| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 04/09/19 through 04/10/19. The facility was in substantial compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 04/09/19 through 04/10/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during this survey.<br><br>The census in this 60 certified bed facility was 53 at the time of the survey. The survey sample consisted of 14 current resident reviews and three closed record reviews. | F 000 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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 | F 656 | | 4/19/19 |

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

Electronically Signed | 04/17/2019

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 1<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for two of 17 residents, Resident #9 and Resident #28.<br><br>1. Resident #9 did not have a care plan for the use of a compression glove to her left hand.<br><br>2. Resident #28 did not have a care plan for the use of TED (Thrombo-Embolic Deterrant) hose.<br><br>Findings were: | F 656 | 1.) The careplan for Resident # 9 was updated to indicate the use of a compression glove. The careplans for Resident #28 was updated to indicate the use of TED hose. These careplans were updated at the time of the survey. No negative outcomes to either resident observed with this care plan updating omission.<br>2.) A 100% audit was completed on all residents with compression devices and/or TED hose was completed to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 2<br><br>1. Resident #9 was admitted to the facility on 11/03/2017 with the following diagnoses but not limited to: dysphagia, type II Diabetes Mellitus, supraventricular tachycardia, obesity, cerebral infarct (stroke), and major depressive disorder.<br><br>A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/24/2019, assessed Resident #9 as cognitively intact with a summary score of "11".<br><br>On 04/09/2019, at approximately 10:15 a.m., Resident #9 was observed lying in bed. During an interview Resident #9 stated that she had a stroke in the past and, "It left me with pain on my left side, I can't use that arm."<br><br>On 04/10/2019 at approximately 2:10 p.m., Resident #9 was observed sitting up in a chair at her bedside. Her left arm and hand were elevated on the chair arm. Her left hand was in a tan compression glove. Resident #9 was asked what the glove was for and how long she had been using it. She stated, "It helps with the pain and the swelling in that hand...It was in the laundry yesterday when you were here so I didn't have it on then...I've had it for a long time."<br><br>CNA (certified nursing assistant) #2 was in the hallway. She was asked if she was caring for Resident #9. She stated, "Yes." She was asked about the compression glove on Resident #9's left hand. She stated, "I've been here since January and she's had it on since then." She was asked if she helped the resident don the glove. She stated, "No, I think they do it on the night shift before we get here in the mornings." | F 656 | ensure they have a comprehensive plan of care. No negative outcomes to any residents observed.<br>3.) An inservice was conducted by the RDCS (Regional Director of Clinical Services) for the MDS Coordinator on developing comprehensive care plans that includes compression devices and/or TED hose. An inservice was conducted by the RDCS for the Interdisciplinary Care Team on developing comprehensive care plans that includes compression devices and/or TED hose. Physician orders will be written for all compression devices and/or TED hose. New and discontinued orders will be discussed at morning clinical meeting and careplans will be updated at the time of the meeting for all residents with new or discontinued orders for compression devices and/or TED hose.<br>4.) DON or designee will run an order listing report once a month for three months for all residents with compression devices and/or TED hose and audit the care plan to ensure that the resident has a comprehensive plan of care that includes the use of these devices. Results of this audit will be discussed at monthly QAPI meetings for three months.<br>5.) Date of Completion: 4/19/19 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 3<br>On 04/10/2019 at approximately 2:30 p.m.,, the clinical record was reviewed for orders or a care plan regarding the use of the compression glove by Resident #9. There were no orders or care plan interventions in place. A copy of the physician order sheet, the care plan and the CNA Kardex were requested from the DON (director of nursing)<br><br>At approximately 2:50 p.m., the DON presented the requested information and was interviewed regarding orders for the use of compression gloves and care plans. She stated, "We don't need an order for the use of compression gloves, and we don't put them on the care plan. They are on the task list for the CNAs to do." The DON reviewed the CNA task list for Resident #9. She stated, "I don't know where the glove came from, it isn't on the list. I didn't know she had one. It might be something [Name of Resident #9's daughter] brought in...I'll need to check on that."<br><br>At approximately 3:00 p.m., the DON presented a device list used by the nursing staff. She stated, "This is what the nurse's use to make sure the devices are in place...her glove isn't listed."<br><br>At approximately 3:40 p.m., LPN (licensed practical nurse) #1 was interviewed about the device list. She went to the medication room and stated, "It's hanging here." She was asked about Resident #9's glove. She stated, "She's had that for a while, it should be on the list...as a matter of fact we had therapy look at it...we thought that she was wearing a right handed glove on her left hand because it was turned inside out, but therapy said no, that it needed to be that way so the seam didn't press into her hand when it is swollen." | F 656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 4 | F 656 | | |

The above information was discussed with the DON, the administrator and the nurse consultant during an end of the day meeting on 04/10/2019 at approximately 5:30 p.m. Concerns were voiced that Resident #9 was receiving services that were not included on her care plan. The nurse consultant stated, "We added it to her Kardex."

No further information was obtained prior to the exit conference on 04/10/2019.

2. Resident #28 was admitted to the facility on 08/31/2018 with the following diagnoses, but not limited to: Parkinson's disease, dysphagia, hypertension, and Type II Diabetes Mellitus.

An MDS (minimum data set) with an ARD (assessment reference date) of 03/02/2019, scored Resident #28 as cognitively intact with a summary score of "14".

On 04/09/2019 at approximately 10:00 a.m., during initial tour of the facility Resident # 28 was observed sitting in his wheelchair in his room. He was wearing bilateral TED hose. Resident #28 was asked if he wore the TED hose everyday. He stated, "Yes, they come up to my knees, they help with the swelling."

The clinical record was reviewed on 04/10/2019 at approximately 11:45 a.m. There were no orders observed for the TED hose, nor were there any interventions on the care plan for the TED hose.

On 04/10/2019 at approximately 2:15 p.m., CNA (certified nursing assistant) #1 was interviewed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 5<br>regarding Resident #28's TED hose. She stated, "I know that he wears them, but they put them on in the mornings before I get here." She was asked if the TED hose were on his Kardex. She stated, "I think so."<br><br>A copy of the physician order sheet, the care plan and the CNA Kardex were requested from the DON (director of nursing)<br><br>At approximately 2:50 p.m., the DON presented the requested information and was interviewed regarding orders and care plans for the use of TED hose. She stated, "We don't need an order for the use of TED hose, and we don't put them on the care plan. They are on the task list for the CNAs to do." The DON reviewed the CNA task list for Resident #28. She stated, "I don't see the TED hose on here." The DON was asked how staff knew what to do for the residents if the TED hose were not on the care plan, the Kardex, or the task list that the CNAs referred to. She stated, "There's a device list that the nurse's use."<br><br>At approximately 3:00 p.m., the DON presented a device list used by the nursing staff. She stated, "This is what the nurse's use to make sure the devices are in place...his TED hose are on here...the nurse's look at the residents and use this list to make sure everything is on place. "<br><br>The above information was discussed with the DON, the administrator and the nurse consultant during an end of the day meeting on 04/10/2019 at approximately 5:30 p.m. Concerns were voiced that Resident #28's was receiving services that were not included on his care plan. The nurse consultant stated, "We added the TEDs to his Kardex." | F 656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 6<br><br>No further information was obtained prior to the exit conference on 04/10/2019. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based observation, resident interview, staff interview, and clinical record review the facility staff failed to ensure the CCP (comprehensive | F 657 | 1.) The careplan for Resident # 40 was reviewed and revised to indicate the change from TED hose to Ace Wraps for | 4/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 7<br>care plan) was reviewed and revised for one of 17 residents in the survey sample, Resident #40.<br><br>The facility staff failed to review and revise the CCP for Resident #40 for the treatment of edema to BLE (bilateral lower extremities).<br><br>Findings include:<br><br>Resident #40 was admitted to the facility on 03/01/19. Diagnoses for Resident #40 included, but were not limited to: atrial fibrillation, congestive heart failure, diabetes mellitus, history of acute and chronic and respiratory failure, CKD (chronic kidney disease) and high blood pressure.<br><br>The most current MDS (minimum data set) was a five day admission assessment dated 03/08/19. This assessment documented the resident as a 15, indicating the resident was cognitively intact for daily decision making skills. The resident triggered in the CAAS (care area assessment summary) section of this MDS for ADL's (activities of daily living), urinary, falls, nutrition, and pressure ulcers.<br><br>On 04/09/19 at approximately 11:30 AM, Resident #40 was interviewed in his room. The resident was lying in bed with oxygen via a nasal cannula. The resident was asked about the condition of his skin, the resident stated that he had a place on his right foot and that he had a lot of swelling when he was admitted on 03/01/19. The resident had visible edema on exposed body parts (arms and hands); the resident's legs were covered. The resident stated that the swelling was getting better and that nursing were applying "stockings" (compression stockings) to his bilateral lower extremities for the large amount of swelling in his | F 657 | compression to his BLE. This care plan up was updated at the time of the survey. No negative outcome to resident with this care plan revision error.<br>2.) A 100% audit was completed on all new orders since April 1, 2019 to ensure that the careplan was updated to reflect order changes and to ensure the resident has a comprehensive plan of care. No negative outcomes observed to any residents.<br>3.) An inservice was conducted by the RDCS (Regional Director of Clinical Services) for the MDS Coordinator on reviewing and revising comprehensive care plans that includes compression devices and/or TED hose. An inservice was conducted by the RDCS for the Interdisciplinary Care Team on reviewing and revising comprehensive care plans that includes compression devices and/or TED hose. Physician orders will be written for all compression devices and/or TED hose. New and discontinued orders will be discussed at morning clinical meeting and careplans will be updated at the time of the meeting for all residents with new or discontinued orders for compression devices and/or TED hose.<br>4.) DON or designee will run an order listing report once a month for three months for all residents with compression devices and/or TED hose and audit the care plan to ensure that the resident has a comprehensive plan of care that includes the use of these devices. Results of this audit will be discussed at monthly QAPI meetings for three months.<br>5.) Date of Completion: 4/19/19 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 8<br>legs.<br><br>On 04/10/19 at approximately 8:30 AM, Resident #40 was observed in his room. Resident #40 was sitting up in his wheel chair with his oxygen on. The resident had on "slipper socks", and the resident's feet and ankles were visibly swollen. Resident #40 did not have any type of stockings or compression hose applied. Resident #40 was asked why he did not have the compression stockings on now. The resident stated that he went to the shower last night and that staff had taken them off and "that was the end of that." Resident #40 was asked if they were going to put them on this morning the resident stated, "I suppose they'll get around to it."<br><br>The clinical record was then reviewed, including the physician's orders. Resident #40 had a current physician's order to, "Apply Ace Wraps bilateral lower extremities during day and remove at night for edema every day and night for edema...[start date: 04/04/19]."<br><br>The resident's TARs (treatment administration records) were reviewed for the month of April and revealed that the Ace wraps were listed and staff were documenting that the wraps were applied and removed each day.<br><br>The resident's CCP (comprehensive care plan) was then reviewed and documented, "...Monitor for chest pain, BP [blood pressure]...SOB [shortness of breath]...edema...TED hose as ordered [03/01/19]..."<br><br>No physician's order for TED was found.<br><br>Resident #40 was again observed at 12:10 AM on | F 657 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 657 | Continued From page 9<br>04/10/19, the wound care nurse was applying Ace wraps at this time to the resident's BLE.<br><br>On 04/10/19 at approximately 3:30 PM, the DON (director of nursing) and the corporate nurse were made aware in a meeting with the survey team of the above information. The DON stated that the resident does not have TED hose, he has Ace wraps. The corporate nurse asked for clarification that the resident's physician's orders, the resident's actual treatment and the resident's CCP did not match; confirmation was given to the DON and the corporate nurse that was correct, they did not match.<br><br>No further information and/or documentation was presented prior to the exit conference on 04/10/19 at 6:30 PM to evidence the resident's CCP was reviewed and revised to reflect the correct and actual treatment the resident was receiving for BLE edema. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medication pass and pour observation, staff interview, facility document review, and clinical record review, facility staff failed to follow professional standards of clinical practice for medication administration for two of 17 residents in the survey sample, Residents #21 and #23. | F 658 | 1.) On 4/9/19, a physician□s orders was obtained for Resident # 21 and Resident #23 to administer the resident□s medication at a later time. No negative outcomes were observed due to the late administration.<br>2.) A report was run on 4/9/19 that | 4/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 658 | Continued From page 10<br>Facility staff failed to administer medications in a timely manner during the morning medication pass and pour observation conducted 04/09/2019 for Residents #21 and #23.<br><br>Findings included:<br><br>During the medication pass and pour observation conducted 04/09/19, RN #1 (registered nurse) administered nine medications scheduled for 9:00 a.m. at 10:07 a.m. to Resident #23 and administered seven medications scheduled for 9:00 a.m. at 10:22 a.m. to Resident #21. On 04/09/19 at 10:35 a.m., RN #1 was asked what the pink boxes on the resident medication administration screen meant. RN #1 stated, "The pink indicates they are late. I have half of the 100 and 300 halls plus this one [referring to the 200 hall]. The 100 hall is done. I have one more on the 300 hall. You want to make sure you give them [medications] right. Seven pink boxes were observed on the 200 hall medication administration screen, indicating seven residents with past due medications.<br><br>A copy of the facility medication administration policy was requested from the DON (director of nursing) on 04/10/19 at 9:30 a.m. The policy, "6.0 General Dose Preparation and Medication Administration...Effective Date: 12/01/07; Revision Date: ...01/01/13...included: ...4. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered...at the correct time...5.4 Administer medications within timeframes specified by facility policy..." An additional policy, | F 658 | indicated residents with late administration of medication. A physician□s order was obtained to administer the medications at a later time. No negative outcomes were observed due to the late administration of medication.<br>3.) An individual in-service was conducted by the DON for RN #1 on the facility policy and procedure for timeliness of the medication pass. An in-service was conducted by the DON or ADON for all licensed nurses on the facility policy and procedure for timeliness of the medication pass. A late medication report will be run at the morning clinical meeting for 4 weeks and then two times a week for two months.<br>4.) The ADON or designee will complete 4 random medication observations per week for four weeks and then 2/week for two months to ensure that medications are passed timely. Results will be discussed at monthly QAPI meetings for three months.<br>5.) Date of Completion: 4/19/19 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 658 | Continued From page 11<br>"6.2 Medication Administration Times...Effective Date: 12/01/07; Revision Date: 05/01/10...included: ...2. Facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration..."<br><br>LPN #1 (licensed practical nurse) was interviewed on 04/10/19 at 12:20 p.m. regarding morning medication administration. LPN #1 stated, "Normally we have two nurses and a treatment nurse. Sometimes will have a third nurse if no treatment nurse, but only two giving meds. It is tough especially if you are interrupted for an emergency, a family member, the phone or whatever. I can usually get them done."<br><br>The Administrator and DON were informed of the above findings during an end of the day meeting on 04/10/19 with the survey team. The DON stated, "We have the halls divided up with different administration times to keep in compliance. I'm not sure why she was so late yesterday."<br><br>No further information was received by the survey team prior to the exit conference on 04/10/19. | F 658 | | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in | F 684 | | 4/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 12<br>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medication pass and pour observation, staff interview, and clinical record review, facility staff failed to follow physician orders for one of 17 residents in the survey sample, Resident #23.<br><br>Facility staff failed to follow physician orders for administration of Calcium with Vitamin D for one of 17 residents in the survey sample, Resident #23.<br><br>Findings included:<br><br>Resident #23 was admitted to facility on 01/25/2019 with diagnoses including, but not limited to: Atrial Fibrillation, Hypertension, Congestive Heart Failure, and a Colostomy.<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/17/19. Resident #23 was assessed as cognitively intact with a total cognitive score of 15 out of 15.<br><br>During the medication pass and pour observation conducted 04/09/19, RN #1 (registered nurse) administered nine medications scheduled for 9:00 a.m. at 10:07 a.m. to Resident #23. Resident #23 received Calcium 500 mg (milligrams) with Vit. D 200 I.U. (international units), one tablet by RN #1. When reconciling Resident #23's medication orders a physician order dated 02/26/19 stated, "Caltrate 600+D Tablet 600-400 MG-UNIT (Calcium Carbonate-Vitamin D) Give 1 tablet by mouth in the morning for supplement..." | F 684 | 1.) A medication error report was created for Resident # 23. The resident□s responsible party and physician were notified of the incorrect dosage of the prescribed OTC medication. The resident□s order for Calcium plus Vitamin D was changed to indicate the correct dose for the house stock medication. No negative outcome to the resident with this error.<br>2.) A 100% audit was conducted on residents with physician orders for Calcium with Vitamin D to ensure that the dose on the order matches the dose of the house stock medication.<br>3.) An individual in-service was conducted by the DON for RN #1 for following physician orders to ensure that the correct dosage of medication is administered. An in-service was conducted by the DON or ADON for all licensed nurses on following physician orders to ensure that the correct dosage of medication is administered.<br>4.) The ADON or designee will complete 4 random medication observations per week for four weeks and then 2/week for two months to ensure that the correct dose of medication was administered. Results will be discussed at monthly QAPI meetings for three months.<br>5.) Date of Completion: 4/19/19 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 13<br><br>On 04/10/19 at 10:35 a.m. LPN #2 (licensed practical nurse) was interviewed regarding Resident #23's Calcium with Vit. D. dose. LPN #2 stated, "No she doesn't have a card for it. This is what we use." LPN pulled a bottle of Calcium with Vit. D out of the medication cart. "This is what we have at the facility. Geri-Care Oyster Shell Calcium 500 mg plus Vitamin D 200 I.U. This is what I gave her today." LPN pulled resident's order up in the computer. The physician order is for "Caltrate 600+D Tablet 600-400 mg-unit (Calcium Carbonate-Vitamin D) Give 1 tablet by mouth in the morning for supplement." Order Date: 02/26/2019 Start Date: 02/27/2019 LPN stated, "We do have just Calcium 500 mg, but no Vit. D. The Vitamin D is 1000 I.U." She proceeded to show this surveyor both over the counter bottles.<br><br>Resident #23's MAR's (medication administration records) for January, February, March and April 2019 were reviewed on 04/10/19 at 12:30 p.m. All MAR's included documentation that Resident #23 had received the incorrect dose of Calcium with Vit. D since admission.<br><br>The Administrator and DON were informed of the above findings during an end of the day meeting on 04/10/19 with the survey team. The DON stated, "We have the halls divided up with different administration times to keep in compliance. I'm not sure why she was so late yesterday."<br><br>No further information was received by the survey team prior to the exit conference on 04/10/19. | F 684 | | |
| F 695 | Respiratory/Tracheostomy Care and Suctioning | F 695 | | 4/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 SS=D | Continued From page 14<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based observation, resident interview, staff interview, and clinical record review, the facility staff failed to administer oxygen as ordered and per professional standards of practice for one of 17 residents in the survey sample, Resident #40 .<br><br>The facility staff failed to titrate Resident #40's oxygen as ordered by the physician.<br><br>Findings include:<br><br>Resident #40 was admitted to the facility on 03/01/19. Diagnoses for Resident #40 included, but were not limited to: atrial fibrillation, congestive heart failure, diabetes mellitus, history of acute and chronic and respiratory failure, CKD (chronic kidney disease), and high blood pressure.<br><br>The most current MDS (minimum data set) was a five day admission assessment dated 03/08/19. This assessment documented the resident as a 15, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring oxygen while not a resident and, while a resident of the facility. | F 695 | 1.) The resident□s physician was contacted to clarify the resident□s order to titrate his oxygen. The order was discontinued. No negative outcome to the resident.<br>2.) A 100% audit was conducted on residents with orders to titrate oxygen and the orders were clarified with the physician. No negative outcomes found with any residents when audit performed.<br>3.) All licensed nursing staff will be in-serviced by the DON/ADON on how to input oxygen orders with a separate order to indicate the specifics of titrating.<br>4.) Orders for oxygen and or titration of oxygen will be reviewed in morning clinical meeting for 3 months to ensure they are entered correctly into PCC. DON or designee will run an order listing report for all residents with oxygen orders once a month for three months to ensure the orders were entered correctly. Results will be discussed at monthly QAPI meetings for three months.<br>5.) Date of Compliance: 4/19/19 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 15<br><br>On 04/09/19 at approximately 11:30 AM, Resident #40 was interviewed in his room. The resident was lying in bed with oxygen via a nasal cannula. Resident #40 was asked about his breathing and stated that it "wasn't too bad." The resident was asked if he knew what the setting (amount) of oxygen was and the resident responded that he thought it was "4." The resident was then asked if he had wore oxygen at home prior to being admitted. Resident #40 stated that he only wore oxygen "at night" when he was at home, but after he got "sick" and came to the nursing home he has been wearing it day and night. The resident's oxygen concentrator was observed and was set on 4 LPM (liters per minute).<br><br>On 04/10/19 at approximately 8:30 AM, Resident #40 was observed in his room. He was sitting up in his wheel chair with his oxygen on. Resident was #40 asked again about his breathing. He stated that he thought it was "pretty good today." The oxygen concentrator was observed again and was set to 3 LPM.<br><br>Resident #40's clinical record was reviewed, including physician's orders. The resident had a current physician's order for, "Oxygen @ 3 LPM via Nasal Cannula every shift...May titrate to 2L [liters] to keep sats greater than 90% wears continuously [start date: 03/01/19-date of admission]."<br><br>Progress notes were reviewed and did not reveal any evidence that the resident's oxygen had been titrated to a lesser amount. The MARs/TARs (medication administration records/treatment administration records) were reviewed and did not reveal that Resident #40 had received less | F 695 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 16<br>than 3 LPM of oxygen at any time or oxygen titration of a lower amount of oxygen.<br><br>The TARs were reviewed for the month of April and revealed that staff were checking the resident's O2 sats (oxygen saturation) every shift. During the month of April, the resident's O2 sats were 90 or above for all shifts (from 04/01/19 through the day shift of 04/10/19). The three shifts that were less than 90% were documented as 88% on one shift and the other two were 89%. The resident's oxygen saturation for 04/10/19 was 96% for day shift.<br><br>The resident's CCP (comprehensive care plan) documented, "...respiratory failure, CHF...assist resident to elevate head of bed...monitor pulse oximetry as indicated...assess and educate resident on signs and symptoms of respiratory distress...confusion, restless...supplemental oxygen as indicated...administer oxygen as ordered..."<br><br>On 04/10/19 at approximately 5:30 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware in a meeting with the survey team of the above information, and asked what they thought the order meant. The DON stated that the order may mean to try to wean the resident down on oxygen to 2 liters if the resident is able to tolerate. The corporate nurse stated that "maybe they want to try to get him back down to night time use only." The DON, administrator and corporate nurse were asked if nursing were to titrate a resident's oxygen and the response to the titration, where would that be. The DON stated it should be in the resident's progress notes. The DON and staff were made aware that no information could be | F 695 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495262 | A. BUILDING _____ B. WING _____ | C 04/10/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHENANDOAH NURSING HOME | 339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 17<br>found in the resident's progress notes, MARs/TARs, or clinical records that would indicate the resident's oxygen was attempted to be titrated down. The facility staff were asked for any assistance in locating any evidence that the resident's oxygen was titrated per physician's orders.<br><br>At approximately 5:45 PM, the DON returned and stated that there was no additional information/documentation.<br><br>No further information and/or documentation was presented prior to the exit conference on 04/10/19 at 6:30 PM. | F 695 | | |