team.

Findings were:

Resident #70 was admitted to the facility on 06/04/2018 with the following diagnoses, but not limited to: Dysphagia, Type II Diabetes Mellitus, Major Depressive Disorder, Hypertension, Anxiety, and Progressive Supranuclear Opthalmoplegia (Steele-Richardson-Olszewski Syndrome).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment

F692 Nutrition/Hydration Status Maintenance
CFR(s): 483.25(g)(1)-(3)

Resident Affected:

The care plan and Kardex were updated to reflect need for feeding assistance for resident #70 on 3/6/19. The resident began receiving feeding assistance with meals on 3/6/19.

Residents with Potential to be Affected:

All residents are at risk for a decline in Activities of daily living function. 100 % audit of all residents was completed to identify any changes in activities of daily living.

Systemic Changes:

Activities of Daily Living documentation will be reviewed in clinical morning meeting by the interdisciplinary team to identify residents with decline in eating. The interdisciplinary team will identify and implement interventions as appropriate. The Minimal Data Set Coordinators will update Kardex and care plans with changes identified by the interdisciplinary team. Staff will be educated on utilizing the Kardex to know the level of care needed for residents. Nurse Managers will perform observations of residents who require feeding assistance to verify they are receiving appropriate assistance 5 days a week for 2 weeks, then 2x/week x 1 month, then weekly x 1 month, then monthly x 3 months or until resolved.

Monitoring:

The Director of Nursing will discuss the audit results during the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimum Data Set Coordinators, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.

(X5) COMPLETE DATE: 4/3/19

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F692	Continued From page 20 reference date) of 01/29/2019. Resident #70 was assessed as cognitively intact with a summary score of "15". In Section G: Functional Status, Resident #70 was coded as "0/1" for eating, indicating she was independent with eating and needed set up only for her meals. On 03/05/2019, Resident #70 was observed sitting in a chair in her room. Her husband was in the room and he was feeding her lunch. An interview was conducted with both Resident #70 and her husband. Resident #70's speech was very slow, halting and deliberate. Her husband stated, "She has difficulty talking." The husband stated, "She doesn't eat if I'm not here." He was asked what that meant. He stated, "She can't feed herself...she can't get the food to her mouth...I've told them she does okay with finger foods, but she can't pick up those peas on her tray." He handed the spoon to Resident #70 and stated, "Honey, try to feed yourself a little bit." Resident #70 took the spoon and attempted to scoop up peas on her plate. She pushed the peas all around on her plate before getting one or two on her spoon. She attempted to put the spoon to her mouth, but either it had no food on it, or dropped the peas before getting them to her mouth. Her husband was asked who assisted her when he was not at the facility. He stated, "Nobody does...I've been sick myself and haven't been in as much...she's lost some weight." The care plan was reviewed on 03/05/2019 at approximately 4:30 p.m., and contained the following information: "Focus: ADL [activities of daily living] self-care performance deficit.. Interventions: EATING: [Name] is able to feed self after tray set up. If [Name] is dropping food or getting tired, staff to feed her. 10/16/18: [Name] needs lids and straws for all cups and	F692		

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F692	Continued From page 21 for all meals. Requires set up for straws for coffee cups. Plate guard for all meals. Date initiated: 06/12/2018...Revision on: 10/16/2018. On 03/06/2019 at approximately 8:45 a.m., Resident #70 was observed lying in bed. Her breakfast tray had been picked up. Her CNA (certified nursing assistant) was located and interviewed regarding Resident #70's intake at breakfast. CNA #1 stated, "I think she just needs set up only...I don't think she needs any assistance...I didn't put her tray in there this morning, or pick it up...maybe [name] did. CNA #1 went down the hall and spoke with three other staff members, none of which had been in Resident #70's room. CNA #2 was coming down the hallway. CNA #1 asked her if she had picked up or set up Resident #70's tray. She stated, "Yes, I put straws in her cups...She drank about 240 cc of fluid and ate about 25%." CNA #2 was asked if she had offered to assist Resident #70 with eating. She stated, "No." The CNAs were asked who delivered and picked up trays. CNA #1 stated, "We work together...we all deliver and pick them up...then we write on a piece of paper at the nurse's station how much they eat." The clinical record was reviewed. The following weights (in pounds) were documented: 06/04/2018: 154 (standing) 06/05/2018: 157 (mechanical lift) 06/09/2018: 152 06/24/2018: 153 07/05/2018: 149 (standing) 07/18/2018: 148 07/25/2018: 147 08/08/2018: 148 09/06/2018: 147 10/05/2018: 145 11/05/2018: 143	F692		

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F692	Continued From page 22 12/06/2018: 138 01/04/2019: 134 01/13/2019: 134 01/19/2019: 137 01/27/2019: 136 02/02/2019: 133 02/09/2019: 134 02/16/2019: 136 02/23/2019: 135 03/02/2019: 132 From 09/06/2019 until 12/06/2018 (3 months) Resident #70 lost 9 pounds, 6.12% in three months and from 09/06/2018 until 03/02/2019 (6 months) Resident #70 lost 15 pounds, a significant loss of 10.20%. The MDS nurse, RN (registered nurse) #1 was interviewed at approximately 11:00 a.m. Observed in the clinical record was an MDS assessment that was in progress but had not been completed. The functional ability section "G" was completed on the MDS and Resident #70 was coded as a 4/2 for eating, indicating she needed extensive assistance of 1. RN #1 stated, "That populates from within the system...we make changes to it as we finalize it." The observations of Resident #70 eating and the interview with her husband were discussed. At approximately 1:00 p.m., RN #1 came to the conference room and stated, "I contacted Resident #70's RP [responsible party] and I updated her care plan." She presented an updated care plan that contained the previous mentioned interventions and the addition of the following: "03/06/2019 [Name] is able to feed herself finger foods, anything she can hold in her hand. [Name] needs assist with foods that require using a utensil to eat. She needs to be fed slowly."	F692		

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F692	Continued From page 23 The above information was discussed during an end of the day meeting on 03/06/2019 with the administrator, the DON (director of nursing) and the corporate nurse consultant. The DON stated that Resident #70 had recently had speech therapy. On 03/07/2019 at approximately 9:00 a.m., Resident #70 was observed lying in bed. She was asked if she had eaten her breakfast. She slowly stated, "No." She was asked if anyone had assisted her with breakfast. She slowly responded, "No." She was asked if she was hungry. She slowly answered, "Yes." A nurse in the hallway was asked who the CNA assigned to Resident #70 was. She stated, "[Name of CNA #3]....there she is, coming around the corner." CNA #3 was observed coming down the hallway, she was wearing a coat, talking on a cell phone, and carrying a small white plastic bag. She went into an office on the unit and shut the door. This surveyor knocked on the door and asked to speak with the CNA when available. CNA #3 was asked if she was caring for Resident #70. CNA #3 asked, "What room is that?" CNA #3 was told the room number. She asked, "A bed or B bed?" She was told which bed. She stated, "Yeah, she's mine." CNA #3 was asked how much breakfast Resident #70 had eaten that morning. She stated, "I didn't do her...I think [name of CNA #4] did." CNA #3 was asked what that meant. She stated, "We all hand out the trays and pick them up, you don't always do your own rooms...We can look at the intake sheet and see how much she ate." CNA #3 went to the nurse's station looked at a piece of paper and stated, "She refused breakfast, but she drank 360 cc," CNA #3 was asked who	F692		

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F692	Continued From page 24 wrote that down. She stated, I guess [CNA #4] did. CNA #3 was asked if she had gotten report on Resident #70. She stated, "We make rounds and they tell us if anything has changed." CNA #3 was asked if she was aware that Resident #70's care plan stated that if she was dropping food or getting tired while eating that staff were to assist her. She stated, "No, I didn't know that." CNA #3 was asked if she had reviewed Resident #70's care plan. She stated, "No." She was asked if that was something she normally did. She stated, "I do it when I get time...I try to do it before I give them care...I've taken care of her before I just didn't know that...I think somebody should have told me that in report." CNA # 4 was located. She was asked if she had given Resident #70 her tray or picked it up. She stated, "No, [name of CNA #3] did. CNA #4 and this surveyor located CNA #3. CNA #4 and CNA #3 had a discussion about which one of them had gotten Resident #70's tray. They were both asked if either of them had offered to assist Resident #70 with her food or if Resident #70 had stated that she didn't want breakfast. Both stated, "No." Information was presented on 03/07/2019 regarding speech therapy services received by Resident #70 from January through March of 2019. Review of the evaluation included the following goals: "Patient will increase use of breath support and control strategies up to 70% accuracy during production of words increase speech intelligibility; Patient will articulate words with 60% intelligibility using over-articulation, breath support and control, environmental modifications and pacing in order to improve functional communication skills; Patient will communicate yes/no responses using non-	F692		

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F692	Continued From page 25 speech generating AAC system with moderate cueing." At approximately 9:25 a.m., the speech therapist who worked with Resident #70 was interviewed. He was asked if he had observed Resident #70 eat while she was receiving speech therapy services. He stated, "No I was in there to facilitate her ability to communicate...her communication board had been misplaced so I was consulted to work with her on ways to communicate." On 03/07/2019 at approximately 10:00 a.m., observed in the clinical record was an "Angel Care Welcome Survey". The survey was dated 6/4/2018. One of the questions was: "How had the food been?" Resident #70's response was "She can't feed [her]self." The DON was asked what the Angel Care Welcome Survey was; she stated "a survey done a few days after a resident's admission to the facility to see how things were going." The information regarding Resident #70 not being able to feed herself was pointed out to the DON. The RD (registered dietitian) was interviewed on 03/07/2019 at approximately 10:30 a.m., regarding Resident #70. She was asked if she was aware of Resident #70's weight loss. She stated, "Yes, I saw her this month [March] because she has been referred to Hospice so I did a significant change assessment...I also saw her in February for her quarterly assessment...I increased her supplements then, and we are still doing weekly weights." The RD was asked if she had watched Resident #70 eat. She stated, "The PA [physician's assistant] was in there when I saw her last so, no I didn't." She was asked if she had watched Resident #70 eat in February when she did her quarterly assessment. She stated, "No, I didn't...I really can't be here to watch everyone eat...I have	F692		

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F692	Continued From page 26 watched her in the past but not either of those times." The observations of Resident #70 eating and the interview with her husband were discussed with the RD. The RD stated, "We discuss her weight meeting every week, I've increased her supplements and I am going to liberalize her diet more." A note written on 03/07/2019 at 9:59 a.m., by the unit manager, was observed in the clinical record at approximately 11:45 a.m. The note contained the following: "Res [resident] noted with dysphagia and overall decline with ADL's. Res states that she is not able to feed self, res is able to consume liquid by self with no assistance. Staff assisted with eating this day and res noted with difficulty. This nurse followed up with Hospice to have someone come to assess these concerns and assist with any changes that may be needed..." The unit manager was interviewed at approximately 12:00 p.m. and was asked about the note written that morning. She stated, "Yes, I noticed that she had refused breakfast this morning so I got her another tray and had the CNA try to feed her." The unit manager was asked if she was aware that Resident #70's care plan contained interventions for staff to feed her if she was becoming tired or dropping food and most recently updated to include that staff assist her with food requiring utensils and for staff to feed her slowly. The unit manager stated, "No, I was not aware of any of that being on her care plan." On 03/07/2019 at approximately 12:45 p.m., a meeting was held with the DON, the administrator and the corporate nurse consultant. The above information was discussed, The corporate nurse consultant	F692		

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F692	Continued From page 27 stated, "She had an occupational therapy consult in June [2018] and she was able to feed herself then." The Occupational therapy notes from June 2018 were presented. Under the section "Functional Skills Assessment...the area Self Feeding" was marked "Self Feeding=Supervised (A)." The occupational therapist that completed the eval was interviewed on 03/07/2019 at approximately 2:35 p.m. He was asked what the "A" stood for in his notes. He stated, "Assist." He was asked what that meant in regards to Resident #70 eating. He stated, "Assist means that might need cueing...move her plate or cup over to her if it gets pushed away, that type of thing." An end of survey meeting was held with the administrator, the DON and the corporate nurse consultant. The above information was discussed. Concerns at the level of harm were voiced due to the fact that the facility staff had not provided assistance to Resident #70 at meal time, nor were the staff aware that Resident #70 required assistance per her care plan. The RD nor the speech therapist had observed Resident #70 eating, and the CNA staff while working as a team on the unit to get trays out to residents and picked back up in a timely manner had not assured that the CNA setting up or picking up her tray had offered assistance with eating. No further information was obtained prior to the exit conference on 03/07/2019.	F692		
F758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) 483.45(e) Psychotropic Drugs. 483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with	F758		

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F758	Continued From page 28 mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- 483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; 483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and 483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F758	**F758 Free from Unnecessary Psychotropic Meds/As Needed Use CFR(s): 483.45(C)(3)(E)(1)-(5)** ***Resident Affected:*** Resident medication reviewed by Physician for resident #35 and resident #83. Gradual Dose Reduction review completed for resident #35 and medical doctor recommended continuation for hospice. Medication reviewed by medical doctor and medications were discontinued for resident # 83. ***Residents with Potential to be Affected:*** Audit was conducted to identify all residents on as needed psychotropic medications on 3/8/19 to ensure each medication has a stop date. ***Systemic Changes:*** New medications will be reviewed in clinical morning meeting Monday- Friday to verify orders for as needed antipsychotic and anxiolytic medications have 14 days stop dates. The Medical Provider will be contacted for stop dates as appropriate. Nurse Managers will complete a monthly audit of as needed antipsychotic and anxiolytic medications for compliance. All licensed nurses will be educated on the psychoactive drug use policy that includes obtaining a 14 day stop date for as needed antipsychotic and anxiolytic medications. ***Monitoring:*** The Director of Nursing will discuss the audit results during the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimal data set coordinators, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F758	Continued From page 29 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for two of 24 residents in the survey sample (Residents # 35 and 83) to ensure PRN (as needed) psychotropic medications were not ordered for more than 14 days. 1. Resident # 35 had a PRN order for Lorazepam with out end date. 2. Resident # 85 had two PRN orders for Lorazepam; one for 29 days without a rationale for the extended use, and one with no end date. The findings include: 1. Resident # 83 was admitted to the facility on 12/17/18, and most recently readmitted on 1/30/19 with diagnoses that included atrial fibrillation, congestive heart failure, hypertension, renal insufficiency, pneumonia, diabetes mellitus, osteoporosis, seizure disorder, chronic obstructive pulmonary disease, and respiratory failure. According to the most recent Minimum Data Set (MDS), a Significant Change with an Assessment Reference Date (ARD) of 2/6/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Review of the Medication Administration Record (MAR) for the months of January and February 2019, located in Resident # 83's Electronic	F758		

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F758	Continued From page 30 Health Record (EHR), revealed the following order, "Lorazepam Intensol Concentrate 2 mg/ml (milligrams per milliliter). Give 0.25 ml (milliliter) by mouth every 4 hours as needed for anxiety." The start date for the order was 1/30/2019, and the end date was 2/27/2019, a period of 29 days. There was no rationale listed for the extended use of PRN Lorazepam beyond 14 days. The PRN Lorazepam was not used in January 2019, but was used twice in February 2019; once on 2/23/19, and once on 2/26/19. The MAR for February 2019 included a second order for "Lorazepam Intensol Concentrate 2 mg/ml. Give 0.5 ml by mouth every 4 hours as needed for anxiety." The start date was listed as 2/27/2019, but there was no end date listed. (NOTE: Lorazepam (Ativan) is a short acting benzodiazepine with uses that include the treatment of anxiety. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722.) At 7:40 a.m. on 3/7/19, the Director of Nursing (DON) was interviewed concerning the PRN use of Lorazepam for longer than 14 days. The DON said the physician "...was aware of the requirement for PRN psychotropics. I don't know if he just missed it." The DON was advised that Resident # 35 had a similar PRN order for Lorazepam. 2. Resident # 35 was admitted to the facility on 12/6/17, and most recently readmitted on 12/25/18 with diagnoses that included anemia, hypertension, diabetes mellitus, arthritis, Non-Alzheimer's dementia, Parkinson's disease, malnutrition, acute kidney failure, metabolic encephalopathy, insomnia, adult failure to thrive, and dementia without behavioral disturbance. According to the most recent MDS, a Significant	F758		

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F758	Continued From page 31 Change with an ARD of 1/3/19, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 5 out of 15. Resident # 35's MAR for March 2019 included the following order, "Lorazepam Solution 2 mg/ml. Give 0.25 ml by mouth every 4 hours as needed for anxiety or agitation." The start date for the order was 12/25/18. There was no end date for the order. According to the MAR's for January and February 2019, the PRN Lorazepam was administered twice in January, once on 1/27/19 and once on 1/30/19; and twice in February, once on 2/14/19 and once on 2/15/19. As of 3/7/19, the date of record review, the PRN Lorazepam had not been used in March 2019. The PRN use of Lorazepam for Residents # 35 and 83 was discussed during a meeting at 4:15 p.m. on 3/7/19 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F758		
F759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) 483.45(f) Medication Errors. The facility must ensure that its- 483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview, and clinical record review, the facility staff failed to ensure a medication error rate of less than 5% (percent).	F759		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT HARRISONBURG TRANSITIONAL CARE & REHAB CT	94 SOUTH AVENUE HARRISONBURG, VA 22801

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F759	Continued From page 32 The facility staff had a three medication errors out of 26 opportunities which resulted in a medication error rate of 11.54 percent (%). Findings include: 1. The facility staff failed to administer Resident #44 an Epoetin (Epogen) 10000 units/ml (milliliter) injection for a hemoglobin less than 11.0, per physician's orders; and failed to administer an OcuSoft Lid Scrub pad to each eye, per manufacturer's instructions (only one was used for both eyes). 2. The facility staff failed to administer insulin per physician's order for Resident #90. Findings include: 1. On 03/06/19 at 8:10 AM, the medication pass and pour observation was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 prepared medications for Resident #44. While pulling the medications, the LPN stated that this resident took her medications whole in applesauce and stated that this resident was supposed to get an Epogen injection every day, but the medication was not on the cart. The LPN then stated that she would go check to see if it (the medication) came in last night. LPN #1 was asked if she had to order the medication from the pharmacy and the LPN stated, "Yes." LPN #1 continued preparing the medications. LPN #1 then pulled one single packet of OcuSoft from the box, opened it and proceeded into the resident's room with the medications. LPN #1 attempted to administer the PO (by mouth) medications to the resident, but the resident was lethargic and difficult to arouse. LPN #1 attempted to put the medications up to	F759	**F759 Free of Medication Error Rates 5% or More CFR(s): 483.45(f)(1)** *Resident Affected:* Resident # 44 has not had any signs or symptoms of eye infection. Lab was obtained 3/5/19 and medication was administered on 3/6/19 resident for # 44. Schedule changed on Epogen to put resident back on weekly track with no negative effects. The insulin administration time was adjusted for resident # 90. *Residents with Potential to be Affected:* All residents on medication have the potential to be affected. Audit of all residents receiving blood sugar checks and insulin administration times completed on 3/7/19. Orders for eye wipes were updated to include instructions. *Systemic Changes:* Medication administration education and competencies to be completed for licensed nurses. The "Medication Pass Observation" pathway will be completed by Nurse Managers with all licensed nurses to verify compliance with medication administration. Licensed nurses to be educated on eye wipe administration by nurse managers. Unit manager educated on preparing lab books prior to the first of the month, Director of Nursing will check to be sure that lab books are prepared before the 1st of the month to ensure labs are in place. Medication pass audits will be completed weekly by nurse managers with licensed nurses on each shift for 3 months. *Monitoring:* The Director of Nursing will discuss the audit results during the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimal date set coordinators, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F759	Continued From page 33 the resident's mouth and the resident turned her head away several times. LPN #1 was asked if this was normal for Resident #44 and the LPN stated that this was not normal for this resident and that this was a change. LPN #1 then took the one OcuSoft wipe and explained to the resident that she was going to clean her eyes. The LPN applied gloves. The resident's eyes were matted and crusted. LPN #1 took the wipe and wiped both eyes with the same wipe. LPN #1 removed the gloves and then washed her hands and exited the room. LPN #1 stated that she was "done" with this resident and was moving on to the next resident. LPN #1 then stated that she would let this surveyor know when the Epogen injection arrived from the pharmacy. The LPN did not inform this surveyor of any information regarding the Epogen injection for Resident #44. At approximately 9:00 AM, a medication reconciliation was completed for Resident #44. The resident's current physician's orders included an order for, "Start date: 10/11/17...Epoetin Alfa Solution 10000 UNIT/ML Inject 10000 unit subcutaneously one time a day every Wed for anemia *****DO NOT GIVE IF HEMOGLOBIN IS GREATER THAN 11." The resident also had an order for "(start date: 09/28/17) CBC (complete blood count) every Monday one time a day every Mon for anemia"...and an additional order (dated 01/30/18) to "FAX results of CBC to pharmacy every Monday for them to send Epoetin." The resident's orders also included an order for "OcuSoft Lid Scrub Pads (Eyelid Cleansers) Apply to both eyes topically two times a day for	F759		

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F759	Continued From page 34 start date of 05/04/18. The resident's current CCP (comprehensive care plan) was reviewed and documented, "...Anemia...give medications as ordered...observe for...pallor, fatigue...syncope...weakness...Low Hgb/hct [hemoglobin/hematocrit]...changes in condition...obtain and review lab/diagnostic work as ordered..." At approximately 10:30 AM, the resident's MARs (medication administration records) were reviewed again and did not reveal that the Epogen had been administered at 8:00 AM, as ordered by the physician. The resident's labs were reviewed. No current lab work was found in the resident's clinical record. At approximately 11:00 AM, the physician was interviewed regarding Resident #44. The physician stated that the resident has had a few days of not feeling well and he thought that the resident may be a little dehydrated and was putting in an order for fluids. The physician also stated that the resident was very anemic and "that may have something to do with it." The physician was made aware that the resident was not given her Epogen today and was made aware that no labs could be located for the resident (as ordered). The physician stated that the lab staff may not have been able to draw the labs, and then stated that "maybe" the resident may have refused. At approximately 11:30 AM, the wound care nurse, LPN #3, presented lab results for Resident #44. The lab was dated 03/05/19 (Tuesday). The resident's hemoglobin was 9.2 [range: 12.0 - 16.0], which indicated the resident should have been administered the	F759		

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F759	Continued From page 35 for a hemoglobin less than 11.0. This LPN was asked where was this lab found. LPN #3 stated, "I heard you talking to [name of physician] about labs for [name of Resident #44] and I went and found this." The LPN was again asked where this lab was located. LPN #3 stated that it was in [name of lab computer software system] of the lab company. LPN #3 stated that the lab was not in the resident's clinical record, and that it had not been printed or pulled from the lab system for anyone to know whether to give the Epogen or not. LPN #3 did not know why the lab was not collected on Monday and faxed to the pharmacy as ordered or why this lab had not been in the resident's clinical record. On 03/06/19 at 02:10 PM, LPN #1 was interviewed regarding the above information. LPN #1 was asked about the Epogen for Resident #44. LPN #1 stated that she did not administer Epogen injection and stated that the medicine was usually here from the pharmacy, but it wasn't here. LPN #1 stated that she went to the stat box and the facility didn't have it. LPN #1 was asked if she had the resident's lab work or was she just going to administer the Epogen. LPN #1 stated the labs were faxed to the pharmacy every Monday so they will send the Epogen. LPN #1 stated that she did not know if the labs were done and did not know if the labs were faxed, but she told her supervisor (LPN #3) and LPN #3 was going to order it from the pharmacy. LPN #1 was then asked to see the OcuSoft wipe package. LPN #1 pulled out the box of wipes. The box of wipes documented instructions to, "Use one wipe per eye..." The LPN stated, "I used one wipe for both eyes, you are right I should be using one wipe for each eye." The administrator, DON (director of nursing) and	F759		

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F759	Continued From page 36 the corporate nurse were made aware in a meeting with the survey team on 03/06/19 4:45 PM. No further information and/or documentation was presented prior to the exit conference on 03/07/19 at 5:15 PM. 2. Resident # 90 was admitted to the facility 1/18/19 with diagnoses including but not limited to: stroke, anemia, high blood pressure, and diabetes. The most recent MDS (minimum data set) was the admission assessment dated 1/25/19 and had Resident # 90 coded with severe cognitive impairment with a total summary score of 03 out of 15. A medication pass and pour observation was conducted with RN (registered nurse) # 2 on 3/6/19 beginning at 7:55 a.m. RN # 2 prepared medications to be administered to Resident # 90, including 5 units of Humalog insulin. RN # 2 was then observed administering the resident's medications and the insulin. On reconciliation of medications 3/6/19 at 8:55 a.m., the order for the insulin documented "Inject 5 units subcutaneously (sc) before meals for DM (diabetes mellitus) Give 10 minutes before eating." The insulin was observed administered after 8:00 a.m., approximately 45 minutes after the resident's tray was delivered. On 3/6/19 at approximately 9:45 a.m. lead CNA (certified nursing assistant) # 6 was asked when Resident # 90's breakfast tray had been delivered. She stated she delivered the resident's breakfast tray around 7:15 a.m. or	F759		

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F759	Continued From page 37 sooner. She further stated "The trays for this wing usually get here around 7:05 a.m., so while I can't be sure exactly what time I took the tray in the room, I know it was at least 7:15 a.m." On 3/6/19 at 9:50 a.m. RN # 2 was asked about the administration of insulin per the order. She stated "We (nurses) are in report by 7:00 a.m., and the trays are delivered sometimes around 7:05 a.m. Out of 20-some residents, we might have 10-12 that are sliding scale insulin or to have insulin prior to meals...how are we supposed to do that? We have discussed this issue, but not really sure how to solve it..." The administrator, DON (director of nursing) and the nurse consultant were informed of the above findings during an end of the day meeting 3/6/19 beginning at 4:15 p.m. No further information was provided prior to the exit conference.	F759		
F791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) 483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. 483.55(b) Nursing Facilities. The facility- 483.55(b)(1) Must provide or obtain from an outside resource, in accordance with 483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F791		

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F791	Continued From page 38 483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; 483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; 483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and 483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, clinical record review, and facility document review, the facility staff failed to ensure one of 24 residents was provided routine and/or emergency dental services, Resident #95. Resident #95's lower denture was broken and the facility did not promptly assist the resident with dental services. The facility staff did not document any information regarding the damaged dentures and did not document any	F791	**F791 Routine/Emergency Dental Services in NFs CFR(s): 483.55 (b)(1)-(5)** ***Resident Affected:*** Resident # 95 went to dental appointment on 3/13/19 was fitted for dentures and received dentures on return appointment 03/21/19. ***Residents with Potential to be Affected:*** All residents needing dental services are at risk for this deficiency. 100% audit of all residents to identify any dental needs was completed. ***Systemic Changes:*** Nursing staff will be in-serviced on system for reporting dental needs by Medical Records/Social Services. Social Services and Medical Records will perform a monthly dental interview with all residents to determine residents who have a dental need. New residents will be asked by Social Worker during admission interview. Residents who are not able to be interviewed will have a monthly oral assessment to determine if there are any dental problems. Residents identified with dental issues will be presented to the Interdisciplinary Team to follow up to obtain dental appointment and arrange transportation. ***Monitoring:*** The Director of nursing will discuss the audit results during the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimal Data Set Coordinators, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F791	Continued From page 39 information regarding the resident's ability to adequately consume meals during this time. Findings include: Resident #95 was admitted to the facility on 08/31/18. Diagnoses for this resident included, but were not limited to: DM (diabetes mellitus), history of wrist fracture, COPD (chronic obstructive pulmonary disease), anemia, gout, obesity, major depressive disorder, poly neuropathy, colitis, and diverticulitis. The most current full MDS (minimum data set) was an admission assessment dated 09/07/18. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was assessed as independent with setup only for consuming meals and was assessed as requiring extensive assistance with one person for personal hygiene. This MDS documented the resident as having no natural teeth and no other oral/dental concerns. A quarterly assessment dated 02/15/19 documented the resident with a cognitive score of 15 and independent with setup only for meals, extensive assistance of one with hygiene and having no broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable, or loose) and no mouth or facial pain, discomfort or difficulty with chewing in Section L Oral/Dental Status of this MDS. A interview was conducted Resident #95 on 03/05/19 at 4:05 PM. The resident stated that she had a full upper and lower denture, but a "good while" ago, she dropped her lower denture plate and they broke in half. The resident stated that she reported it and that staff	F791		

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F791	Continued From page 40 knew about it. The resident stated that after a few days her son came in and took them and repaired them. The resident stated that the repair held for a long time and then stated, "They broke in half, right in my mouth." The resident stated that was about 2 weeks ago; when that happened and she had an appointment on Monday (March 4th, 2019), but the transport people canceled. The resident went on to say that she thought she had another appointment next week and thought it was on Wednesday (March 13th). Resident #95's nursing notes and clinical records were reviewed from admission 08/31/18 through present 03/06/19. There was no documentation regarding the broken/damaged dentures or any information regarding an appointment for dental services. The resident's physician's orders were reviewed and did not reveal any orders for dental services. The Resident's CCP (comprehensive care plan) documented, "...resident is able to feed self after set up...personal hygiene/oral care: requires assist of one...uses upper and lower dentures...potential for oral/dental health problems related to dentures...coordinate arrangements for dental care, transportation as needed/as ordered...observe/document/report as needed any signs or symptoms or oral/dental problems needing attention...teeth missing...loose....broken...Provide mouth care BID [twice daily] and as needed..." On 03/07/19 at 11:02 AM, an interview was conducted with the resident's son, in the presence of the resident. The son stated that the dentures were broken (dropped by the	F791		

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F791	Continued From page 41 resident) about two and half months ago. The son stated that he took the broken denture to a dental place and they told him that they needed to see the resident. The son then got a kit and repaired the denture himself. The resident stated that she reported it and the staff knew about it. The son stated that he had the denture back in a few days. The resident stated that when the denture broke she reported it, but was told by staff that they were sorry, but they couldn't offer any help. The resident stated that the denture broke again about 2 weeks ago, right in her mouth. The son stated that the resident and family started asking questions about transport and how to get her to an appointment and that his daughter (the resident's granddaughter) got the ball rolling. The resident stated that she mentioned to staff a few weeks ago that they had broke again and the SW (social worker) made an appointment. The resident stated that she was supposed to go on Monday, but they canceled for some reason. The resident stated that they told her that it was not a confirmed appointment. The resident was asked about eating. The resident stated that she can eat without the denture, but the food has to be soft. On 03/07/19 at 9:14 AM, the SW was interviewed regarding Resident #95. The SW was asked about knowledge of the broken dentures. The SW stated, "Yes, I was made aware probably the week before last." The SW could not remember who told her about the damaged denture, but thought it was nursing staff. The SW was asked if she should have documented any of this information. The SW stated, "Normally I document, it didn't come to me initially, it came to me through nursing...I thought they [nursing] would have documented it...I thought they had already done that...I don't	F791		

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F791	Continued From page 42 know if they [nursing] documented it, I think I heard it from a CNA (certified nursing assistant)...with this I took the lead and made the appointment; I try to document yes, it's something that I need to be better with." The SW stated that she did not exactly know when she made the appointment for the dentures, but knew that it was rescheduled. The SW was made aware that the resident's appointment had been canceled and that it was documented on the form that the family could not arrange for transport on the specific day of the appointment so the appointment was canceled. The SW was asked why was family responsible for transport for this appointment and the SW stated that she did not know and that the medical records/transportation person might know. The medical records/transport staff was interviewed on 03/07/19 at 9:26 AM. The medical records/transport staff stated that the appointment was made on 02/27/19 with Affordable dentures for 03/04/19 (Monday). The resident was supposed to be picked up at 8:30 AM, registration at 9:15 and appointment at 9:30, and that the location was just a few miles from the facility. The medical records/transport staff stated that transport called on Friday 03/01/19 (did not provide specific time) and stated that they could not find transportation for this resident. The medical records/transport staff was asked why this resident could not have had other transportation. The medical records/transport staff stated that this resident had (name of insurance compay) and that the company finds transport to and from the appointments. The medical records/transport staff stated that she called the number and after that, "it's out of my hands." The medical records/transport staff was asked if they have a contract with the resident's insurance company	F791		

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F791	Continued From page 43 or guidelines of the expectations/responsibilities. The medical records/transport staff stated, "I assume we have a contract, but I'm not sure...a lot of times I don't get called if they can't find a transporter...I know we have a contract with [name of ambulance company], they will take skilled patients, if one of these companies calls them they will try to take the resident...I did not try to set up an alternate transport, I don't know if the [insurance company] tried [name of contract transport with facility], but once I make that call initially, it's out of my hands." On 03/07/19 at 11:45 AM, a policy on dentures was presented by the corporate nurse, which documented, "...residents are assisted with obtaining routine dental services and emergency dental...appropriate safekeeping measures are taken to protect dentures from being misplaced or damaged and to ensure timely replacement, if appropriate...emergency dental services...broken or otherwise damaged teeth, or any problem of the oral cavity by a dentist that requires immediate attention...assists the resident with making appointments and arranging for transportation to and from the dentist's office...resident with lost or damaged dentures to a dentist as soon as the dentures are lost or damaged, within three days...if referral does not occur within three days...document steps taken to ensure resident could still eat and drink adequately while awaiting dental services...document extenuating circumstances that led to the delay...assist residents who are eligible and wish to participate to apply for reimbursement of dental services as a incurred expense under Medicaid...if unable to pay...center should attempt to find alternative funding sources...Lost or Damaged Dentures: Immediately notify the charge nurse and/or SS [social services]...conduct an investigation...the	F791		

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	495146	A. BUILDING ______ B. WING ______	C 03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT HARRISONBURG TRANSITIONAL CARE & REHAB CT	**94 SOUTH AVENUE HARRISONBURG, VA 22801**

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F791	Continued From page 44 center is to arrange and ensure that any and all of appointments related to the loss/damage of dentures are not charged to the resident...SS will maintain contact with dental services, the resident and/or resident representative...documentation must reflect this communication, verification that the resident is able to eat and drink adequately..." On 03/07/19 the administrator presented a contract for the transportation company for the nursing facility. The contract documented, "...facility will contact [name of ambulance company] for any transports in or out of their facility...[name of ambulance company] is an anthem, medicare, medicaid and multiple other insurance provider in Virginia. We accept assignment on all claims submitted...will work with self pay...will provide a 24 hour phone number for the facility...for any non-emergency or pre-scheduled transports the facility will supply...billing information when scheduling the transport...will provide...ambulance and wheelchair transport to and from facility..." The administrator then presented an email letter from (resident's insurance company) which documented, "...being that your facility does not offer transportation to your clients we do no have a contract with your company..." On 03/07/19 at approximately 4:00 PM the survey team met with the administrator, DON and corporate nurse. The staff were made aware of the multiple concerns listed above with Resident #95's damaged/broken denture, from the lack of documentation and reporting, to the delay in treatment to get an appointment, and then after making an appointment, the failure with the transportation system to get the resident to the appointment.	F791		

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F791	Continued From page 45 No further information and/or documentation was provided prior to the exit conference on 03/07/19 at 5:15 PM.	F791		
F800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, clinical record review, and facility document review, the facility staff failed to provide a nourishing, well-balanced diet, that meets nutritional and special dietary needs; and failed to take into consideration dietary preference for two of 24 residents in the survey sample, Residents #55 and #95. 1. The facility staff failed to provide menu items and serving portions per resident choice for Resident # 55. 2. The facility staff failed to honor the dietary needs and preferences of Resident #95. The resident had a diagnoses of colitis and diverticulitis and was served corn and other food items that were communicated by the resident and documented by staff that the resident did not like or want, but the resident continued to receive the food items. Findings include:	F800	**F800 Provided Diet Meets Needs of Each Resident CFR(s): 483.60** ***Resident Affected:*** The District Food Service Manager (DFSM) interviewed Resident #95 and #55 for food preference on 3/6/19 and updated the resident's food preference in the dietary electronic system. ***Residents with Potential to be Affected:*** All residents have the potential to be affected. The Dietary Manager will complete an audit of 100% of resident population food preferences to ensure they are accurate in the dietary electronic system and updates recorded. ***Systemic Changes:*** District Food Service Manager provided education to all dietary staff on portion sizes and tray card review for resident centered nutrition plans and preferences. Dietary manager will monitor tray line and tray ticket three times a week for twelve weeks for accuracy of meal preparation. ***Monitoring:*** The Executive Director will discuss the audit results with during the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimal Data Set Coordinators, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F800	Continued From page 46 1. Resident # 55 was admitted to the facility 1/11/19 for therapy following a fall at home resulting in a fractured hip. Other diagnoses for the resident included, but was not limited to: high blood pressure, GERD, and gastroparesis (delayed gastric emptying). The most recent MDS (minimum data set) was the admission assessment dated 1/18/19 and had Resident # 55 coded as cognitively intact with a total summary score of 15 out of 15. On 3/5/19 at 12:15 p.m. resident # 55's was observed dining in his rom. Resident # 55 was eating a lunch brought to him by his sister, and was asked what had come on his tray. He pointed to the covered plate on his bed and said "Lift that up." The plate was observed with one small chicken leg, approximately 1/2 cup of peas and carrots mixture, and approximately 1/4 cup or less of black eyed peas. Resident # 55 said "Who would eat that?" The resident's roommate had finished his lunch, and there were 2 chicken bones on his table. He stated he had been served 2 pieces of chicken. At 12:25 p.m. the meal plate was brought to the kitchen and the dietary manager (DM) was interviewed. The lid was lifted and he was informed the resident had not touched the food. The DM looked at the plate and stated "It needs more beans." The DM was asked about the small piece of chicken, and informed that this was for a male...and did he think that would be enough food for him? The DM stated "No." He was then informed the roommate was served 2 pieces of chicken. The DM stated "If they are ordered double portions, they would get 2 pieces. But as small as that piece is (pointing to the plate) that should have gotten 2 pieces as	F800		

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

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F800	Continued From page 47 well." On 3/5/19 at 12:45 p.m. Resident # 55's room was observed. The roommate was asked if he had gotten enough to eat, and he stated "Yes." Resident # 55 was asked if he had eaten the lunch as served to him would that have been enough. He stated "No. That is usually how much I get...it's pretty slim...I would not have eaten much of that because I can't have peas, so would not have eaten those. I also can't have corn. I do get those things on my tray. I talked with the dietitian, but I don't remember being asked about any likes/dislikes, or any food restrictions. I mean, they might have asked, but I don't remember to be honest." Resident # 55's sister was present and stated "That's why I always bring him something when I come...the servings are really pitiful." The resident and the resident's roommate were asked if they had a meal ticket, and they stated "yes." The ticket for the roommate revealed he was not on double portions, and confirmed verbally he was not. The ticket also included ""Dislikes Pancakes." Resident # 55's meal ticket had no additional information other than documenting he was on a "regular" diet. The administrator, DON (director of nursing) and the nurse consultant were informed of the above findings during an end of the day meeting 3/6/19 beginning at 4:15 p.m. On 3/7/19 when the survey team entered the conference room there were folders of information requested during the meeting on 3/6/19. There was a folder with Resident # 55's name on it, and in the folder was a "Food and Beverage Preference list." The form had several categories of foods and had a space to check whether the resident liked or disliked food items.	F800		

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F800	Continued From page 48 Under the "Meat" section was written "No corn. No peas." No other information was documented on the form. The form was dated 3/6/19. On 3/7/19 at 8:45 a.m. Resident # 55 was asked if someone had talked with him about his food preferences. He stated "Yes, some woman came yesterday evening to talk to me...it wasn't the same woman I talked to the first time. She asked me about the peas and corn. I told her about my gastroparesis; I thought the first woman knew about that since she said she had looked at my medical record." He further stated that he was served peas and corn on a fairly regular basis, but did not eat them. On 3/7/19 at 9:45 a.m. the registered dietitian (RD) was shown the form and asked if it was considered "complete." She stated she did not do the form, that the district dietary manager had done it. The RD was then asked if there was an initial form done, and where would it be located. The RD stated "It should be kept in the kitchen so the information from that form can be put in the system to generate on the meal ticket the resident's likes and dislikes. I can try to get the initial assessment..." The RD then stated the current dietary manager should have the form in the kitchen. At this time, the DM was asked for the initial form completed for Resident # 55. The DM stated I've only been in this position a couple of weeks; I am not sure where the initial form would be." At 10:15 a.m. the RD stated "I spoke with the DM; he's looking through the old records now..." On 3/7/19 at 12:00 p.m. the district dietary manager was interviewed about the information on the form. She stated "Yes, I went down and spoke with the resident last night. I did not fill	F800		

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F800	Continued From page 49	F800		

the form out in it's entirety as he informed me of his inability to eat peas and corn specifically. We were able to find the initial form done by the former dietary manager; it did include the resident's dislike of peas and corn, as well as his preference for regular portion sizes. Unfortunately that information did not get put in the system so he has continued to get food items he did not like." The district dietary manager added "I'm happy to see he has not had any weight loss."

The administrator, DON (director of nursing) and nurse consultant were informed of the above findings during a meeting 3/7/19 at 12:45 p.m.

No further information was provided prior to the exit conference.

2. Resident #95 was admitted to the facility on 08/31/18. Diagnoses for this resident included, but were not limited to: DM (diabetes mellitus), history of wrist fracture, COPD (chronic obstructive pulmonary disease), anemia, gout, obesity, major depressive disorder, poly neuropathy, colitis, and diverticulitis.

The most current full MDS (minimum data set) was an admission assessment dated 09/07/18. This MDS assessed the resident with a cognitive score of 15, indicating the resident is cognitively intact for daily decision making skills. The resident was assessed as independent with setup only for consuming meals.

A quarterly assessment dated 02/15/19 documented the resident with a cognitive score of 15 and independent with setup only for meals.

On 03/05/19 at approximately 12:15 PM, the resident was observed in her room in bed. The

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F800	Continued From page 50 resident's lunch tray was on the bedside table next to her. The resident was asked about lunch. The resident stated that she didn't eat much because they usually bring stuff that she doesn't like. The resident pointed to her tray and stated, "Like that, I don't like dark meat chicken and that's all they ever bring." There was an untouched chicken thigh on the resident's tray. On 03/05/19 at 3:55 PM, an interview was conducted with Resident #95. The resident repeated the information from above, stating that she does not like dark meat chicken, but that is all that is served. The resident then stated, "I can't eat corn, I have diverticulitis and I get corn every other day it seems." The resident then stated that the staff added a sandwich to her tray due to her not eating much or not liking what was being served, but they kept bringing chicken salad sandwiches and stated, "I can't stand chicken salad!" The resident was asked if she had spoken to anyone about her likes and dislikes. The resident stated that she had told them, but they don't listen, "they're just going to do what they want to do." The resident then stated that she had spoken with the dietary manager (did not know his name, only that he was male) and that it was an "extensive" conversation. The resident stated, "It didn't do any good, as you seen I got dark meat chicken for lunch, I'm not going to eat it." The resident stated that out of the lunch meal she ate black-eyed peas and the green peas, but did not eat the carrots or dark meat chicken. The resident also stated that the portions are not very big. The resident's clinical records were reviewed and documented that the resident had an order for a Carbohydrate Consistent Diet with regular texture and thin liquids.	F800		

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F800	Continued From page 51 The resident's CCP (comprehensive care plan) was reviewed and documented, "...Offer substitutes for food not eaten...dietary consult for nutritional and ongoing monitoring...resident has GERD...avoid foods...acidic...spicy...fried or fatty foods...monitor intake...serve diet as ordered...RD [registered dietitian] to evaluate and make diet change recommendations..." Three Nutritional data collection screens were completed on this resident by the RD. The first dated 09/12/18 documented, that food preferences were obtained, informed of alternatives and informed of location of posted menu, in addition to allergies (that listed) milk, corn upsets diverticulitis. The second dated 12/05/18 documented the same information as above. The third dated 03/06/19 at 1:17 PM documented the same information as the above. On 03/06/19 at 5:50 PM, a meeting was conducted with the administrator, DON (director of nursing), corporate nurse and corporate staff with the survey team. The facility staff were informed of the above interview with Resident #95. The corporate staff member stated that there is not formal documentation of the food preferences for residents, but it is done upon admission and quarterly. The corporate staff member stated that due to the change of ownership, they don't have an actual form and can't use the old forms due to the change, and felt there may be a binder or notebook with that information in it for residents regarding food choices, preferences, likes and dislikes. The facility staff were asked for assistance in locating	F800		

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F800	Continued From page 52 any and all information regarding this. At 7:30 AM, information was provided by the facility staff regarding food for Resident #95. The form titled, "Food and Beverage Preference List" was presented and reviewed. The form was dated 03/06/19. The form documented, "...no dark meat chicken, no corn, no sausage, no Salisbury steak..." On 03/07/19 at 8:30 AM, Resident #95 was observed in her room, in her bed with her breakfast tray on her bedside table in front of her. The resident was eating pancakes. The resident's tray also had a piece of sausage that had not been touched. The resident was left to finish her breakfast. On 03/07/19 at 7:43 AM, Resident #95 was again interviewed regarding food preferences and stated that a woman came to talk to her yesterday. Resident #95 stated that this morning's breakfast was pretty good. The resident stated that they did bring sausage and she had requested not to have sausage. It was documented on the food preference sheet dated 03/06/19 that the resident did not want sausage. The facility staff were again informed of the above information and concerns that the resident has been requesting not to be served certain items, but they are still being served even after verbal confirmation and documentation. No further information and/or documentation was presented prior to the exit conference on 03/07/19 at 5:15 PM.	F800		
F801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F801		

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F801	Continued From page 53 483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70(e) This includes: 483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements	F801	**F801 Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)** ***Resident Affected:*** Dietary Manager completed Serv Safe credentialing on 03/13/2019 and was enrolled in the Health Care Services Group credentialing course for becoming a certified dietary manager on 3/27/19 ***Residents with Potential to be Affected:*** Human Resources Manager will complete a 100% audit of dietary department staff to ensure that all required employees have required credentials. ***Systemic Changes:*** Dietary Manager was educated on the regulation requirement for qualified personnel in the dietary department. Human Resource Manager will ensure on all new hires to verify and record the credentials for all dietary staff. ***Monitoring:*** The Human Resource Manager will discuss the results during the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimal Data Set Coordinators, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F801	Continued From page 54 no later than 5 years after November 28, 2016 or as required by state law. 483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure qualified dietary staff in the main kitchen. The Dietary Manager (DM) failed to provide evidence of certification or a degree from an accredited institute of higher learning to qualify him as the director of food and nutrition services.	F801		

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F801	Continued From page 55 Findings include: During an interview with the district dietary manager 3/7/19 at 12:00 p.m. she stated "The dietary manager (DM) is a certified Chef; I don't have the information because it's at my house which is 2 hours away...what he has is at his house. I'll have to do a little research to see if a certified chef meets the requirements for the regulation you are referencing. He is going to begin the CDM (certified dietary manager) classes soon..." The DM was interviewed 3/7/19 at 12:40 p.m. about his education status and if he had his certified chef certificate or any degree he may hold either at his home, or if the corporate entity for whom he worked had a copy of the information. The DM stated "I graduated from the Culinary Institute of America in Hyde Park, NY in 1991. I also have an associates degree in culinary science. I am enrolled for the online class through the University of Florida for the CDM class. I don't have my certificates or degrees with me here in Virginia; I left Florida and came up here with literally the clothes on my back." On 3/7/19 at approximately 12:45 p.m. during a meeting with facility staff, the administrator was asked if the DM had an employee file in the building. He stated "No; the contract agency should have that information. I can call them and see if they can fax the information here." On 3/7/19 during a meeting with facility staff beginning at 4:15 p.m. the administrator presented a packet of information from the corporate agency though which the DM was employed. After review of the information, which	F801		

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F801	Continued From page 56 did not include any certification or copy of a degree, the administrator stated "They sent a copy of what the degree he has from the culinary school he went had in the curriculum." This surveyor then asked the administrator how it was known if the curriculum described currently was what the curriculum included in 1991 when the DM says he graduated? The administrator stated "I don't know; that's all the information I could get." No further information was provided prior to the exit conference.	F801		
F812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) 483.60(i) Food safety requirements. The facility must - 483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F812	**F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)** ***Resident Affected:*** The Dietary Manager immediately corrected storage of scoops, flour, sugar, and cleanliness of can opener blade. ***Residents with Potential to be Affected:*** All residents have the potential to be affected. A 100% kitchen audit was completed by the Dietary Manager to ensure that all items within the dietary department were within storage and sanitary compliance. ***Systemic Changes:*** The Dietary Manager was educated on regulatory requirements for storage and sanitation requirements of scoops, flour, sugar, and kitchen equipment. Executive Director will complete a kitchen walk through audit on a weekly basis for three months. ***Monitoring:*** The Executive Director will discuss the audit results during the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimal Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F812	Continued From page 57 Based on observation, staff interview and facility document review, the facility staff failed to procure, store, prepare, and serve food in a sanitary manner in the main kitchen. Items in the freezer were observed covered in ice due to a malfunctioning condenser, the freezer door did not seal with resulting ice crystals/frost on the items near the freezer door, scoops were stored with handles touching both the flour and sugar in the storage bins, and the can opener blade was covered with dry food debris. Findings were: Initial tour of the kitchen was conducted on 03/05/2019 with the DM (dietary manager). During the tour the DM stated, "We are having a lot of maintenance issues with our freezer." The DM opened the door of the freezer, the floor of the freezer below the was covered in ice. There were frozen water droplets on the ceiling of the freezer. The fans of the condenser on the back wall of the freezer had small icicles hanging down. Stored on a rack below the condenser was a box of pizza dough, a large round container of ice cream, a box of frozen vegetables, and a large piece of beef. The aforementioned items all had frozen water across and around their sides. The DM was asked what had happened. He stated, "The condenser is leaking...whenever it goes into the defrost mode, the water leaks down and then freezes on everything below it. He pointed to a black square container sitting on the top shelf under the condenser. He stated, "I try to catch the water in this and then it freezes...I have to get it out and run water over it to get it out and then put this back in here to catch it the next time. The DM was asked why food was stored under the leaking area. He stated, "It really	F812		

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F812	Continued From page 58 shouldn't be." He was asked about the amount of ice on the floor that was approximately 2 inches thick. He stated, "I've tried to break it up...I don't think it's going to come up unless we defrost the whole thing." Also observed in the freezer was a rack near the door. The rack was covered in frost. The food items on the rack had a layer of frost on the tops. A bag was observed with food items covered in white ice crystals. The DM was asked what was in the bag. He stated, "I think those are polish sausages." He was asked about the food inside the bag. He stated, "That needs to be tossed." The DM was asked why the food near the door and racks were covered in frost. He stated, "The door doesn't seal...it's a new seal but it's not working." After exiting the freezer, the DM stated, "See. He pushed on the freezer door shut and stated. "The seal isn't tight, so air gets around it and that cause the frost right inside." The DM was asked how dry goods such as flour and sugar were stored. He pointed to two white buckets near the serving line. He opened the first bucket and revealed a large bag of sugar. Observed lying inside the bag of sugar was a scoop with the handle touching the contents. The DM removed the scoop and stated, "I tell them and tell them...they still leave them in here." He then opened the second bucket and revealed a scoop lying on top of the flour with the handle touching the contents. He removed the scoop and stated, "See what I mean?" The DM was asked where the can opener was. He pointed to a prep table in the kitchen. He stated, "We run it through the dishwasher every day. The can opener blade was covered with thick, dried brown food debris. The DM asked if the items on the can opener were from that day. He stated, "No, it doesn't look like they have	F812		

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F812	Continued From page 59 washed it in a while." On 03/06/2019 at approximately 9:00 a.m., the DM came to the conference room and stated, "I moved all the food from under the condenser in the freezer and threw all that other stuff that had ice on it away." At approximately 2:00 p.m., this surveyor returned to the kitchen. The freezer was observed. There was food stored under the condenser. The DM stated, "They just put that there...I need to move it." The regional dietary manager was in the kitchen and stated, "We have put information in [name of system used for work orders] everyday and it's still not fixed. The above information was discussed with the administrator and the DON (director of nursing) during an end of the day meeting on 03/06/2019. No further information was obtained prior to the exit conference on 03/07/2019.	F812		
F880 SS=E	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:	F880		

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F880	Continued From page 60 483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards; 483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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	F880	**F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)** *Resident Affected:* Education initiated immediately with nursing and therapy staff on proper handwashing and use of personal protective equipment. The resident was discontinued from droplet precautions until 3/8/19. Maintenance Director immediately identified water flow areas of opportunity where legionella and other organisms could grow. Water samples were collected and submitted for result processing. Results will be logged in facility water plan. *Residents with Potential to be Affected:* All residents have the potential to be affected. Nurse Management completed a 100% audit of residents on isolation precautions and verified that appropriate precautions were implemented. All residents have the potential to be affected. A 100% facility operations assessment was completed by the Executive Director and Maintenance Director to identify highest areas of risk for organism growth opportunity. *Systemic Changes:* Nurse Management has educated nursing staff on handwashing hygiene. Nurse management will educate nursing and rehabilitation staff on transmission-based precautions and personal protective equipment policies. Observations of 5 staff members by Nurse Managers for compliance in handwashing 5 times a week for 2 weeks, 3 times a week for 1 month, twice weekly x 1 month then monthly x 3 months. Weekly audits of isolation precautions to verify appropriate precautions are in place and utilized x 1 month, then monthly x 3 months by nurse manager.	

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F880	Continued From page 61 corrective actions taken by the facility. 483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. 483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to develop and implement a water management program to identify where Legionella and other opportunistic waterborne bacteria/viruses could grow and spread in the facility water system; failed to follow proper handwashing technique on one of 2 units during medication pass: A wing; and also failed to follow infection control practices for droplet precautions for one of 24 residents in the survey sample: Resident # 48. 1. The facility staff failed to develop and implement a water management program to identify areas where Legionella and other opportunist organisms could potentially grow. 2. RN (registered nurse) # 2 failed to perform proper handwashing technique during a medication pass and pour observation. 3. LPN (licensed practical nurse) # 1 failed to perform proper handwashing technique during a medication pass and pour observation. 4. The facility staff failed to ensure infection	F880	**F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) (continued)** *Systemic Changes (continued):* The Executive Director will educate the Maintenance Director on the requirements for infection control and Legionella. The Maintenance Director completed facility water flow risk assessment for growth opportunities and will submit water samples for testing on a quarterly basis. The Executive Director will audit the water plan, testing log, results, and corrective action plan on a quarterly basis. *Monitoring:* The Executive Director and Director of Nursing Services will discuss the audit results to the monthly Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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F880	Continued From page 62 control practices were followed for Resident # 48. Findings include: 1. The survey team entered the facility 3/5/19 at 11:00 a.m. The administrator was asked for the Legionella protocol during the entrance conference. Throughout the survey process the maintenance director and the administrator presented several documents for review, but the documents did not include an assessment of the facility water flow to identify areas where Legionella could grow; the information also did not include control measures such as physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. On 3/7/19 at 4:00 p.m. the administrator stated "I'm not going to waste your time; we don't have an adequate Legionella program. It's weak, but we will work to get it where it needs to be." No further information was presented prior to the exit conference. 2. A medication pass and pour observation was conducted 3/6/19 beginning at 7:55 a.m. with RN # 2. RN # 2 was observed washing her hands, turned off faucet with her bare hands, and then dried her hands with paper towel. When asked about the observation, she stated "Oh my...no, I didn't use paper towel to turn off faucet and I know better." The administrator was asked for a policy on handwashing 3/6/19 at approximately 10:30 a.m. The policy "Hand Hygiene/Handwashing" was reviewed. Under "Procedure" directed "Soap and Water: 1. Wet hands, wrists and exposed	F880		

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F880	Continued From page 63 portions of arms...2. Rub hands together with vigorous friction for 20 seconds...3. Rinse...4. Prevent recontamination by holding hands down...5. Dry hands with individual disposable paper towel. 6. Turn off faucets with paper towel." The administrator, DON (director of nursing) and the nurse consultant were informed of the above findings during an end of the day meeting 3/6/19 beginning at 4:15 p.m. No further information was provided prior to the exit conference. 3. On 03/06/19 at 8:10 AM, the medication pass and pour observation was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 prepared medications for Resident #44. While pulling the medications, the LPN stated that this resident took her medications whole in applesauce and then LPN #1 pulled one single packet of OcuSoft (eye lid scrub cloth) from the box, opened it and proceeded into the resident's room with the medications. LPN #1 attempted to administer the applesauce mixture with medications to the resident several times without success. LPN #1 then applied gloves and took the single OcuSoft cloth and began wiping the resident's eyes, the right eye, then the left and then the right again. LPN #1 then removed her gloves went to the sink and turned on the water. LPN #1 applied soap to her hands and washed her hands for approximately two seconds under the running water. LPN #1 then took her bare left hand, turned the water off, dried her hands and exited the room. LPN #1 then proceeded to the next resident.	F880		

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F880	Continued From page 64 LPN #1 stated that she was "done" with this resident and was moving on to the next resident. At approximately 11:45 AM the administrator was asked for a policy on handwashing. The policy was presented and documented, "...Hand Hygiene/Handwashing...single most important procedure for preventing the spread of infection...after touching...secretions, excretions and contaminated items, whether or not gloves are worn...between task and procedures...after removal of...gloves...after contact with a resident's skin...wet hands, wrist, exposed portions of the arms under clean running water...apply soap...rubs hands together vigorously for 20 seconds (the amount of time to sing Happy Birthday through twice)...rinse hands...prevent recontamination by holding hands below elbow...turn faucets off with paper towel..." On 03/06/19 at 02:10 PM, LPN #1 was interviewed regarding the above information. LPN #1 stated "OK, just pay more attention to handwashing." The administrator, DON (director of nursing) and the corporate nurse were made aware in a meeting with the survey team on 03/06/19 4:45 PM. No further information and/or documentation was presented prior to the exit conference on 03/07/19 at 5:15 PM. 4. Resident #48 was originally admitted to the facility on 07/11/18 and readmitted on 08/28/18 with diagnoses including, but not limited to: Diabetes, End Stage Renal Disease requiring Hemodialysis, Asthma, Obesity, Hypertension	F880		

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F880	Continued From page 65 The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/15/19. Resident #48 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 03/05/19 at approximately 11:50 a.m. Resident #48's room was observed with an isolation caddy hanging on the door and a stop sign beside the door frame. LPN #7 (licensed practical nurse) was asked who was on isolation in that room. LPN #7 stated, "I am new here. I'm not sure." Meanwhile LPN #8 approached this surveyor and LPN #7 and stated she was orienting this nurse to the unit. Together LPN #7 and LPN #8 reviewed Resident #48's clinical record along with this surveyor. LPN #8 stated, "She (Resident #48) tested positive for Flu A on 2/28. She was started on Tamiflu prophylactically." When asked if Resident #48 was out to dialysis and if she actively had the flu, LPN #8 stated, "She wouldn't be out to dialysis if she had active flu." Subsequent review of Resident #48's clinical record included a "Progress Note" signed by the PA (physician assistant) and dated 2/28/19. This note included: "...History of Present Illness: ...is being seen today for worsening cough and congestion in chest that has been worsening in he past day...She notes feeling tired and poorly due to ongoing cough...Physical Exam: ...Respiratory: Normal respiratory effort w/o (without) accessory muscle use at rest with normal symmetric vesicular sounds throughout upper and lower lobes with deep inspiration. Occassional (sic) constricted cough...Plan: Guaifenesin 600 mg BID (twice daily) x7 (times seven) days, Cough drop QID (four times daily) x7 days, Albuterol neb TID (three times daily) x5	F880		

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	495146	A. BUILDING ______ B. WING ______	C 03/07/2019

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F880	Continued From page 66 days, Influenza A&B culture, Maintain fluid hydration..." A physician order dated 2/28/19 at 14:50 (2:50 p.m.) included all the interventions mentioned above under "Plan." A second physician order dated 2/28/19 included: "Tamiflu 30 mg (milligrams) in AM (morning). Then Tamiflu 30 mg q (every) dialysis for 5 dialysis days, Tues, Thurs, Sat." A "Lab Results Report" dated 02/28/2019 included the following results: "Influenza A/B Result: Positive A, Negative B." "Progress Notes" included the following documentation: 02/28/2019 - 11:26 p.m. "Resident received new order for Tamiflu for testing positive for Influenza A, 30mg PO (orally) in a.m., then Tamiflu 30mg PO with dialysis on Tues., Thurs., & Sat. for 5 days." 03/04/2019 - 1:00 p.m. "Patient Infection Report completed. See report for details." 03/05/2019 - 9:10 a.m. "Tamiflu Capsule 30 MG Give 30 mg by mouth one time a day every Tue, Thu, Sat for Influenza for 5 Daysout (sic) to dialysis" (sic) 03/05/2019 - 10:45 p.m. "Patient on Tamiflu for pos. test. Patient had no s/s (signs/symptoms) throughout shift. Patient out of bed in wheelchair through out (sic) shift. No c/o (complaints of) voiced during shift. Will continue to monitor." 03/06/2019 - 11:08 p.m. "Patient on Tamiflu. Patient had no s/s during shift. Patient out of	F880		

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F880	Continued From page 67 bed for part of shift. Patient had no c/o voiced during shift." A "Patient Infection Report" dated 03/04/2019 at 1:00 p.m. included: "...Date symptoms observed 02/28/2019...Date physician notified 02/28/2019...D. Respiratory Infections Dd. Are there any signs of a Respiratory Infection? 1. Yes...2. Influenza...2d. Myalgia (muscle ache)...2g. Dry cough...L. Conclusion and Follow-Up 1. Infection Site cultured? 1. Yes 2. Date cultured 02/28/2019 3. Results of culture and organism present. Influenza A...8. Antibiotics administered 1. Yes 9. Type of Antibiotic, dose, frequency, stop and start date Tamiflu 30mg po Q Tues., Thurs., Sat for 5 days thru 3/5/19 10. Precautions to prevent cross contamination: 1. Standard..." Included in the March 2019 POS (physician order sheet) was, "...Droplet precautions r/t influenza every shift for prophylactic influenza until 03/08/2019 23:59 (11:59 p.m.) Order Status: Active Order Date: 03/06/2019 Start Date: 03/06/2019. Droplet precautions r/t prophylactic influenza every shift for prophylactic influenza until 03/07/2019 23:59 Order Status: Discontinued Order Date: 03/05/2019 Start Date: 03/05/2019..." On 03/06/19 at 8:40 a.m. Resident #48's room door was observed with an isolation caddy in place and a stop sign. LPN #2, Unit Manger was interviewed on whether Resident #48 was on isolation for flu. LPN #2 stated, "Can I have ten minutes to look at her record and I will get back with you?" At 11:10 a.m., Resident #48's room door no longer had an isolation caddy in place, but the stop sign was still by the doorway. Resident #48 was observed in therapy sitting in her wheelchair without a mask in place. At 11:	F880		

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F880	Continued From page 68 35 a.m., LPN #2 approached this surveyor and stated, "(Name) Resident #48 tested positive for flu, Type A on 2/28/19. Our protocol for people needing to go out while receiving treatment is to mask them." LPN #2 confirmed Resident #48 was on droplet precautions for Influenza. A copy of the facility's isolation policy for droplet precautions was requested. Resident #48's doorway to her room was observed on 03/07/2019 at 9:05 a.m. No isolation caddy was on the door and the stop sign had been removed from the wall. The policy for "Transmission Based Precautions" was received on 03/07/2019 at 9:15 a.m. The policy included: "...Droplet Precautions: 1. Don a surgical mask, if substantial spraying of respiratory fluids is anticipated. Wear goggles or face shield in addition to gloves and gown. 2. Perform hand hygiene before and after touching the resident and after contact with respiratory secretions and contaminated objects/materials...3. Instruct resident to wear a face mask when exiting their room, avoid coming into close contact with other residents, and practice respiratory hygiene and cough etiquette. *Note: If the resident has a respiratory infection and is in a common area, the resident should wear a mask. A resident in Droplet precautions should only be in an open area for essential purposes. 4. Post the Droplet Precaution notice immediately visible outside the room. 5. Staff and visitors don a surgical mask when exposure is anticipated or within 3 feet of the resident's immediate environment. 6. The resident wears a surgical or procedural mask during transport. *Note: No mask is required for persons transporting residents on Droplet Precautions. 7. Upon identification of a positive culture or report of a diagnosis that requires	F880		

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F880	Continued From page 69 Droplet Precautions, the nurse implements precautions, notifies appropriate administration, staff, and physician and document the institution of Droplet Precautions in the medical record..." The DON (director of nursing) was interviewed on 03/07/2019 at 11:10 a.m. regarding Resident #48's isolation. The DON stated, "We normally do not write an order for droplet isolation for the flu. That is why you can't find an original isolation order. That is also why I am not sure why (Name) LPN wrote an order. We do not put an isolation caddy on the door for isolation involving the flu. I think the evening supervisor must have put that on her door by accident. There are supplies in the supply room." No further information was received by the survey team prior to the exit conference on 03/07/19.	F880		
F908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) 483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure the walk-in freezer in the main kitchen was in safe operating condition. The freezer was observed with frozen water on the floor, on food stored under the condenser, and the freezer door did not seal properly. Findings were:	F908		

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F908	Continued From page 70 Initial tour of the kitchen was conducted on 03/05/2019 with the DM (dietary manager). During the tour the DM stated, "We are having a lot of maintenance issues with our freezer." The DM opened the door of the freezer, the floor of the freezer below the was covered in ice. There were frozen water droplets on the ceiling of the freezer. The fans of the condenser on the back wall of the freezer had small icicles hanging down. Stored on a rack below the condenser was a box of pizza dough, a large round container of ice cream, a box of frozen vegetables, and a large piece of beef. The aforementioned items all had frozen water across and around their sides. The DM was asked what had happened. He stated, "The condenser is leaking...whenever it goes into the defrost mode, the water leaks down and then freezes on everything below it. He pointed to a black square container sitting on the top shelf under the condenser. He stated, "I try to catch the water in this and then it freezes...I have to get it out and run water over it to get it out and then put this back in here to catch it the next time. The DM was asked why food was stored under the leaking area. He stated, "It really shouldn't be." He was asked about the amount of ice on the floor that was approximately 2 inches thick. He stated, "I've tried to break it up...I don't think it's going to come up unless we defrost the whole thing." Also observed in the freezer was a rack near the door. The rack was covered in frost. The food items on the rack had a layer of frost on the tops. A bag was observed with food items covered in white ice crystals. The DM was asked why the food near the door and racks were covered in frost. He stated, "The door doesn't seal...it's a new seal but it's not working." After exiting the freezer, the DM stated, "See. He pushed on the freezer door shut and stated. "The seal isn't tight, so air gets	F908	**F908 Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)** ***Resident Affected:*** Maintenance Director immediately scheduled vendor repair of freezer door and condenser. The repairs are scheduled for 04/01/19. A freezer box will be utilized to store the foods during the repair. ***Residents with Potential to be Affected:*** All residents have the potential for being affected. Executive Director will educate the Maintenance Director on the requirements for maintenance related food storage compliance. ***Systemic Changes:*** The Executive Director will complete audit weekly for 3 months post repair to ensure that the maintenance repairs are compliant with storage requirements. ***Monitoring:*** The Executive Director will discuss the audit results to the Performance Improvement for three months consisting of the Executive Director, Director of Nursing, Assistance Director of Nursing, Registered Dietitian, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.	4/3/19

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PRINTED: 03/18/2019
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F908	Continued From page 71 around it and that cause the frost right inside." The maintenance director was in the kitchen and was asked about the freezer. He stated, "I got all the information and gave it to [name of administrator] to replace the thing about two weeks ago...I haven't heard anything since." On 03/06/2019 at approximately 10:00 a.m., the administrator was in the conference room. He was asked if he was aware of the issues with the freezer in the kitchen. He stated, "Yes...that thing is older than I am...it needs to be replaced...I have gotten bids on it and turned it in to corporate...I'm spending money all the time to try to fix it and it's not working...to be honest I would appreciate a survey tag to help with the problem." On 03/07/2019 work orders for the freezer were requested. The administrator presented work orders from August 28, 2018 to February 18, 2019. He pointed to an estimate dated 01/16/2019 and stated, "It's going to cost about $8,000.00 to fix it." The estimate to "Replace evap coil and condenser unit for freezer" was reviewed. The administrator was asked what the plan was for the freezer door that didn't seal to prevent air from entering the freezer. He stated, "I'm just asking you to work with me on this...I'm trying to get it fixed." No further information was obtained prior to the exit conference on 03/07/2019.	F908		

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