State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0086	A. BUILDING: _____ B. WING _____	05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS MARION MANOR HEALTH & REHABILITATI	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

(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
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 04/30/19 through 05/03/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 110 certified bed facility was 89 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for Licensure of Nursing Facilities. Policies and Procedures 12 VAC 5-371-140 (D)- cross reference to F622, F623. and F625. Resident Rights 12 VAC 5-371-150- cross reference to F550, and F583 Infection Control 12 VAC 5-371-180- cross reference to F880 Director of Nursing 12 VAC 5-371-200 (B.1)- cross reference to F658	F 001	Policies and Procedures F622, F623, F625 cross reference to 12 VAC 5-371-140 (D) Resident Rights F550, F583 cross reference to 12 VAC 5-371-150 Infection Control F880 cross referenced to 12 VAC 5-371-180 Director of Nursing F658 cross referenced to 12 VAC 5-371-200 (B.1)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teri Martin — TITLE: Administrator — (X6) DATE: 5/24/19

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F 001	Continued From page 1 Nursing Services 12 VAC 5-371-220 (A, B, D, G, H)- cross reference to F580, F677, F695, F698, F757, F758, and F760 Resident Assessment and Care Planning 12 VAC 5-371-250 (C)- cross reference to F657 Pharmaceutical Services 12 VAC 5-371-300- cross reference to F755 Dietary and Food Service 12 VAC 5-371-340- cross reference to F812 Clinical Records 12 VAC 5-371-360 (E)- cross reference to F842 Maintenance and Housekeeping 12 VAC 5-371-370- cross reference to F584	F 001	Nursing Services F580, F677, F695, F698, F757, F758, F760 cross referenced to 12 VAC 5-371-220 (A, B, D, G, H) Resident Assessment and Care Planning F657 cross referenced to 12 VAC 5-371-250 (C) Pharmaceutical Services F755 cross referenced to VAC 5-371-300 Dietary and Food Services F812 cross referenced to 12 VAC 5-371-340 Clinical Record F842 cross referenced to 12 VAC 5-371-360 (E) Maintenance and Housekeeping F584 cross referenced to 12 VAC 5-371-370	

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/30/19 through 5/3/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 110 certified bed facility was 89 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews.	F 000	Francis Marion Manor Health & Rehabilitation is licensed for 109 beds, not 110.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	F550 Ensuring Resident Rights are upheld is a priority for the team at FMM 1. Resident #53 experienced no ill effects from the C.N.A. not knocking on the door prior to entry. However, the C.N.A. responsible was re-educated to be aware to knock on the door and request to enter the room prior to entering any resident room.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lori Martin — TITLE: Administrator — (X6) DATE: 5/24/19

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 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.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to treat 1 of 18 residents with dignity and respect (Resident #53). The findings included: 1. The facility staff failed to knock on the door or announce themselves before entering Resident #53's room. The clinical record of Resident #53 was reviewed 4/30/19-5/3/19. Resident #53 was admitted to	F 550	2. All residents have the potential to be affected by the same practice. 3. 5/2/19 the Skilled Nurse provided re-education to all team members regarding knocking on the doors and waiting for permission to enter, prior to entering a resident room. The Skilled Nurse will continue to provide education 1:1 with team members who may have missed the 5/2/19 education. 4. Weekly audits to ensure team members are knocking on the door and getting permission to enter the resident room, prior to entering a room. The Social Worker will conduct the audit 5 rooms x 12 weeks and 10 x monthly for 6 months. Data will be reported to the QAPI team for further evaluation. 5. Corrective action will be complete by 06/07/19. 6. DON and Social Worker	

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F 550	Continued From page 2	F 550		

the facility 5/22/18 with diagnoses, that included but not limited to sepsis, pneumonia, chronic back pain, dementia, high cholesterol, GERD (gastroesophageal reflux disease), anxiety, hypertension, depression, fatigue, and tiredness.

Resident #53's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/5/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #53 was not assessed with any signs or symptoms of delirium, psychosis, or behaviors that affected others.

Current comprehensive care plan was undated but identified a focus area that the resident had impaired cognitive function r/t (related to) Alzheimer's. Interventions: Communication: Identify yourself at each interaction.

The surveyor observed incontinence care with certified nursing assistant #1 on 5/2/19 at 7:01 a.m. C.N.A. #1 entered the resident's room without knocking on the door. When the surveyor knocked on the door, C.N.A. #1 turned around and stated to the surveyor she forgot to knock and then apologized.

The surveyor informed the administrator and the director of nursing of the above concern on 5/2/19 at 4:34 p.m. Both stated they would expect staff to knock on the door before entering. The surveyor requested a copy of Resident Rights.

The facility's "Resident Rights & Responsibilities" found in the admission packet was reviewed 5/3/19. Resident Rights included "1. Considerate and respectful treatment including being fully informed in advance about care and treatment

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F 550	Continued From page 3 and of any changes in that care or treatment that may affect your well-being. 15. Personal freedom and dignity and 19. Privacy." No further information was provided prior to the exit conference on 5/3/19.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580	F580 Ensuring Residents, Resident Representatives and Physicians are notified of changes is a priority for the team at FMM 1. Resident #45 was assessed for suicidal ideations on 5/1/19 and physician was consulted for orders for the resident to see LCSW on 5/2/19. She was evaluated and found to be safe and without suicidal ideations. 2. All residents expressing suicidal ideations have the potential to be affected by the same practice. 3. All nursing team members will be re-educated regarding the need to not only notify the Resident, Resident Representative and Physician of change, but also the need to document those notification of changes in the resident record.	

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F 580	Continued From page 4 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to notify the physician of a change in condition for 1 of 18 residents in the survey sample (Resident #45). The findings included: The facility failed to notify the physician of Resident #45's suicidal thoughts that were verbally expressed to the facility staff on 2/26/19. Resident #45 was admitted to the facility on 7/23/28 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, dementia and anxiety disorder. On the quarterly MDS (Minimum Data Set) with an ARD of 3/27/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #45 was also	F 580	4. An audit of the 24 hour report will be conducted by the Assistant Nurse Managers (ANM) or designee to ensure all changes in condition have been reported to the Resident, Resident Representative and Physician as needed. These audits will be done 10 audits per week x 12 weeks and 10 x monthly for 6 months. If notification is not documented, it will be investigated. Notification will be made and documented and responsible staff member will be re-educated. The ANM or Designee will monitor the above audits for trends and need for additional education and or disciplinary action. Data will be reported to the QAPI team for further evaluation and interventions if needed. 5. Corrective action will be complete by 06/07/19. 6. Assistant Nurse Managers	

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F 580	Continued From page 5 coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and was totally dependent on 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #45 on 5/1/19. In the "Care Focus" documentation dated for 2/27/19, the surveyor noted under the area of "Review area(s) of Concern", it read in part: " " ...02/26 nurse called to res (resident) room by CNA (certified nursing assistance), CNA stated that the res told her she wanted to kill herself (by grabbing) her own throat) when she had asked her to pull herself up in bed but when nurse walked in res was sitting on the toilet and noted to be crying ..." The Care Focus sign in sheet had the following signatures that were in attendance: assistant director of nursing, dietitian, wound care nurse #1, director of nursing, activities coordinator and MDS (minimum data set) nurse #1. Under the section "Interdisciplinary Recommendation" of the Care Focus documentation, the following recommendation/interventions were suggested: " " ...freq (frequent visual checks made ..." The surveyor also noted the following documentation dated for 2/26/19 at 2130 (9 pm) which reads, " ...Called to res room by CNA, CNA stated that res had told her she wanted to kill herself (by grabbing her own throat) when she had asked her to pull herself up in bed but when this nurse walked in res was sitting on toilet and noted to be crying upon questioning res res stated she didn't know why she was crying but states, I just want to go home encouraged res to	F 580		

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F 580	Continued From page 6 keep doing her therapy and she would be able to go home soon ...No suicidal actions were noted for the few minutes I was in the room ...(sic)" Resident #45's care plan did not reflect a focus area or interventions to be utilized by the staff. On 3/6/19, the surveyor noted a physician order for "Buspar 10 mg (milligram) po (by mouth) BID (twice a day)". On 3/9/19, the physician progress note read in part " ...Episodes of screaming out crying/anxious ... There was no documentation in the clinical record that the physician had been notified of the above documented findings. The surveyor notified the administrative team of the above documented findings on 5/1/19 at 4:45 pm. The surveyor asked if the staff notified the physician of Resident #45's suicidal thoughts. The administrator stated, "When the staff went back to talk to the resident, the resident said she didn't know why she did that. This is why the physician was not notified." The surveyor was given a copy of a progress note that the social worker had documented for 5/1/19 at 2056 (8:56 pm). It read as follows: " SW (social worker) on first floor and interviewed _____ (name of resident). She remembers me. SW explains that in the past she had stated she wanted to die and she put her hands around her neck. She remembers that and states yes and I think I said that one time in the hospital too. SW asked if she would really harmed herself when she stated this. She stated no SW asked if she felt like harming herself at this time. She also no and stated she likes	F 580		

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F 580	Continued From page 7 having a room by herself. SW asked how she likes the first floor and she stated she liked it. SW to monitor." The surveyor was also given a copy of a physician order dated for 5/2/19 at 1310 (1:10 pm) which stated "Consult with _____ (name of counseling services). No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583	F583 Maintaining personal privacy of residents during dressing changes and providing a private place for residents to meet is important to the team at FMM 1. (a) Team members were re-educated to provide privacy during care of residents, including pulling the privacy curtain, closing the door and shutting the blinds. (b) Team members and volunteers will be re-educated to provide privacy for residents during resident council. 2. All residents have the potential to be affected by the same practice.	

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F 583	Continued From page 8 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide privacy during care for 1 of 18 residents (Resident #73) and failed to ensure a private location for the resident council to meet. Volunteers interrupted the resident council meeting for five minutes on 5/1/19. The findings included: 1. The facility staff failed to provide privacy during a wound care observation on Resident #73. The clinical record of Resident #73 was reviewed 4/30/19 through 5/3/19. Resident #73 was admitted to the facility 7/26/15 and readmitted 2/22/19 with diagnoses, that included but not limited to, wound and cellulitis of right leg, anemia, chronic kidney disease stage 3, CVA (cerebrovascular accident), falls, CHF (congestive heart failure), depression, rheumatoid arthritis, hypertension, acute decline, DVT (deep vein thrombosis), CAD (coronary artery disease) and chronic peripheral edema. Resident #73's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 4/19/19 assessed the	F 583	3. Team members will be re-educated regarding protecting the privacy of residents during care and while they are having private meetings. Team members and volunteers will be re-educated to provide privacy for residents during resident council. A "meeting in progress – do not enter" sign will be placed on the door during resident council meetings. 4. The RN Skilled Nurse will audit privacy practices (for closing blinds, privacy curtains and closing the door during care) 3 x weekly x 12 weeks and monthly for six months. Activities Coordinator will monitor privacy during resident council meetings monthly for six months. If variances are observed during the above audits, responsible team members/volunteers will be re-educated at the time. Data will be reported to the QAPI team.	

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F 583	Continued From page 9 resident with a BIMS (brief interview for mental status) as 5/15 and with no signs or symptoms of delirium, psychosis, or behaviors affecting others. The surveyor observed wound care 5/3/19 beginning at 9:52 a.m. with registered nurse #1 and registered nurse #2. The surveyor asked Resident #73 if care could be observed and the resident stated yes. Both registered nurses took part in wound care; however, registered nurse #1 was the primary caregiver. Registered nurse #1 and R.N. #2 both entered the resident's room after knocking. The privacy curtain was not pulled, the door was not closed, and the blinds were not closed. R.N. #1 and R.N. #2 entered and exited the resident's room on five different occasions without closing the door or pulling the privacy curtain with each exit and re-entry. The surveyor interviewed registered nurse #1 on 5/3/19 at 10:29 a.m. R.N. #1 was informed of the surveyor's observation and agreed that the door had not been closed, the privacy curtain not pulled and the blinds not closed. The surveyor informed the administrator and the director of nursing of the above observation during wound care on 5/3/19 at 3:52 p.m. The surveyor reviewed the admission packet and the Resident Rights & Responsibilities found there. The Resident Rights read "1. Considerate and respectful treatment including being fully informed in advance about care and treatment and of any changes in that care or treatment that	F 583	5. Corrective action will be complete by 06/07/19. 6. RN Skilled Nurse and Activities Coordinator	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 583	Continued From page 10 may affect your well-being. 15. Personal freedom and dignity and 19. Privacy." No further information was provided prior to the exit conference on 5/3/19. 2. The facility staff failed to ensure the resident council had a private place to meet. The resident council meeting was interrupted when two volunteers entered the meeting and stayed for approximately five minutes. The surveyor conducted a resident council meeting on 5/1/19 beginning at 1:30 p.m. with seven (7) resident council members. The council requested that the activity director stay in the meeting. During the meeting, two volunteers entered the resident council meeting without knocking. One volunteer asked, "Are you all still coloring?" The volunteers walked to the activity director's (AD) desk, one of the volunteers chatted with the AD, and the second volunteer sat down in a chair for approximately five minutes before leaving. The surveyor stopped the group meeting until both volunteers left approximately 5 minutes later. The surveyor interviewed the activity director on 5/1/19 after the meeting. The activities director stated she had not put a sign on the doors prior to the meeting. The AD stated one of the volunteer's works at the state hospital and should know better than to enter the meeting. The surveyor informed the administrator and the director of nursing of the resident council concern during the end of the survey meeting on 5/3/19 at	F 583		

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F 583	Continued From page 11 3:52 p.m. No further information was provided prior to the e exit conference on 5/3/19.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584	F584 Ensuring a clean homelike environment is important to the team at FMM 1. Environmental Services (EVS) team members conducted a deep cleaning on the day room and resident #53's room. Resident #53 received no ill effects from the practice. 2. All residents have the potential to be affected by the same practice. Environmental rounds will be made by the EVS Manager, Supervisor and Administrator.	

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F 584	Continued From page 12 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure a clean and comfortable homelike environment in 1 of 18 resident rooms (Resident #53) and on 1 of 2 day/activity rooms. The findings included: The facility staff failed to ensure Resident #53's room was clean and failed to ensure the 1st floor day room was clean. The surveyor and the housekeeping supervisor other #2 toured the first floor on 5/2/19 at 10:12 a.m. During the tour on 5/2/19 of the 1st floor day room, dust was observed on the wall across from the long windows. The dust was hanging near the wall and had what appeared to be a spider's web attached with a dead spider. The housekeeping supervisor confirmed the presence of the dust and stated the housekeepers should have removed the dust/spider web. The housekeeping supervisor stated high dusting was a challenge. The surveyor observed approximately 8-12 inches above the chair railing, dark black marks on the wall behind a row of chairs which resembled black shoe marks. The housekeeping supervisor stated that was part of	F 584	3. Team members were counseled on the importance of routine high dusting as scheduled. Team members also counseled on importance of working with nursing to notify them when a resident has been moved in order to do deep cleaning for certain areas of the rooms. 4. The EVS Manager, Administrator or designee will five audits will be done weekly for twelve weeks and then monthly for six months to ensure high dusting and dusting in the corners of the rooms is completed. If dust is detected, the EVS supervisor will address deficiency with the EVS worker and the variance will be corrected. Results of the audits will be presented to the QAPI team for further recommendations.	

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F 584	Continued From page 13 maintenance's upkeep to do painting. The housekeeping supervisor stated the black markings were from the higher chairs hitting the wall. A large picture on the wall behind the row of chairs was covered with dust on the top. The picture was loose and removed by the surveyor and the housekeeping supervisor and taken to the 1st floor unit manager's office for safety. The housekeeping supervisor stated the picture was wobbly and difficult to clean. The housekeeping supervisor stated, "That's one of our biggest challenges in housekeeping." The surveyor and the housekeeping supervisor checked Resident #53's room for cleanliness. In the corner of the resident's room near the hospital bed, a collection of dust was observed behind the chair and a folding chair in the room. The housekeeping supervisor confirmed and stated housekeeping should have gotten the dust. The housekeeping supervisor stated when the residents are in the room, the staff can't move the chairs and therefore some of the corners don't get cleaned. The housekeeping supervisor stated five (5) room inspections were completed each week. Resident #53's most recent room inspection was 4/24/19 and scored 16/18-unsatisfactory in lights and high dusting and vents. The housekeeping supervisor stated the issue was corrected the next day and stated the resident may have been in the room when the housekeeper cleaned the room. The housekeeping supervisor stated there were seven (7) staff members in the building-one in laundry, one supervisor, and five employees that were on the floor. The housekeeping supervisor stated one employee takes care of projects and stated there were four (4) wing	F 584	5. Corrective action will be complete by 06/07/19. 6. EVS Manager, Administrator or designee	

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F 584	Continued From page 14 cleaners and the staff alternate weekends. The housekeeping supervisor stated at least one (1) day a week, there were only three (3) housekeepers to clean the units and the resident rooms due to projects and days off. The housekeeping supervisor stated projects included stripping floors in the lobby, rehab unit, activities and 27 resident rooms thus far. Resident #53's room was scheduled for stripping and waxing of the floors on 8/14/19 per the QAPI (Quality Assurance Performance Improvement) Plan. The issue/concern was resident rooms stripped and waxed on a scheduled basis. The surveyor requested the job description for housekeepers and a daily schedule of tasks done from the housekeeping supervisor on 5/2/19. The Environmental Services Department Duty List for 1st floor East Wing read 7:00 a.m. Sign in EVS 7:05 a.m. Assemble cart 7:15 a.m. High profile cleaning, dayroom and break room 7:45 a.m. Clean/Eye Wash Rm (room) 7:55 a.m. Supply Room 8:05 a.m. Soiled Utility Room 8:15 a.m. Rm 165 Wound Care 8:45 a.m. High Profile Cleaning-110, 111, and 167 9:15 a.m. Break 9:30 a.m. EVS daily meeting 9:45 a.m. High Profile Cleaning-166, 164, 163, 162, 161, and 160 High profile cleaning-showers/trash 12:00 p.m. lunch 12:30 p.m. High Profile Cleaning 159, 158, 157, 156, 155, 154, 153, 152 Daily Focus	F 584		

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F 584	Continued From page 15 Monday-High dust/trash cans Tuesday-Sinks, commodes, stainless steel Wednesday-Corners, edges, door, walls Thursday-Window glass, drinking fountains Friday-Disinfect furniture Sunday-Terminal clean nurse's station from 9:30-10:30 a.m. High profile cleaning read "1. Knock, enter room & cheerfully greet patients, using names. 2. (T) Empty waste can/trash. 3. (D) High dust. 4. (DIS) Disinfect Horizontal Surfaces. 5. (DIS) Disinfect Vertical Surfaces. 6. (RR) Disinfect bathroom. 7. (V) Dust mop. 8. Inspect your work. 9. (D) Damp mop. 10. Thank you and say "Goodbye". The surveyor informed the administrator and the director of nursing of the observation during the tour with the housekeeping supervisor on 5/2/19 in the end of the day meeting on 5/2/19 at 4:34 p.m. The clinical record of Resident #53 was reviewed 4/30/19-5/3/19. Resident #53 was admitted to the facility 5/22/18 with diagnoses, that included but not limited to sepsis, pneumonia, chronic back pain, dementia, high cholesterol, GERD (gastroesophageal reflux disease), anxiety, hypertension, depression, fatigue, and tiredness. Resident #53's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/5/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #53 was not assessed with any signs or symptoms of delirium, psychosis, or behaviors that affected others.	F 584		

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F 584	Continued From page 16 No further information was provided prior to the exit conference on 5/3/19. This is a complaint deficiency.	F 584		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the	F 622	F622 Following the discharge and transfer requirements is an important priority for the team at FMM 1. Residents #9, #73, #6, #29, #28 and #49 received no ill effects due to the required information not being sent to the ED or not documented as have been sent. Each resident returned to FMM. 2. All residents who are transferred to the ED have the potential to be affected by the same practice.	

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F 622	Continued From page 17 resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following:	F 622	3. The nursing team will be re-educated regarding the requirements of transfer and discharge, including DNR/Advance Directive, 30 days of Nurses Notes, SBAR, Care plan goals, MAR/TAR, Labs (most recent), H&P, any x-rays pertinent, immunization, bed hold policy and nursing skilled/LTC Weekly Evaluation (minimum of 2) . The Notice of Transfer and Discharge form in PCC will be revised to include a checklist of items to be sent to the ED or given to the resident upon transfer. The form will also be edited so that all fields are not required for completion so that the user is not forced to put "na" in the block.	

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F 622	Continued From page 18 (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure the clinical record contained documentation of information sent with 6 of 18 residents when transferred from the facility that affected Resident #9, Resident #73, Resident #6, Resident #29, Resident #28, and Resident #49. The findings included: 1. The facility staff failed to ensure the clinical record contained documentation of information sent to the emergency room on 4/30/19 for Resident #9. The clinical record of Resident #9 was reviewed 4/30/19 through 5/3/19. Resident #9 was admitted to the facility 7/13/16 with diagnoses that included but not limited to acute urinary tract infections, sepsis, hypoxia, CHF (congestive heart failure), hypothyroidism, excessive upper gastrointestinal gas, obesity, paranoid schizophrenia, depression, hypertension, anemia, and thrombocytopenia.	F 622	4. The DON or designee will audit to ensure all information is sent with the resident when transferred as required. An audit will be conducted of the records for residents who have been transferred two times a week for 12 weeks and then five records per month will be reviewed for accuracy x 6 months. Any discrepancy will be addressed with the nurse in charge of the transfer. Data will be reported to the QAPI team for further intervention. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 622	Continued From page 19 Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/10/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #9 was assessed without any signs or symptoms of delirium, psychosis, or behaviors that affected others. The clinical record progress note dated 2/4/19 at 17:30 (5:30 p.m.) revealed the resident was found in the floor by a certified nursing assistant on 2/4/19 at 5:30 p.m. c/o (complained of) left hip and neck pain. Reported to medical doctor with new order to send to ED (emergency department) for eval (evaluation). Ambulance called for transport (name omitted). 2/4/19 18:30 (6:30 p.m.) Ambulance service here to transport to ED (emergency department) for eval (evaluation) & tx (treatment) re: fall. Report called to ED. The clinical record did not have documentation of information sent to the receiving provider, a completed transfer/discharge form or information about bed holds for resident #9's emergency room visit on 2/4/19. Resident #9's clinical record revealed the resident was found in the floor 4/30/19 at 1945 (7:45 p.m.). The resident was found lying in front of her roommate's bed. Resident was lying in the prone position with her face against the floor and stated she had stood up and was bending over to pick something up from the floor when she lost her balance and fell. The resident stated she did not lose consciousness. Resident was wearing tennis shoes but was not using walker. Call light	F 622		

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F 622	Continued From page 20	F 622		

had not been used for assist. Small amount of blood noted in the floor above resident's head. Resident assessed for back and neck injury and was then assisted to roll on to her back. Resident noted to have a discolored, raised area over her right eye. Small laceration also noted over right eye. Raised discolored area noted to right hand. Resident stated she was hurting all over. Nurse practitioner, on call for MD (medical doctor) contacted and new order was received to send resident to ED (emergency department) at 1948 (7:48 p.m.). TAS (ambulance service) contacted for transport at 1947 (7:47 p.m.) report called to hospital ED at 2003 (8:03 p.m.), resident's brother notified of fall and transport to ED at 2010 (8:10 p.m.). Upon TAS arrival at 2000, (8:00 p.m.) resident was transferred on to backboard for assist from floor to stretcher. Resident stabilized. Paperwork given to ambulance staff.

The clinical record did not document what paperwork was sent with the resident, if a bed hold was offered and if a transfer form had been completed for 4/30/19.

The surveyor interviewed licensed practical nurse #1 on 5/2/19 at 2:49 p.m. on what information was sent with residents when they are sent to the emergency room.

L.P.N. #1 stated face sheet, history and physical, medication administration records (MARs)s, any pertinent labs, ER (emergency room) order, advanced directives, POA # (power of attorneys), and emergency transfer sheet. L.P.N. #1 was asked if the facility sent the comprehensive care plan goals with the resident. L.P.N. #1 stated she doesn't send them and didn't know about bed holds. L.P.N. #1 stated the business office does

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 21 the bed holds. The surveyor interviewed the admissions assistant on 5/2/19 at 2:57 p.m. The admissions assistant stated bed hold information was provided on admission but not when the residents were sent to the emergency room. The surveyor informed the director of nursing on 5/2/19 at 2:57 p.m. about the transfer form sent with Resident #9. The DON stated "I looked and there was none done. I spoke with the staff responsible for the transfer and the last one completed was 8/25/18." The surveyor requested from the DON the facility policy on transfers/discharges on 5/2/19. The DON did provide the surveyor with paperwork from the emergency room visits on 2/4/19 and 4/30/19; however, the paperwork did not include a transfer form and the documentation in the clinical record did not state what paperwork was sent with the resident. The surveyor informed the administrator and the director of nursing of the above concern about paperwork not provided to the receiving provider when the resident was sent to the emergency department on 2/4/19 and 4/30/19 and lack of documentation of information sent with the resident on 2/4/19 and 4/30/19 in the end of the day meeting on 5/2/19 at 4:34 p.m. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 2. The facility staff failed to ensure the clinical record contained documentation of information	F 622		

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F 622	Continued From page 22 sent to the emergency room for Resident #73. The clinical record of Resident #73 was reviewed 4/30/19 through 5/3/19. Resident #73 was admitted to the facility 7/26/15 and readmitted 2/22/19 with diagnoses, that included but not limited to, wound and cellulitis of right leg, anemia, chronic kidney disease stage 3, CVA (cerebrovascular accident), falls, CHF (congestive heart failure), depression, rheumatoid arthritis, hypertension, acute decline, DVT (deep vein thrombosis), CAD (coronary artery disease) and chronic peripheral edema. Resident #73's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 4/19/19 assessed the resident with a BIMS (brief interview for mental status) as 5/15 and with no signs or symptoms of delirium, psychosis, or behaviors affecting others. The clinical record progress note dated 2/9/19 at 0035 that the nurse was called to the room by aide-resident sitting on side of bed-c/o (complains of) increase in pain RLE (right lower extremity)-dark purple, raised area to RLE increasing in size-appears to have large hematoma of blood under skin-resident grimaces when area is touched-no other c/o (complaints of)-v/s (vital signs) 97.7, 97%, 72, 221/85. 2/9/19 0037 Nurse practitioner, on call, contacted-new order received to send to ed (emergency department) for eval (evaluation) and tx (treatment). 2/9/19 0041 resident family notified 2/9/19 0045 tas (ambulance service) contacted	F 622		

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F 622	Continued From page 23 for transport 2/9/19 0054 report called in to rn (registered nurse) at name of hospital ed. 2/9/19 0058 tas here for transport. 2/9/19 0230 received report from ed-stated pt (patient) was on her way back-stated clot had been removed from hematoma and area has been wrapped. The clinical record did not have documentation of what information was sent with the resident to the emergency department on 2/9/19. The surveyor was unable to locate a transfer/discharge form in the clinical record. The surveyor interviewed licensed practical nurse #1 on 5/2/19 at 2:49 p.m. on what information was sent with residents when they are sent to the emergency room. L.P.N. #1 stated face sheet, history and physical, medication administration records (MARs)s, any pertinent labs, ER (emergency room) order, advanced directives, POA # (power of attorneys), and emergency transfer sheet. L.P.N. #1 was asked if the facility sent the comprehensive care plan goals with the resident. L.P.N. #1 stated she doesn't send them and didn't know about bed holds. L.P.N. #1 stated the business office does the bed holds. The surveyor interviewed the admissions assistant on 5/2/19 at 2:57 p.m. The admissions assistant stated bed hold information was provided on admission but not when the residents were sent to the emergency room.	F 622		

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F 622	Continued From page 24 The surveyor informed the director of nursing on 5/2/19 at 2:57 p.m. about the transfer form sent with Resident #73. The DON stated "I looked and there was none done." The surveyor requested from the DON the facility policy on transfers/discharges on 5/2/19. The surveyor informed the administrator and the director of nursing of the above concern about paperwork not provided to the receiving provider when the resident was sent to the emergency department on 2/9/19 in the end of the day meeting on 5/2/19 at 4:34 p.m. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 3. The facility staff failed to provide the receiving provider with information that included Resident #6's comprehensive care plan goals and failed to document what information was sent with the resident when transported to the emergency room on 2/1/19. The clinical record of Resident #6 was reviewed 4/30/19 through 5/3/19. Resident #6 was admitted to the facility 9/1/18 with diagnoses that included but not limited to syncope, weakness, acute renal failure, hyponatremia, acute bronchitis, acute-on-chronic respiratory failure, pneumonia, anemia, chronic obstructive pulmonary disease (COPD), obesity, CKD (chronic kidney disease (stage 4), depression, diabetes mellitus, hypertension, hypothyroidism, psychosis and insomnia. Resident #6's quarterly minimum data set (MDS)	F 622		

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F 622	Continued From page 25	F 622		

with an assessment reference date (ARD) of 4/29/19 assessed the resident with a BIMS (brief interview for mental status) as 14/15. Resident #6 was assessed without any signs or symptoms of delirium, psychosis, or behaviors that affected others.

The surveyor interviewed Resident #6 on 5/1/19 at 9:43 a.m. Resident #6 was asked if there had been any recent hospitalizations and the resident responded her right ankle /leg had been broken about seven (7) months ago during a fall. The clinical record revealed Resident #6 had been sent to the emergency room on 2/1/19 at 19:10 (7:10 p.m.). There was no documentation of what information was provided to the receiving provider when the resident was sent to the emergency room or when the resident returned. The clinical record did not contain any information about bed holds

The clinical record did contain a form titled "Emergency Department Referral" dated 2/1/19 which included the code status, brief history of present condition, contact information of the practitioner and emergency contact. The clinical record did not have documentation of information sent to the provider.

The surveyor interviewed licensed practical nurse #1 on 5/2/19 at 2:49 p.m. on what information was sent with residents when they are sent to the emergency room.

L.P.N. #1 stated face sheet, history and physical, medication administration records (MARs)s, any pertinent labs, ER (emergency room) order, advanced directives, POA # (power of attorneys), and emergency transfer sheet. L.P.N. #1 was

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F 622	Continued From page 26 asked if the facility sent the comprehensive care plan goals with the resident. L.P.N. #1 stated she doesn't send them and didn't know about bed holds. L.P.N. #1 stated the business office does the bed holds. The surveyor interviewed the admissions assistant on 5/2/19 at 2:57 p.m. The admissions assistant stated bed hold information was provided on admission but not when the residents were sent to the emergency room. The surveyor requested from the DON the facility policy on transfers/discharges on 5/2/19. The surveyor informed the administrator and the director of nursing of the above concern about the comprehensive care plan goals not sent with Resident #6 to the emergency room on 2/1/19 and the lack of documentation of the information sent to the ED on 2/1/19 in the end of the day meeting on 5/3/19 at 4:32 p.m. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 4. The facility staff failed to ensure correct information was contained on the transfer form for Resident #29. Resident #29 was admitted to the facility on 5/16/16 with the following diagnoses of, but not limited to cancer, anemia, coronary artery disease, neurogenic bladder and seizure disorder. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/4/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15.	F 622		

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F 622	Continued From page 27 During the clinical record review on 5/3/19, the surveyor noted there was documentation on the "Notice of Transfer or Discharge" dated for 4/24/19. On this date, the resident had abnormal labs and the physician had ordered for him to go to ER (emergency room) to be evaluated. In the nursing notes dated 4/24/19 at 17:34 (5:34 pm) the following was documented: " "Face sheet, Code status sheet, H and P (History and Physical) current physician orders, current progress note from PCP (primary care provider), discharge delivery sheet ...faxed to _____ (name of hospital) ER." " 4/24/19 at 20:57 (8:57 pm) "ER called and patient admitted to room 3118 ..." The surveyor reviewed the "Notice of Transfer or Discharge" dated for 4/24/19 and the following items were checked: " "...7. The safety of individuals in the facility is endangered due to the clinical or behavioral status exhibited by you (the resident) as evidenced by ..." " 7a. This section was marked as "NA". " "...9. You (the resident) have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the nursing facility ... The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 5. The facility staff failed to ensure the correct information was contained on the transfer form	F 622		

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F 622	Continued From page 28 for Resident #28. Resident #28 was readmitted to the facility on 2/23/19 with the following diagnoses, but not limited to atrial fibrillation, coronary artery disease, high blood pressure, renal failure, diabetes and arthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #28 was also coded as only requiring supervision with dressing and limited assistance for personal hygiene and bathing. During the clinical record review on 5/2 and 5/3/19, the surveyor noted the following marked on the Transfer sheet dated for 1/18/19: " "...7. The safety of individuals in the facility is endangered due to the clinical or behavioral status exhibited by you (the resident) as evidenced by: ... " 10. The facility will cease to operate on 1/18/19 ..." In addition, a transfer summary sheet dated for 2/20/19 was noted to contain the following information with the boxes beside of these were checked: " "...4. The discharge has been planned in collaboration with you (the resident) and/or your resident representative and represents the choice of such ... " 7. The safety of individuals in the facility is endangered due to the clinical or behavioral status exhibited by you (the resident) as evidenced by: ... " 8. The health of the individuals in the facility would otherwise be endangered as evidenced by:	F 622		

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F 622	Continued From page 29 ... " 9. You (the resident) have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the nursing facility ..." The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 6. For Resident #49 the facility staff failed to ensure the transfer/discharge form was correct. Resident #49 was admitted to the facility on 03/23/18 and readmitted on 03/14/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, neurogenic bladder, diabetes mellitus, dementia, depression, chronic obstructive pulmonary disease, respiratory failure, end stage renal disease, atrial fibrillation and hypothyroidism. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/01/19 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #49's clinical record was reviewed on 05/01/19. It contained a signed physician's order dated 03/11/19, which read in part "Sent (sic) to .... (facility name omitted) ER (emergency room) Dx (diagnosis) critical potassium renal failure". The clinical record also contained a nurse's progress note dated 03/11/19, which read in part "3/11/19 09:24 LAB CALL WITH CRITICAL POTASSIUM (sic) CALL ... (name omitted) AND ... (name omitted) ORDER PT (Patient) TO GO	F 622		

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F 622	Continued From page 30 TO .... (facility name omitted) ER CALL ... (name omitted) AMBULANCE SERVICE TO TRANSPORT PT TO ER, ... (name omitted) KNOWS AND UNDERSTANDS, REPORT CALL TO ER AT ... (facility name omitted) ... (name omitted) HERE PT ON WAS TO .... (facility name omitted) ER". This note did not contained any information on what type of documentation was sent to hospital with the Resident. The Resident's clinical record contained a "Notice of Transfer or Discharge" form, dated 03/11/19. This form contained check boxes of different reasons for transfer/discharge. The boxes reading "6. The transfer or discharge is necessary for your (the Resident's) welfare and your (the Resident's) needs cannot be met in the facility as evidenced by:", "7. The safety of individuals in the facility is endangered due to the clinical or behavioral status exhibited by you (the Resident) as evidenced by:", "8. The health of individual in the facility would otherwise be endangered as evidenced by:", "9. You (the Resident) have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the nursing facility", "9a. Total amount due to the facility is", "9b. You and/or your representative were previously given notice of payment due on", "10. The facility will cease to operate on" and "11. The facility will assist you with a safe and orderly discharge. If discharge does not occur within 30 days, it is the intent of the facility discharge you" were all checked as reason for the Resident's discharge. The concern of the incorrect form was discussed with the administrative team during a meeting on 05/02/19 at approximately 1635. The DON	F 622		

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F 622	Continued From page 31 (director of nursing) stated all of the boxes should have not been checked. No further information was provided prior to exit.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623	F623 Following the notice requirements before discharge and transfer is an important priority for the team at FMM 1. Residents #9, #73 and #6 received no ill effects due to not receiving a copy of the transfer/discharge form as required before being transferred the ED or not documented as have been sent. 2. All residents who are transferred to the ED have the potential to be affected by the same practice. 3. The nursing team will be re-educated regarding the requirements of giving the resident or resident representative a copy of the transfer and discharge form. The form is being revised so that it allows clear documentation of what was given to the resident/resident representative and to the accepting ED.	

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F 623	Continued From page 32 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623	4. The DON or designee will audit to ensure the transfer/discharge form is given to the resident or resident representative prior to being transferred or discharged from FMM. At least five records per month will be reviewed for accuracy x 6 months. Any discrepancy will be addressed with the nurse in charge of the transfer. Data will be reported to the QAPI team for further intervention. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 623	Continued From page 33 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide a written notice of transfer to the resident and resident representative for 3 of 18 residents when transferred to the hospital (Resident #9, Resident #73, and Resident #6). The findings included: 1. The facility staff failed to provide a written notice of transfer to the resident and the resident representative when Resident #9 was sent to the emergency room on 2/4/19 and 4/30/19. The clinical record of Resident #9 was reviewed	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

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F 623	Continued From page 34	F 623		

4/30/19 through 5/3/19. Resident #9 was admitted to the facility 7/13/16 with diagnoses that included but not limited to acute urinary tract infections, sepsis, hypoxia, CHF (congestive heart failure), hypothyroidism, excessive upper gastrointestinal gas, obesity, paranoid schizophrenia, depression, hypertension, anemia, and thrombocytopenia.

Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/10/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #9 was assessed without any signs or symptoms of delirium, psychosis, or behaviors that affected others.

The clinical record progress note dated 2/4/19 at 17:30 (5:30 p.m.) revealed the resident was found in the floor by a certified nursing assistant on 2/4/19 at 5:30 p.m. c/o (complained of) left hip and neck pain. Reported to medical doctor with new order to send to ED (emergency department) for eval (evaluation). Ambulance called for transport (name omitted).

2/4/19 18:30 (6:30 p.m.) Ambulance service here to transport to ED (emergency department) for eval (evaluation) & tx (treatment) re: fall. Report called to ED.

The clinical record did not have documentation of written transfer/discharge information that was provided to the resident and the resident representative when transferred to the emergency room on 2/4/19.

Resident #9's clinical record revealed the resident was found in the floor 4/30/19 at 1945 (7:45

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F 623	Continued From page 35 p.m.). The resident was found lying in front of her roommate's bed. Resident was lying in the prone position with her face against the floor and stated she had stood up and was bending over to pick something up from the floor when she lost her balance and fell. The resident stated she did not lose consciousness. Resident was wearing tennis shoes but was not using walker. Call light had not been used for assist. Small amount of blood noted in the floor above resident's head. Resident assessed for back and neck injury and was then assisted to roll on to her back. Resident noted to have a discolored, raised area over her right eye. Small laceration also noted over right eye. Raised discolored area noted to right hand. Resident stated she was hurting all over. Nurse practitioner, on call for MD (medical doctor) contacted and new order was received to send resident to ED (emergency department) at 1948 (7:48 p.m.). TAS (ambulance service) contacted for transport at 1947 (7:47 p.m.) report called to hospital ED at 2003 (8:03 p.m.), resident's brother notified of fall and transport to ED at 2010 (8:10 p.m.). Upon TAS arrival at 2000, (8:00 p.m.) resident was transferred on to backboard for assist from floor to stretcher. Resident stabilized. Paperwork given to ambulance staff. The clinical record did not have documentation of written transfer/discharge information that was provided to the resident and the resident representative when transferred to the emergency room on 4/30/19. The surveyor informed the director of nursing on 5/2/19 at 2:57 p.m. about the transfer form sent with Resident #9 and given to the resident and the resident representative. The DON stated "I looked and there was none done. I spoke with	F 623		

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F 623	Continued From page 36 the staff responsible for the transfer and the last one completed was 8/25/18." The surveyor requested from the DON the facility policy on transfers/discharges on 5/2/19. The DON did provide the surveyor with paperwork from the emergency room visits on 2/4/19 and 4/30/19; however, the paperwork did not include a transfer form and the documentation in the clinical record did not state what paperwork was sent with the resident. The surveyor informed the administrator and the director of nursing of the above concern regarding transfer/discharge forms not provided to the resident and the resident representative when transferred on 2/4/19 and 4/30/19 in the end of the day meeting on 5/2/19 at 4:34 p.m. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 2. The facility staff failed to provide the resident and the resident representative with a written transfer form when Resident #73 was transferred to the emergency room on 2/9/19. The clinical record of Resident #73 was reviewed 4/30/19 through 5/3/19. Resident #73 was admitted to the facility 7/26/15 and readmitted 2/22/19 with diagnoses, that included but not limited to, wound and cellulitis of right leg, anemia, chronic kidney disease stage 3, CVA (cerebrovascular accident), falls, CHF (congestive heart failure), depression, rheumatoid arthritis, hypertension, acute decline, DVT (deep vein thrombosis), CAD (coronary artery disease) and chronic peripheral edema.	F 623		

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F 623	Continued From page 37 Resident #73's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 4/19/19 assessed the resident with a BIMS (brief interview for mental status) as 5/15 and with no signs or symptoms of delirium, psychosis, or behaviors affecting others. The clinical record progress note dated 2/9/19 at 0035 that the nurse was called to the room by aide-resident sitting on side of bed-c/o (complains of) increase in pain RLE (right lower extremity)-dark purple, raised area to RLE increasing in size-appears to have large hematoma of blood under skin-resident grimaces when area is touched-no other c/o (complaints of)-v/s (vital signs) 97.7, 97%, 72, 221/85. 2/9/19 0037 Nurse practitioner, on call, contacted-new order received to send to ed (emergency department) for eval (evaluation) and tx (treatment). 2/9/19 0041 resident family notified 2/9/19 0045 tas (ambulance service) contacted for transport 2/9/19 0054 report called in to rn (registered nurse) at name of hospital ed. 2/9/19 0058 tas here for transport. 2/9/19 0230 received report from ed-stated pt (patient) was on her way back-stated clot had been removed from hematoma and area has been wrapped. The clinical record did not have documentation	F 623		

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F 623	Continued From page 38	F 623		

that the transfer/discharge form was provided to the resident and the resident representative or that the transfer/discharge form was completed for 2/9/19.

The surveyor was unable to locate a transfer/discharge form in the clinical record.

The surveyor informed the director of nursing on 5/2/19 at 2:57 p.m. about the transfer form sent with Resident #73. The DON stated "I looked and there was none done."

The surveyor informed the administrator and the director of nursing of the above concern regarding transfer/discharge forms not provided to the resident and the resident representative when transferred on 2/9/19 in the end of the day meeting on 5/2/19 at 4:34 p.m.

No further information was provided to the surveyor prior to the exit conference on 5/3/19.

3. The facility staff failed to provide the resident and the resident representative the transfer /discharge form when Resident #6 was sent to the hospital on 2/1/19.

The clinical record of Resident #6 was reviewed 4/30/19 through 5/3/19. Resident #6 was admitted to the facility 9/1/18 with diagnoses that included but not limited to syncope, weakness, acute renal failure, hyponatremia, acute bronchitis, acute-on-chronic respiratory failure, pneumonia, anemia, chronic obstructive pulmonary disease (COPD), obesity, CKD (chronic kidney disease (stage 4), depression, diabetes mellitus, hypertension, hypothyroidism, psychosis and insomnia.

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 623	Continued From page 39 Resident #6's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 4/29/19 assessed the resident with a BIMS (brief interview for mental status) as 14/15. Resident #6 was assessed without any signs or symptoms of delirium, psychosis, or behaviors that affected others. The surveyor interviewed Resident #6 on 5/1/19 at 9:43 a.m. Resident #6 was asked if there had been any recent hospitalizations and the resident responded her right ankle /leg had been broken about seven (7) months ago during a fall. The clinical record revealed Resident #6 had been sent to the emergency room on 2/1/19 at 19:10 (7:10 p.m.). The clinical record did contain a form titled "Emergency Department Referral" dated 2/1/19 that included the code status, brief history of present condition, contact information of the practitioner and emergency contact. The clinical record did not indicate the resident and the resident representative were given a copy of the transfer/discharge form on 2/1/19. The surveyor requested from the DON the facility policy on transfers/discharges on 5/2/19. The surveyor informed the administrator and the director of nursing of the above concern about no evidence the resident and the resident representative were given a written notice of discharge when Resident #6 was transferred to the emergency room on 2/1/19 in the end of the day meeting on 5/3/19 at 4:32 p.m. No further information was provided to the	F 623		

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F 623	Continued From page 40 surveyor prior to the exit conference on 5/3/19.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to offer and provide written information about bed holds when 5 of 18 residents were	F 625	F625 Following the requirement to give notice of Bed Hold Policy before / upon transfer is an important priority for the team at FMM 1. Residents #9, #73, #6, #29, and #49 received no ill effects due to not receiving a copy of the bed hold policy prior to being sent to the ED. Each resident returned to FMM, without issue. 2. All residents who are transferred to the ED have the potential to be affected by the same practice. Residents who are currently in the hospital and have not returned to the facility will be provided a copy of the bed hold notice. Residents being sent to the ED will be provided of the facility bed hold notice.	

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F 625	Continued From page 41 transferred to the hospital (Resident #9, Resident #73, Resident #6, Resident #29, and Resident #49). The findings included: 1. The facility staff failed to offer and provide written bed hold information when Resident #9 was transferred to the emergency room on 4/30/19. The clinical record of Resident #9 was reviewed 4/30/19 through 5/3/19. Resident #9 was admitted to the facility 7/13/16 with diagnoses that included but not limited to acute urinary tract infections, sepsis, hypoxia, CHF (congestive heart failure), hypothyroidism, excessive upper gastrointestinal gas, obesity, paranoid schizophrenia, depression, hypertension, anemia, and thrombocytopenia. Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/10/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #9 was assessed without any signs or symptoms of delirium, psychosis, or behaviors that affected others. The clinical record progress note dated 2/4/19 at 17:30 (5:30 p.m.) revealed the resident was found in the floor by a certified nursing assistant on 2/4/19 at 5:30 p.m. c/o (complained of) left hip and neck pain. Reported to medical doctor with new order to send to ED (emergency department) for eval (evaluation). Ambulance called for transport (name omitted). 2/4/19 18:30 (6:30 p.m.) Ambulance service here	F 625	3. Nursing, Social Worker and Business Office team members will be re-educated regarding the requirement to provide each resident or resident representative a copy of the bed hold policy, prior to the resident leaving the facility or in the case of an emergency, within 24 hours. 4. The DON or designee will audit to ensure a copy of the bed hold policy is given to the resident or resident representative when being transferred as required. Audits will be done twice weekly, when transfers occur, for 12 weeks and then monthly x 6 months. Any discrepancy will be addressed with the nurse in charge of the transfer. Data will be reported to the QAPI team for further intervention. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 625	Continued From page 42 to transport to ED (emergency department) for eval (evaluation) & tx (treatment) re: fall. Report called to ED. The clinical record did not have documentation that bed holds were offered and information about bed holds provided to Resident #9 on 2/4/19. Resident #9's clinical record revealed the resident was found in the floor 4/30/19 at 1945 (7:45 p.m.). The resident was found lying in front of her roommate's bed. Resident was lying in the prone position with her face against the floor and stated she had stood up and was bending over to pick something up from the floor when she lost her balance and fell. The resident stated she did not lose consciousness. Resident was wearing tennis shoes but was not using walker. Call light had not been used for assist. Small amount of blood noted in the floor above resident's head. Resident assessed for back and neck injury and was then assisted to roll on to her back. Resident noted to have a discolored, raised area over her right eye. Small laceration also noted over right eye. Raised discolored area noted to right hand. Resident stated she was hurting all over. Nurse practitioner, on call for MD (medical doctor) contacted and new order was received to send resident to ED (emergency department) at 1948 (7:48 p.m.). TAS (ambulance service) contacted for transport at 1947 (7:47 p.m.) report called to hospital ED at 2003 (8:03 p.m.), resident's brother notified of fall and transport to ED at 2010 (8:10 p.m.). Upon TAS arrival at 2000, (8:00 p.m.) resident was transferred on to backboard for assist from floor to stretcher. Resident stabilized. Paperwork given to ambulance staff. The clinical record did not have documentation	F 625		

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F 625	Continued From page 43 that bed holds were offered and information about bed holds provided to Resident #9 on 4/30/19. The surveyor interviewed licensed practical nurse #1 on 5/2/19 at 2:49 p.m. on what information was sent with residents when they are sent to the emergency room. L.P.N. #1 stated face sheet, history and physical, medication administration records (MARs)s, any pertinent labs, ER (emergency room) order, advanced directives, POA # (power of attorneys), and emergency transfer sheet. L.P.N. #1 was asked if the facility sent the comprehensive care plan goals with the resident. L.P.N. #1 stated she doesn't send them and didn't know about bed holds. L.P.N. #1 stated the business office does the bed holds. The surveyor interviewed the admissions assistant on 5/2/19 at 2:57 p.m. The admissions assistant stated bed hold information was provided on admission but not when the residents were sent to the emergency room. The surveyor informed the administrator and the director of nursing of the above concerns on 5/2/19 at 4:32 p.m. The administrator stated every resident was welcomed back and bed holds were not done. The surveyor requested a copy of the facility policy on bed holds. The facility policy titled "I. Title: Bed-Hold and Readmission Policy-Francis Marion Manor" read in part "VI. Policy: A. Residents or their legal representative will receive two (2) bed-hold notifications that includes information for readmission. B. The first notice is given on admission and the second anytime they are	F 625		

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F 625	Continued From page 44	F 625		

transferred to the hospital or takes therapeutic leave. VII. Procedure: A. On admission the resident or legal representative will receive the first Notice of Bed-Hold. 1. Whenever a resident is transferred to a hospital or takes therapeutic leave, they will receive another Notice of Bed Hold. A. In cases of emergency transfer, notification is provided within twenty-four (24) hours of the transfer. i. This requirement is met if the resident's copy of the notice is sent within other papers to the hospital."

No further information was provided to the surveyor prior to the exit conference on 5/3/19.

2. The facility staff failed to offer and provide written bed hold information when Resident #73 was transferred to the emergency room on 2/9/19.

The clinical record of Resident #73 was reviewed 4/30/19 through 5/3/19. Resident #73 was admitted to the facility 7/26/15 and readmitted 2/22/19 with diagnoses, that included but not limited to, wound and cellulitis of right leg, anemia, chronic kidney disease stage 3, CVA (cerebrovascular accident), falls, CHF (congestive heart failure), depression, rheumatoid arthritis, hypertension, acute decline, DVT (deep vein thrombosis), CAD (coronary artery disease) and chronic peripheral edema.

Resident #73's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 4/19/19 assessed the resident with a BIMS (brief interview for mental status) as 5/15 and with no signs or symptoms of delirium, psychosis, or behaviors affecting others.

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F 625	Continued From page 45 The clinical record progress note dated 2/9/19 at 0035 that the nurse was called to the room by aide-resident sitting on side of bed-c/o (complains of) increase in pain RLE (right lower extremity)-dark purple, raised area to RLE increasing in size-appears to have large hematoma of blood under skin-resident grimaces when area is touched-no other c/o (complaints of)-v/s (vital signs) 97.7, 97%, 72, 221/85. 2/9/19 0037 Nurse practitioner, on call, contacted-new order received to send to ed (emergency department) for eval (evaluation) and tx (treatment). 2/9/19 0041 resident family notified 2/9/19 0045 tas (ambulance service) contacted for transport 2/9/19 0054 report called in to rn (registered nurse) at name of hospital ed. 2/9/19 0058 tas here for transport. 2/9/19 0230 received report from ed-stated pt (patient) was on her way back-stated clot had been removed from hematoma and area has been wrapped. The clinical record did not have documentation of bed hold information. The surveyor interviewed licensed practical nurse #1 on 5/2/19 at 2:49 p.m. on what information was sent with residents when they are sent to the emergency room. L.P.N. #1 stated face sheet, history and physical,	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 625	Continued From page 46	F 625		

medication administration records (MARs)s, any pertinent labs, ER (emergency room) order, advanced directives, POA # (power of attorneys), and emergency transfer sheet. L.P.N. #1 was asked if the facility sent the comprehensive care plan goals with the resident. L.P.N. #1 stated she doesn't send them and didn't know about bed holds. L.P.N. #1 stated the business office does the bed holds.

The surveyor interviewed the admissions assistant on 5/2/19 at 2:57 p.m. The admissions assistant stated bed hold information was provided on admission but not when the residents were sent to the emergency room.

The surveyor informed the administrator and the director of nursing of the above concerns on 5/2/19 at 4:32 p.m. The administrator stated every resident was welcomed back and bed holds were not done. The surveyor requested a copy of the facility policy on bed holds.

The facility policy titled "I. Title: Bed-Hold and Readmission Policy-Francis Marion Manor" read in part "VI. Policy: A. Residents or their legal representative will receive two (2) bed-hold notifications that includes information for readmission. B. The first notice is given on admission and the second anytime they are transferred to the hospital or takes therapeutic leave. VII. Procedure: A. On admission the resident or legal representative will receive the first Notice of Bed-Hold. 1. Whenever a resident is transferred to a hospital or takes therapeutic leave, they will receive another Notice of Bed Hold. A. In cases of emergency transfer, notification is provided within twenty-four (24) hours of the transfer. i. This requirement is met if

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 625	Continued From page 47	F 625		

the resident's copy of the notice is sent within other papers to the hospital."

No further information was provided to the surveyor prior to the exit conference on 5/3/19.

3. The facility staff failed to offer and provide written bed hold information when Resident #6 was transferred to the emergency room on 2/1/19.

The clinical record of Resident #6 was reviewed 4/30/19 through 5/3/19. Resident #6 was admitted to the facility 9/1/18 with diagnoses that included but not limited to syncope, weakness, acute renal failure, hyponatremia, acute bronchitis, acute-on-chronic respiratory failure, pneumonia, anemia, chronic obstructive pulmonary disease (COPD), obesity, CKD (chronic kidney disease (stage 4), depression, diabetes mellitus, hypertension, hypothyroidism, psychosis and insomnia.

Resident #6's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 4/29/19 assessed the resident with a BIMS (brief interview for mental status) as 14/15. Resident #6 was assessed without any signs or symptoms of delirium, psychosis, or behaviors that affected others.

The surveyor interviewed Resident #6 on 5/1/19 at 9:43 a.m. Resident #6 was asked if there had been any recent hospitalizations and the resident responded her right ankle /leg had been broken about seven (7) months ago during a fall. The clinical record revealed Resident #6 had been sent to the emergency room on 2/1/19 at 19:10 (7:10 p.m.). There was no documentation of

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 625	Continued From page 48 what information was provided to the receiving provider when the resident was sent to the emergency room or when the resident returned. The clinical record did not contain any information about bed holds The surveyor was unable to locate any evidence that bed hold information was offered to the resident on 2/1/19. The surveyor interviewed licensed practical nurse #1 on 5/2/19 at 2:49 p.m. on what information was sent with residents when they are sent to the emergency room. L.P.N. #1 stated face sheet, history and physical, medication administration records (MARs)s, any pertinent labs, ER (emergency room) order, advanced directives, POA # (power of attorneys), and emergency transfer sheet. L.P.N. #1 was asked if the facility sent the comprehensive care plan goals with the resident. L.P.N. #1 stated she doesn't send them and didn't know about bed holds. L.P.N. #1 stated the business office does the bed holds. The surveyor interviewed the admissions assistant on 5/2/19 at 2:57 p.m. The admissions assistant stated bed hold information was provided on admission but not when the residents were sent to the emergency room. The surveyor informed the administrator and the director of nursing of the above concerns on 5/2/19 at 4:32 p.m. The administrator stated every resident was welcomed back and bed holds were not done. The surveyor requested a copy of the facility policy on bed holds.	F 625		

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 625	Continued From page 49 The facility policy titled "I. Title: Bed-Hold and Readmission Policy-Francis Marion Manor" read in part "VI. Policy: A. Residents or their legal representative will receive two (2) bed-hold notifications that includes information for readmission. B. The first notice is given on admission and the second anytime they are transferred to the hospital or takes therapeutic leave. VII. Procedure: A. On admission the resident or legal representative will receive the first Notice of Bed-Hold. 1. Whenever a resident is transferred to a hospital or takes therapeutic leave, they will receive another Notice of Bed Hold. A. In cases of emergency transfer, notification is provided within twenty-four (24) hours of the transfer. i. This requirement is met if the resident's copy of the notice is sent within other papers to the hospital." No further information was provided to the surveyor prior to the exit conference on 5/3/19. 4. The facility staff failed to offer a bed hold when Resident #29 was admitted to the hospital on 4/24/19. Resident #29 was admitted to the facility on 5/16/16 with the following diagnoses of, but not limited to cancer, anemia, coronary artery disease, neurogenic bladder and seizure disorder. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/4/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. During the clinical record review on 5/2/19, the surveyor noted that the resident had been admitted to the hospital on 4/24/19. There was no documentation noted in the clinical record that	F 625		

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 625	Continued From page 50 the resident or resident representative had been offered a bed hold. The surveyor notified the administrator of the above documented findings on 5/2/19 at approximately 3:30 pm. The administrator stated, "We don't offer a bed hold because we always take them back." The surveyor interviewed the business office staff #1 of when she notified the resident of a bed hold if they were admitted to the hospital. The business office staff #1 stated, "I tell them about a bed hold when the resident is first admitted to the facility but I don't tell them this when they are sent out to the hospital." The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 5. For Resident #49 the facility staff failed to offer a bed hold when the Resident was transferred to the hospital. Resident #49 was admitted to the facility on 03/23/18 and readmitted on 03/14/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, neurogenic bladder, diabetes mellitus, dementia, depression, chronic obstructive pulmonary disease, respiratory failure, end stage renal disease, atrial fibrillation and hypothyroidism. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/01/19 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.	F 625		

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 625	Continued From page 51 Resident #49's clinical record was reviewed on 05/01/19. It contained a signed physician's order dated 03/11/19, which read in part "Sent (sic) to .... (facility name omitted) ER (emergency room) Dx (diagnosis) critical potassium renal failure". The clinical record also contained a nurse's progress note dated 03/11/19, which read in part "3/11/19 09:24 LAB CALL WITH CRITICAL POTASSIUM (sic) CALL ... (name omitted) AND ... (name omitted) ORDER PT (Patient) TO GO TO .... (facility name omitted) ER CALL ... (name omitted) AMBULANCE SERVICE TO TRANSPORT PT TO ER, ... (name omitted) KNOWS AND UNDERSTANDS, REPORT CALL TO ER AT ... (facility name omitted) ... (name omitted) HERE PT ON WAS TO .... (facility name omitted) ER". This note did not contained any information on what type of documentation was sent to hospital with the Resident or that a bed hold had been offered. The surveyor spoke with the admissions assistant on 05/02/19 at approximately 1530 regarding the offering of bed holds. The admissions assistant stated that she only provides information regarding bed holds upon admission. Admissions assistant stated that she does not offer bed hold when Residents are sent to the hospital because "we always keep their room for them". The surveyor requested and the administrator provided a copy of a facility policy entitled "Bed-Hold and Readmission Policy", which read in part "VI. Policy: B. The first notice is given on admission and the second anytime they (the Resident) are transferred to the hospital or takes a therapeutic leave". The concern of not offering the bed hold was	F 625		

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F 625	Continued From page 52 discussed with the administrative team during a meeting on 05/02/19 at approximately 1635. No further information was provided prior to exit.	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and clinical record review the facility staff failed to	F 657	F657 Updating care plans for all residents is a priority for the team at FMM 1. Resident #49 has not experienced any ill effects from the past care plans/meetings. A bedside care plan meeting is scheduled for 5/30/19. 2. All residents have the potential to be affected by the same practice during their care plan development and meeting. 3. The DON will re-educate team to update the care plan per regulations and to include the interdisciplinary team during the development and the bedside care plan meeting with the resident and/or resident representative. Participation will be documented in the medical record.	

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F 657	Continued From page 53 review and revise a care plan for 1 of 18 residents. The findings included: 1. For Resident #49 the facility staff failed to ensure that all members of the interdisciplinary team were included in the care plan process. Resident #49 was admitted to the facility on 03/23/18 and readmitted on 03/14/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, neurogenic bladder, diabetes mellitus, dementia, depression, chronic obstructive pulmonary disease, respiratory failure, end stage renal disease, atrial fibrillation and hypothyroidism. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/01/19 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. The surveyor spoke with Resident #49 on 04/30/19 at approximately 1430. Surveyor asked Resident #49 if she was invited to and attended her care plan meetings and she stated that she did. She also stated, "The last meeting I had, the only person who showed up was the kitchen girl, because I had been complaining about the food". Resident #49's clinical record was reviewed on 05/02/19. It contained a sign in sheet for a care plan meeting held on 04/04/19. The only staff signatures on the form were the unit nurse and a guest relations specialist (dietary staff). The concern of all members of the interdisciplinary team not participating in the care	F 657	4. The DON or designee will audit care plans 3 x weekly x 12 weeks and 5 x monthly x 6 months. Any variating in the requirement will be identified and shared with the team for correction. Data will be reported to the QAPI team. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 657	Continued From page 54 plan process was discussed with the administrative team during a meeting on 05/01/19 at approximately 1635. No further information was provided prior to exit.	F 657	F658 Providing services that meet professional standards is priority for the team at FMM	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and a medication pass and pour observation the facility staff failed to follow professional standards of practice for 3 of 18 residents (Resident #9, Resident #28 and Resident #54). The findings included: 1. For Resident #9 the facility staff failed to follow professional standards of practice for the administration of medications as evidenced by signing for a medication that was unavailable for administration. Resident #9 was admitted to the facility on 07/13/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension and schizophrenia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/10/19 coded the Resident as 3 of 15 in section C,	F 658	1. (a) Resident #9 had a change in the order of Claritin. The nurses were all counseled regarding signing off medication as given, when not available. Pharmacy was notified and medication was sent on 5/2. (b) Resident #28 was assessed upon her return from the ED on 1/18/19 as the documentation in the progress note demonstrated. Resident #28 was readmitted from a short stay at the hospital on 2/23/19. The record shows a Nursing Admission Assessment was completed upon resident return. (see appendix 1) (c) Resident #54 did not have a diagnosis associated with the medication on the written order. Both medications have associated diagnosis in the electronic medical record. Zoloft 50 mg is for depression and Ibuprofen BID is for pain. Orders were clarified on 5/22 to include the diagnosis.	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 658	Continued From page 55 cognitive patterns. This is a quarterly MDS. Surveyor observed LPN # 1 (licensed practical nurse) on 05/01/19 at approximately 0835 during a medication pass and pour. Surveyor observed LPN #1 prepare and administer the Residents medications. Surveyor reconciled the medications with the clinical record on 05/01/19 at approximately 0930. Resident #9's clinical record contained a signed physician's order summary for the month of May 2019, which read in part "Claritin Tablet 10 mg (Loratadine) Give 1 tablet by mouth one time a day for possible drug reaction". This order is listed as active with a start date of 03/28/19. The surveyor did not observe LPN #1 administer Claritin to the Resident. Resident #9's eMAR (electronic medication record) for the month of May 2019 was reviewed. It contained an entry, which read in part "Claritin Tablet 10 mg (Loratidine) Give 1 tablet by mouth one time a day for possible drug reaction". This entry was initialed as administered on 05/01/19 at 0900. Surveyor spoke with LPN #1 on 05/01/19 at approximately 1125. Surveyor asked LPN #1 if he had administered the Resident's Claritin, and he stated, "I'm sure I did". He then proceeded to check the medication cart for the Resident's Claritin. The Claritin could not be located in the medication cart. Surveyor spoke with the pharmacist on 05/01/19 at approximately 1450 regarding Resident #9's Claritin. Pharmacist stated the Claritin had not been sent to the facility since 03/26/19 and they	F 658	2. All residents have the potential to be affected by the same practice. (a) An audit will be conducted to ensure all medications are available as ordered. Any discrepancy will be reported to the pharmacy and/or physician for clarification and nursing leadership. (b) Licensed Nursing staff will be re-educated on the facility protocol for assessing a resident on return from the ED and/or hospitalizations (c) All Physician Order Sheets for the month of May have diagnoses associated with the medications. An audit will be conducted to check all orders written after the POS was signed in the month of May to ensure a diagnosis is associated with each medication. If deficient practice is found, the physician will be notified and will provide a clarification order. 3. (a) Team members will be re-educated proper procedure when medication is not available and	

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F 658	Continued From page 56 had received a discontinue order for the Claritin on 03/27/19. Surveyor reviewed the pharmacy manifest for the month of April and could not locate any deliveries of Claritin for Resident #9. Surveyor reviewed the pharmacy manifest for 03/26/19. It contained an entry that read in part, "Patient Name: ... (Resident #9), Description: Loratidine 10 mg, Quantity: 14, Status: Delivered". Resident #9's eMAR for the month of April 2019 was reviewed and contained an entry which read in part "Claritin Tablet 10 mg (Loratidine) Give 1 tablet by mouth one time a day for possible drug reaction -Start date- 03/28/19". This entry had been initialed as being administered for each day of the month. Surveyor spoke with the DON on 05/01/19 at approximately 1600 regarding Resident #9's Claritin. DON provided the surveyor with a copy of a physician's order dated 03/27/19, which read in part "Decrease Loratidine 10 mg qd (every day)". DON also provided the surveyor with a copy of a pharmacy recommendation dated 03/27/19, which read in part "2. Resident on BID (twice daily) loratadine, consider reducing to one daily". Surveyor asked the DON how the facility relays orders to the pharmacy, and DON responded, "The nurses input the orders in the computer from the handwritten orders in the paper chart". Surveyor informed the DON at this time that the medication, Claritin was not available in the medication cart to be administered, but the nurses had been signing for it. Surveyor also informed the DON that the medication had not been delivered from the pharmacy since	F 658	proper documentation on the MAR. (The physician will be notified to receive new orders, pharmacy and/or nurse leadership will be notified along with resident and resident representative). (b) A review of findings for assessments will be completed with nursing team and reinforcement of need for assessments upon any return to the facility. (c) Education will be reinforced to include diagnosis with every medication order received. 4. The DON or designee will audit (a) medication passes for five residents to ensure medications are available as ordered weekly x 12 weeks and monthly x 6 months. (b) An audit of all residents who transfer to and return from the ED will be conducted to ensure there is a mini-assessment documented in the progress note weekly x12 weeks and monthly x 6 months.	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 57 03/26/19. The surveyor requested a copy of the facility standards of practice for medication administration and the DON informed the surveyor on 05/03/19 that the facility does not have a one. According to "Lippincott Procedures Safe Medication Administration Practices, General" the nine rights of medication administration are: 1. Right Patient 2. The right medication 3. The right dose 4. The right time 5. The right route of administration 6. The right documentation 7. The right action 8. The right form 9. The right response The concern of not following professional standards of practice was discussed with the administrative team during a meeting on 05/02/19 at approximately 1625. No further information was provided prior to exit. 2. The facility staff failed to document an assessment after Resident #28 returned to facility from ER (emergency room) visits on 1/18/19 and 2/20/19. Resident #28 was readmitted to the facility on 2/23/19 with the following diagnoses, but not limited to atrial fibrillation, coronary artery disease, high blood pressure, renal failure, diabetes and arthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/19; the	F 658	(c) An audit of all new medication orders will be conducted to ensure a diagnosis is present with each medication weekly x 12 weeks and monthly x 6 months. Variances in the above audits will be investigated and correction made as appropriate. The DON/designee will monitor the audit results for trends and needed actions. Data will be reported to the QAPI team for further recommendations. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 658	Continued From page 58	F 658		

resident was code d as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #28 was also coded as only requiring supervision with dressing and limited assistance for personal hygiene and bathing.

The surveyor on 4/30 to 5/3 /19 conducted a clinical record review. The surveyor noted that the resident had been sent to the ER on 1/18 and 2/20/19. There was documentation in the nurses' progress notes dated for 1/18/19 at 1949 (7:49 pm) which read in part, " ...need to transfer resident r/t (related to) shortness of breathe-lower extremity edema." At 2215 (9:15 pm), there was documentation which read, " ...returned from _____ (name of hospital ER) via (by) stretcher via c-trans (C-transportation) Skin w/d (warm and dry) color good no new orders ..."

On 2/20/19 at 1730 (5:30 pm) the following was documented in the nurses' progress note: "This nurse was called to room-resident sitting in w/c (wheelchair) slumped posture-skin pasty gray in color and cyanotic around mouth; eyes glassy; no response to touch or verbal stimuli; pulse 88 respirations 20 O2 (oxygen) sat (saturation) 88% unable to obtain blood pressure; assisted back to bed." There was not an assessment of the resident when she was returned to the facility.

The surveyor notified the administrative team of the above documented findings on 5/1/19 at 4:45 pm and again on 5/3/19 at 3:52 pm in the conference room. The surveyor asked the DON (director of nursing) when a resident returns to the facility from being at the ER, would you expect your nurses' to perform an assessment and document in the nurses' progress notes. The

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F 658	Continued From page 59 DON stated, "Yes". The surveyor requested a copy of the facility's standard of practice concerning performing assessments of the resident that returns to the facility from the ER. On 5/3/19 at 4:30 pm, the surveyor notified the DON that the surveyor needed a standard of practice for nurses' performing assessments. The DON stated, "We have looked and I don't have one. But I do expect the nurses' to do assessments on the residents when they come back to us from the ER." No further information was provided to the surveyor prior to the exit conference on 5/3/19. 3. The facility staff failed to document a diagnosis for medications that the nurses' received as verbal orders from the physician for Resident #54. Resident #54 was admitted to the facility on 7/27/18 with the following diagnoses of, but not limited to anemia, dementia, anxiety disorder, depression, psychotic disorder and asthma. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/5/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #54 was also coded as requiring extensive assistance from 2 staff members for dressing, personal and is totally dependent on 2 staff members for bathing. The surveyor conducted a review of Resident #54's clinical record and noted that on the dates below, these medications did not have a diagnosis as to tell what the medication was being taken for:	F 658		

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F 658	Continued From page 60 " 5/1/19 " ... Zoloft 50 mg (milligram) po (by mouth) qd (every day) ..." " 3/22/19 " ...Start 800 mg Ibuprofen BID (twice a day) ..." The surveyor notified the DON (director of nursing) of the above documented findings in her office on 5/3/19 at 10 am. The surveyor requested a copy of the facility's policy or standard of practice that the facility uses as an expectation of the nursing staff and writing medication orders. At 3:52 pm, the surveyor notified the administrative team of the above documented findings. The surveyor did ask the DON if she had copies of the items documented above. The DON stated, "We don't have a standard or policy on how to write a verbal order." The surveyor asked the DON does she expect her staff to include a diagnosis when they are writing a verbal order for such. The DON stated, "Yes, this should be included on the order sheet." No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This	F 676	F676 Ensuring residents maintain their abilities and receive proper incontinence care is a priority for the team at FMM 1. Resident #53 experienced no infections or skin breakdown due to improper incontinence care. The two C.N.A.s were counseled and re-educated regarding incontinence care.	

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F 676	Continued From page 61 includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide incontinent care to 1 of 18 residents (Resident #53). The findings included: The facility staff failed to provide incontinence	F 676	2. All residents who are incontinent have the potential to be affected by the same practice. 3. The Skilled Nurse provided re-education to team members regarding proper continence care. 4. The DON or designee will conduct weekly audits to ensure team members are performing proper incontinence care. Audits will include 5 residents x 12 weeks and 10 x monthly for 6 months. Any variation in proper skills will be addressed at that time and counseling provided to that team member. Data will be reported to the QAPI team for further evaluation. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 676	Continued From page 62 care to Resident #53. The clinical record of Resident #53 was reviewed 4/30/19-5/3/19. Resident #53 was admitted to the facility 5/22/18 with diagnoses, that included but not limited to sepsis, pneumonia, chronic back pain, dementia, high cholesterol, GERD (gastroesophageal reflux disease), anxiety, hypertension, depression, fatigue, and tiredness. Resident #53's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/5/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #53 was not assessed with any signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #53 required extensive assistance of one person for toilet use. Resident #53 was assessed to be frequently incontinent of bladder and bowel. Current comprehensive care plan was undated but identified a focus area that the resident had ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, impaired balance, fatigue-has chronic intractable pain as well. Interventions: She requires extensive by 1 staff for toileting. A second focus area for incontinence was also undated and read that the resident has incontinence of bladder-dementia, impaired mobility. She has risk for UTI (urinary tract infection) and dx (diagnosis) of chronic kidney disease. Interventions: Clean peri-area with each incontinence episode. If in bed, offer bedpan or BSC (bedside commode), or toilet. She uses disposable diapers. Change prn (as needed). Wash perineum front to back.	F 676		

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F 676	Continued From page 63 The surveyor observed incontinence care with certified nursing assistant #1 on 5/2/19 at 7:01 a.m. C.N.A. #1 entered the resident's room without knocking on the door. When the surveyor knocked on the door, C.N.A. #1 turned around and stated to the surveyor she forgot to knock and then apologized. C.N.A. #1 closed the door and donned a pair of gloves. No handwashing observed prior to glove use. The privacy curtain was pulled on both side of the bed to about mid-bed. When C.N.A. #1 removed the brief, the surveyor observed the resident had been incontinent of urine. C.N.A. #1 removed the brief and placed a clean brief on Resident #53. C.N.A. #1 did not change gloves after removing the soiled brief and failed to provide incontinence care to the resident. C.N.A. #1 then covered the resident up with a blanket and raised the head of the bed. C.N.A. #1 had not changed or removed gloves after changing Resident #53's brief. C.N.A. #1 put the soiled brief in the trash can and removed the trashcan bag, tied it up, and replaced the liner with a clean one. She removed her gloves, walked down the hall to the soiled utility room, and threw away the trash bag. No handwashing or hand hygiene was observed when C.N.A. #1 left the resident's room. C.N.A. #1 then went into the clean utility, placed her pager in the charger, and then rolled the COW (computer on wheels) to the day room. C.N.A. #1 then went to the break room, got her lunch bag and clocked out. The surveyor informed the administrator at 8:00 a.m. of the above observation. The surveyor observed certified nursing assistant #2 in Resident #53's room on 5/2/19 at 9:36 a.m.	F 676		

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F 676	Continued From page 64 CNA #2 was starting to provide incontinent care. C.N.A. #2 had donned gloves on and removed the brief, which was soiled and placed in trashcan. C.N.A. #2 put a clean pull-up on the resident. No incontinence care was provided. Certified nursing assistant #3 came to assist C.N.A. #2. C.N.A. #3 applied gloves. No hand washing or hand hygiene observed prior to donning gloves. C.N.A. #3 assisted with the pull-up, pants, socks and shoes. The surveyor observed a pad and a towel in Resident #53's wheelchair. A gait belt was placed around the resident, then assisted to the side of the bed by both c.n.a.s, and then transferred to the wheelchair. Resident #53's top was changed. C.N.A. #2 took the trash out to the buggy and removed her gloves. The surveyor did not observe handwashing or hand hygiene after C.N.A. #2's gloves were removed. C.N.A. #3 removed her gloves and then combed the resident's hair and then washed her hands after combing hair and left the room. C.N.A. #2 pushed the resident to the hallway. Mouth care not provided. No hand washing after care. C.N.A. #2 then went to the roommate and was observed touching the over the bed table and conversing with the resident. Before C.N.A. #2 exited the room, hands were washed. The surveyor interviewed certified nursing assistant #2 on 5/2/19 at 10:00 a.m. about the care provided and observations made by the surveyor. C.N.A. #2 stated, "I forgot." The surveyor informed the administrator and the director of nursing (DON) of the above concern on 5/2/19 at 4:34 p.m. and requested information on perineal/incontinence care. The DON was asked if incontinence care should have been	F 676		

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 676	Continued From page 65 done after the removal of the soiled brief. The DON stated yes. The surveyor reviewed the Perineal Care skill sheet on 5/3/19. The skill sheet read "Overview: Perineal care involves a thorough cleansing of the patient's external genitalia and surrounding skin. Gloves must be worn during perineal care because of the risk of contracting an infection. Patients who are incontinent of urine or stool require more frequent perineal care. Perineal cleansing is performed with soap and water. Female Perineal Care 1. Perform hand hygiene and don gloves. 2. Introduce yourself to the patient. 10. b. Using a clean washcloth or perineal wipe, wipe from the perineum to the rectum (front to back). Repeat this process on the opposite side, using a new washcloth or perineal wipe. C. Rinse and dry the area thoroughly. 18. Discard supplies, remove gloves and perform hand hygiene." No further information was provided prior to the exit conference on 5/3/19. This is a complaint deficiency.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 677	F677 Providing ADL care for dependent residents is a priority for the team at FMM 1. The C.N.A. caring for resident #53 will be counseled regarding proper oral care for residents. Resident #53 is expressing no complaints with her oral cavity.	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 677	Continued From page 66 document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide mouth care to 1 of 18 residents (Resident #53). The findings included: The facility staff failed to provide mouth care to Resident #53. The clinical record of Resident #53 was reviewed 4/30/19-5/3/19. Resident #53 was admitted to the facility 5/22/18 with diagnoses, that included but not limited to sepsis, pneumonia, chronic back pain, dementia, high cholesterol, GERD (gastroesophageal reflux disease), anxiety, hypertension, depression, fatigue, and tiredness. Resident #53's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/5/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #53 was not assessed with any signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #53 required extensive assistance of one person for toilet use. Resident #53 was assessed to be frequently incontinent of bladder and bowel. Section L Oral/Dental Status was coded for mouth or facial pain, discomfort or difficulty with chewing. Current comprehensive care plan was undated but identified a focus area that the resident had ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, impaired balance, fatigue-has chronic intractable pain as well. Interventions: Oral Care Routine [AM (morning)/HS (bedtime)]: Staff will supervise	F 677	2. All residents are have the potential to be affected by the same practice. 3. The Skilled Nurse will re-educate team members regarding proper oral care. 4. The DON or designee will conduct weekly audits to ensure team members are performing proper oral care. Audits will include 5 residents x 12 weeks and 10 x monthly for 6 months. Any variation in proper skills will be addressed at that time and counseling provided to that team member. Data will be reported to the QAPI team for further evaluation. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 677	Continued From page 67	F 677		

her to brush and rinse her natural teeth twice daily as needed during the day. A second focus area was for oral/dental health problems r/t (related to) poor oral hygiene, Alzheimer's, cognition. Interventions: Provide mouth care as needed at least 2 times daily as tolerated.

The surveyor observed certified nursing assistant #2 in Resident #53's room on 5/2/19 at 9:36 a.m. CNA #2 was starting to provide incontinent care. Upon completion of incontinence care and dressing Resident #53, C.N.A. #2 pushed the resident to the hallway. Mouth care was not offered and not provided. No hand washing after care. C.N.A. #2 then went to the roommate and was observed touching the over the bed table and conversing with the resident. Before C.N.A. #2 exited the room, hands were washed.

The surveyor interviewed Resident #53 after being placed in the hall. The resident was asked if her teeth had been brushed. (Breakfast had already been completed and the trays removed from the rooms). Resident #53 stated, "I don't think so."

The surveyor interviewed certified nursing assistant #2 on 5/2/19 at 10:00 a.m. about the care provided and observations made by the surveyor. C.N.A. #2 stated, "I forgot."

The surveyor informed the administrator and the director of nursing (DON) of the above concern on 5/2/19 at 4:34 p.m. and requested information on mouth care provided to Resident #53 the previous 2 months and information on mouth care.

The surveyor was provided the oral care report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 68 for the previous 2 months. Oral care was provided three times in the past 2 months--4/7/19, 4/21/19, and 5/2/19. The surveyor reviewed the Oral Hygiene Skills Quick Sheet on 5/3/19. The quick sheet read in part, "Frequency of oral care should be based on the condition of the patient's oral cavity and his or her level of comfort. 8. Perform hand hygiene and don gloves. 9. Explain the procedure to the patient and ensure that he or she agrees to treatment. 16. Apply toothpaste to toothbrush bristles while holding the brush over the emesis basin. Pour a small amount of water over the toothpaste. 17. Brush the patient's teeth or assist the patient in brushing. 19. Allow the patient to rinse the mouth thoroughly with water. 20. Allow the patient to floss between all teeth. 21. Have the patient rinse the teeth with therapeutic mouth rinse, and then spit the rinse into the emesis basin. 26. Discard supplies, remove gloves, and perform hand hygiene. No further information was provided prior to the exit conference on 5/3/19. This is a complaint deficiency.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695	F695 Following physician orders for the administration of oxygen is a priority for the team at FMM 1. Residents #27 and #28 have not experienced any ill effects from their oxygen being set on 1 ½ instead of 2 and 2 instead of 3 liters. Nurses caring for the residents will be counseled on the importance of having the oxygen set per the physician's order.	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

(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 69 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure physician's orders were followed for the administration of oxygen for 2 of 18 residents in the survey sample (Resident #27 and #28). The findings included: 1. The facility staff failed to follow physician orders for the administration of oxygen to Resident #27. Resident #27 was admitted to the facility on 5/18/17 with the following diagnoses of, but not limited to renal failure, neurogenic bladder, diabetes, arthritis, Stage 3 pressure ulcer, high blood pressure and depression. On the quarterly MDS (Minimum Data Set) with an ARD of 3/3/19, the resident's BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #27 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and was totally dependent on 1 staff member for bathing. On 4/30/19 at 10:25 am, the surveyor observed the resident's oxygen was at 1 1/2 l/min via NC (nasal cannula). The surveyor asked RN (registered nurse) #1 to come to the resident's room and check to see if the oxygen was being administrated per physician order. RN #1 stated, "This is supposed to be on 2 l/min." RN #1 adjusted the oxygen so that it would administer 2	F 695	2. All residents who utilize oxygen have the potential to be affected by the same practice. So, an audit is being conducted to ensure oxygen is set on the proper settings for all residents. When needed, education will be provided. 3. Team members will be responsible for checking oxygen settings at the first of the shift during rounds. Any variances will be reported to the charge nurse for investigation and correction. 4. The DON or designee will observe oxygen setting for five residents 4 x weekly x 12 weeks and 4 x monthly thereafter. If the oxygen is not on the correct setting, the variance will be investigated, corrected and the nurse will be counseled. Data will be reported to the QAPI team. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 695	Continued From page 70 l/min and would follow the physician's order. The surveyor reviewed Resident #27's clinical record on 4/30/19. According to the physician's order, the resident was to oxygen on at 2 l/min by nasal cannula. The surveyor notified the administrative team of the above documentation on 5/1/19 at 4:45 pm and again on 5/3/19 at 3:52 pm. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 2. The facility staff failed to follow physician's order for the administration of oxygen to Resident #28. Resident #28 was readmitted to the facility on 2/23/19 with the following diagnoses, but not limited to atrial fibrillation, coronary artery disease, high blood pressure, renal failure, diabetes and arthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #28 was also coded as only requiring supervision with dressing and limited assistance for personal hygiene and bathing. During the initial tour on 4/30/19 at 10:35 am, the surveyor observed the resident sitting in her wheelchair and reading a book. The surveyor checked the oxygen to see if was on the right settings and according to the physician's order. The oxygen was being administrated at 2 l/min (liters/minute) by nasal cannula. CNA (certified	F 695		

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F 695	Continued From page 71 nursing assistant) #1 stated it should be at 3 l/min. CNA #1 adjusted the flow of the oxygen so that it would correct. The surveyor reviewed the clinical record for Resident #28 on 4/30/19. The physician had ordered the oxygen to be administrated at 3 l/min by nasal cannula. The surveyor notified the administrative team of the above documented findings on 5/1/19 at 4:45 pm and again on 5/3/19 at 3:52 pm. No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to coordinate care with the contracting dialysis center for 2 of 18 Residents, Resident #49 and Resident #13. The findings included: 1. For Resident #49 the facility staff failed to completed dialysis communication forms. Resident #49 was admitted to the facility on	F 698	F698 Completing dialysis communication forms is a priority for the team at FMM 1. Residents #13 and #49 have not experienced any ill effects from the communication forms not being completely filled in. However, all charge nurses have been re-educated regarding the importance of completing the communication forms in full. Communication forms are being completed and sent to dialysis with the residents.	

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F 698	Continued From page 72 03/23/18 and readmitted on 03/14/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, neurogenic bladder, diabetes mellitus, dementia, depression, chronic obstructive pulmonary disease, respiratory failure, end stage renal disease, atrial fibrillation and hypothyroidism. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/01/19 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #49's CCP (comprehensive care plan) was reviewed and contained a care plan for "Chronic renal failure. Return admission to ... (facility name omitted), will receive dialysis outside facility on Monday, Wednesdays and Fridays, via subclavian tunneled hemodialysis catheter". Interventions for this care plan include "observe subclavian catheter site for erythema, edema, drainage, dressing per order", "observe site for drainage, redness, secured in place, patent", and "vital signs per order, notify MD of significant abnormalities". Resident #49's clinical record was reviewed on 05/01/19. It contained a signed physician's order dated 03/14/19, which read in part "Pt (patient) to dialysis Monday, Wed, Friday". Resident #49's "Dialysis Treatment Report" forms were reviewed on 05/02/19. The forms were incomplete for the "return to facility" section on all forms. This section contains information on vital signs, appearance of access site and date/time of return to facility. The forms were incomplete for the "prior to departure" section on the forms dated, 03/25/19, 03/27/19, 04/01/19, 04/05/19,	F 698	2. All residents who take dialysis have the potential to be affected by the same practice. 3. Nurses will be educated regarding the importance of fully completing the dialysis communication form. 4. The DON or designee will audit forms for completion for two residents weekly x 12 weeks and monthly for six months. If the forms are incomplete, the variance will be investigated, corrected and the nurse will be counseled. Data will be reported to the QAPI team. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 698	Continued From page 73 04/10/19, 04/19/19, 04/24/19, and 04/29/19. This section contains information on weight, vital signs, appearance of access site and date/time of departure from facility. The concern of the incomplete dialysis forms was discussed with the administrative team during a meeting on 05/01/19 at approximately 1625. No further information was provided prior to exit. 2. The facility staff failed to complete the dialysis communication sheets for Resident #13. The clinical record of Resident #13 was reviewed 4/30/19 through 5/3/19. Resident #13 was admitted to the facility 9/5/18 with diagnoses, that included but not limited to end stage renal disease (ESRD), volume overload, hypertension, anemia, hyperphosphatemia, left shoulder arthritis, chronic respiratory failure, type 2 diabetes mellitus, deconditioning, depression, hypothyroidism, peripheral neuropathy, and history of CVA (cerebrovascular accident). Resident #13's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/15/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Dialysis was marked in Section O Special Treatments, Procedures and Programs. Current comprehensive care plan initiated 5/30/18 and revised on 2/26/19 identified the focus area that read the resident is at risk for volume overload-receives dialysis Monday, Wednesday, Friday. Interventions: Dialysis is scheduled for Monday, Wednesday, and Friday. Kitchen to prepare and send lunch for scheduled	F 698		

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F 698	Continued From page 74 dialysis days. Obtain weight and vital signs before dialysis and again once returned. Resident #13's May 2019 physician orders read in part "HD (hemodialysis) Monday, Wednesday, and Friday at frenius (spelling) and assess for bruit and thrill in (R) (right) arm dialysis shunt q shift (every shift)." The surveyor reviewed the "Dialysis Treatment Reports" for March, April, and May 2019. The 3/1/19 dialysis treatment report did not have documentation of the access site appearance, dialysis site location or weight as ordered documented. The 3/8/19 dialysis treatment report did not have documentation of vital signs (Blood pressure, temperature, pulse, and respiration) upon return to the facility. The 3/13/19 dialysis treatment report did not have weight, vital signs, dialysis access location marked or access site appearance documented. The 3/18/19 dialysis treatment report did not have documentation of weight, vs, access site location, or access site appearance, time, date, and signature of the nurse when the resident returned from dialysis. The 3/21/19 dialysis treatment report did not include dialysis site location, access site appearance, or weight when the resident returned from dialysis. The dialysis center failed to document the access site appearance, time, date and signature of the nurse. The 3/22/19 dialysis treatment report did not include vital signs upon return, weight upon return, dialysis access site and the site assessment, time, date, and signature of the nurse upon return to the facility. The 4/5/19 dialysis treatment report did not	F 698		

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F 698	Continued From page 75	F 698		

include vital signs or weight upon return to the facility.
The 4/15/19 dialysis treatment report did not include vital signs or weight upon return to the facility.
The 4/19/19 dialysis treatment report did not include vital signs or weight upon return to the facility, dialysis access site location, or access site appearance.
The 4/22/19 dialysis treatment report did not include vital signs or weight upon return to the facility, dialysis access site location, access site appearance, time, date and signature of the receiving nurse at the facility.
The 4/24/19 dialysis treatment report did not include vital signs or access site appearance upon return to the facility.
The 4/29/19 dialysis treatment report did not include vital signs or weight upon return to the facility, dialysis access site location, access site appearance, time, date and signature of the receiving nurse at the facility.

The surveyor informed the administrator and the director of nursing of the incomplete dialysis treatment reports in the end of the day meeting on 5/2/19 at 4:34 p.m. and requested the facility policy on dialysis and the dialysis contract.

The surveyor reviewed the facility's dialysis contract on 5/3/19. The contract titled "Outpatient Dialysis Services Agreement" read in part "5. The Dialysis Unit will conform to standards not less than those required by any applicable laws and regulations of any local, state or federal regulatory board, as the same may be amended from time to time. C. To establish, modify and implement, policies and procedures concerning the administration of the ESRD Dialysis Unit

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F 698	Continued From page 76 including, purchasing, personnel staffing, inventory control, equipment maintenance, accounting, legal, data processing, medical record keeping, laboratory, billing, collection, public relations, insurance, cash management, scheduling, and hours of operation. No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 698		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide adequate mental health services/interventions for 1 of 18 residents in the survey sample (Resident #45). The findings included: The facility staff failed to provide mental health services/interventions for Resident #45 when she had expressed having suicidal thoughts. Resident #45 was admitted to the facility on 7/23/28 with the following diagnoses of, but not	F 742	F742 Providing mental health services for residents is a priority for the team at FMM 1. Resident #45 has a history of expressing suicidal ideations when frustrated or homesick. When interviewed, Resident #45 states that the suicidal ideation was not meant and realizes the need to stop expressing frustrations in that manner. Resident #45 currently is being seen by a LCSW for counseling services. 2. All residents who express suicidal ideations have the potential to be affected by the same practice.	

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F 742	Continued From page 77 limited to anemia, high blood pressure, diabetes, dementia and anxiety disorder. On the quarterly MDS (Minimum Data Set) with an ARD of 3/27/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #45 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and was totally dependent on 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #45 on 5/1/19. In the "Care Focus" documentation dated for 2/27/19, the surveyor noted under the area of "Review area(s) of Concern", it read in part: o " ...02/26 nurse called to res (resident) room by CNA (certified nursing assistance), CNA stated that the res told her she wanted to kill herself (by grabbing) her own throat) when she had asked her to pull herself up in bed but when nurse walked in res was sitting on the toilet and noted to be crying ..." The Care Focus sign in sheet had the following signatures that were in attendance: assistant director of nursing, dietitian, wound care nurse #1, director of nursing, activities coordinator and MDS (minimum data set) nurse #1. Under the section "Interdisciplinary Recommendation" of the Care Focus documentation, the following recommendation/interventions were suggested: o " ...freq (frequent visual checks made ..." The surveyor also noted the following documentation dated for 2/26/19 at 2130 (9 pm) which reads, " ...Called to res room by CNA, CNA	F 742	3. Team members will be educated to contact the resident representative, physician and the administrator on call when a resident expresses suicidal ideations. The notifications will be documented in the record. Orders will be received from the physician and a plan will be initiated to ensure the safety of the resident. The Physician and/or Social Worker will follow up the next working day to determine if further intervention is needed. 4. The Assistant Nurse Managers or designee will review the 24 hour report for any indication of residents expressing suicidal ideations. An audit will be conducted whenever a resident expresses suicidal ideations to ensure no variations in the plan. If a variation occurs, an investigation will be conducted and disciplinary action will be taken. These audits will be ongoing for six months, as	

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F 742	Continued From page 78 stated that res had told her she wanted to kill herself (by grabbing her own throat) when she had asked her to pull herself up in bed but when this nurse walked in res was sitting on toilet and noted to be crying upon questioning res res stated she didn't know why she was crying but states, I just want to go home encouraged res to keep doing her therapy ad she would be able to go home soon ...No suicidal actions were noted for the few minutes I was in the room ...(sic)" Resident #45's care plan did not reflect a focus area or interventions to be utilized by the staff in regards to the resident having suicidal thoughts. On 3/6/19, the surveyor noted a physician order for "Buspar 10 mg (milligram) po (by mouth) BID (twice a day)". On 3/9/19, the physician progress note read in part " ...Episodes of screaming out crying/anxious ... There was no documentation in the clinical record that mental health services had been notified of the above documented findings. The surveyor notified the administrative team of the above documented findings on 5/1/19 at 4:45 pm. The surveyor asked if the staff notified the physician and mental health services of Resident #45's suicidal thoughts. The administrator stated, "When the staff went back to talk to the resident, the resident said she didn't know why she did that. This is why the physician was not notified." The surveyor was given a copy of a progress note that the social worker had documented for 5/1/19 at 2056 (8:56 pm). It read as follows: o SW (social worker) on first floor and interviewed _____ (name of resident). She	F 742	needed, and results will be reported to the QAPI team for further interventions. 5. Corrective action will be complete by 06/07/19. 6. Assistant Nurse Manager or designee	

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F 742	Continued From page 79 remembers me. SW explains that in the past she had stated she wanted to die and she put her hands around her neck. She remembers that and states yes and I think I said that one time in the hospital too. SW asked if she would really harmed herself when she stated this. She stated no SW asked if she felt like harming herself at this time. She also no and stated she likes having a room by herself. SW asked how she likes the first floor and she stated she liked it. SW to monitor." The surveyor was also given a copy of a physician order dated for 5/2/19 at 1310 (1:10 pm) which stated, "Consult with _____ (name of counseling services). No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 742		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755	F755 Ensuring the physician ordered medication is available for administration is a priority for the team at FMM 1. Resident #13 received no ill effects from the practice. Follow up blood work done on 5/23/19 revealed a potassium level of 4.9 and normal range is 3.5-5.1. 2. All residents have the potential to be affected by the same practice.	

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F 755	Continued From page 80 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure physician ordered medication was available for administration for 1 of 18 residents (Resident #13). The findings included: The facility staff failed to ensure the physician ordered medication Veltassa was available for administration for Resident #13. The clinical record of Resident #13 was reviewed 4/30/19 through 5/3/19. Resident #13 was admitted to the facility 9/5/18 with diagnoses, that included but not limited to end stage renal disease (ESRD), volume overload, hypertension, anemia, hyperphosphatemia, left shoulder arthritis, chronic respiratory failure, type 2 diabetes mellitus, deconditioning, depression, hypothyroidism, peripheral neuropathy, and history of CVA (cerebrovascular accident).	F 755	3. Nursing will be educated to notify the physician for follow up orders, notify resident, resident representative and nursing leadership. The pharmacy will be notified to send meds or obtain from the back-up pharmacy. 4. Assistant Nurse Managers or designee will review up to five new medications for availability per week for 12 weeks and then five monthly for 6 months. If variation is found, an investigation will be initiated and corrections made to the process or education given. Audit results will be reported to the QAPI team for further interventions. 5. Corrective action will be complete by 06/07/19. 6. Assistant Nurse Manager or designee	

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FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, PO BOX 880 MARION, VA 24354

(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 755	Continued From page 81 Resident #13's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/15/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Dialysis was marked in Section O Special Treatments, Procedures and Programs. Current comprehensive care plan initiated 5/30/18 and revised on 2/26/19 identified the focus area that read the resident is at risk for volume overload-receives dialysis Monday, Wednesday, Friday. Interventions: Administer medications as ordered, refer to MAR (medication administration record). The May 2019 physician's orders were reviewed. Resident #53 had orders dated 4/22/19 for Veltassa Packet 8.4 GM (grams) Give 1 packet by mouth one time a day every Tue, (Tuesday), Thu (Thursday), Sat (Saturday), Sun (Sunday) for supplement. Order date 4/22/19 Start date 4/23/19. The surveyor reviewed the April 2019 electronic medication administration record. Veltassa had been entered on the April 2019 eMAR. The 4/23/19 box for administration of Veltassa was marked "NA RCS". 4/23/19 was the start date of the medication. The 4/23/19 08:04 progress note read "Veltasssa Packet 8.4 GM new order not rec'd (received) from pharmacy Give 1 packet by mouth one time a day every Tue, Thu, Sat, Sun for supplement." There was no documentation the physician had been informed that the medication was not available for administration.	F 755		

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F 755	Continued From page 82 The surveyor informed the administrator and the director of nursing of the medication Veltassa not available for administration in the end of the day meeting on 5/3/19 at 4:34 p.m. The surveyor asked the director of nursing what pharmacy was their back up. The DON stated "Walgreens." The surveyor requested the pharmacy manifest for Veltassa and Resident #13's most recent potassium level. The surveyor reviewed the pharmacy manifest on 5/3/19. Veltassa (quantity 4) was delivered on 4/24/19. Resident #13's potassium level obtained 4/17/19 was 5.9 (normal range 3.5-5.1). The DON stated the dialysis center had drawn the laboratory test. Resident #13 received Veltassa on 4/25/19. No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757	F757 Ensuring residents are free of any unnecessary medications is a priority for the team at FMM 1. Resident #13 and #53 received no ill effects from the practice. Team members involved will be counseled regarding administering medications as directed by the physician.	

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F 757	Continued From page 83 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 18 residents were free of an unnecessary medication (Resident #13 and Resident #53). The findings included: 1. The facility staff failed to follow the physician orders for accuchecks with insulin parameters for Resident #13. The facility staff failed to obtain an accucheck on 4/2/19 at 6:00 a.m. The amount of sliding scale insulin was determined by the blood sugar (accucheck) result. The clinical record of Resident #13 was reviewed 4/30/19 through 5/3/19. Resident #13 was admitted to the facility 9/5/18 with diagnoses, that included but not limited to end stage renal disease (ESRD), volume overload, hypertension, anemia, hyperphosphatemia, left shoulder arthritis, chronic respiratory failure, type 2 diabetes mellitus, deconditioning, depression, hypothyroidism, peripheral neuropathy, and history of CVA (cerebrovascular accident). Resident #13's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/15/19 assessed the resident with a BIMS (brief interview for mental	F 757	2. All residents with parameters associated with the medication have the potential to be affected by the same practice. An audit will be conducted to ensure all parameters have been transcribed to the MAR appropriately. 3. Nursing will be re-educated to follow physicians orders related to parameters. 4. The Skilled Nurse or designee will audit ten medications with parameters three times weekly for twelve weeks and then ten per month for six months. The Skilled Nurse will provide education to the team members as needed, if a variance occurs. She will monitor for trends. Audit results will be reported to the QAPI team for further interventions. 5. Corrective action will be complete by 06/07/19. 6. Skilled Nurse or designee	

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F 757	Continued From page 84	F 757		

status) as 15/15. Dialysis was marked in Section O Special Treatments, Procedures and Programs.

Current comprehensive care plan initiated 5/30/18 and revised on 11/7/18 identified the focus area that read the resident has diabetes mellitus type 2. Interventions: Diabetes medication as ordered by doctor, see MAR (medication administration record), observe for side effects and effectiveness. Resident requests to not be removed from day room/social setting to go to their room for accuchecks and med (medication) administration.

The April 2019 physician's orders read in part "Lispro Solution 100 units/ml Inject as per sliding scale:
If 151-200=1 unit
201-250=2 units
251-300=3 units
301-350=4 units
351-400=15 units, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with other diabetic kidney complication. Start date 3/12/19 D/C Date 4/7/12/2019."

The 4/2/19 0600 blood sugar box did not have a recorded blood sugar or the nurse's initials.

The 4/2/19 0600 blood sugar was not obtained. There was no recorded blood sugar result on the summary form, on the April 2019 eMAR or in the 4/2/19 progress notes. The surveyor informed licensed practical nurse #1 of the concern on 5/2/19.

The surveyor informed the administrator and the director of nursing of the above issue with

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F 757	Continued From page 85 diabetic management on 5/2/19 at 4:32 p.m. and asked for the facility policy on diabetes. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 2. The facility staff failed to hold Resident #53's antihypertensive medication Losartan on 2/10/19. The facility staff failed to follow the physician ordered parameters for the administration of Losartan. The clinical record of Resident #53 was reviewed 4/30/19-5/3/19. Resident #53 was admitted to the facility 5/22/18 with diagnoses, that included but not limited to sepsis, pneumonia, chronic back pain, dementia, high cholesterol, GERD (gastroesophageal reflux disease), anxiety, hypertension, depression, fatigue, and tiredness. Resident #53's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/5/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #53 was not assessed with any signs or symptoms of delirium, psychosis, or behaviors that affected others. Current comprehensive care plan was undated but identified a focus area that the resident had altered cardiovascular status r/t (related to) hypertension, history of hyperlipidemia. Interventions: Administer medications as ordered by MD (medical doctor). The February 2019 physician order included an order for Losartan 25 mg (milligrams) Give 1 tablet by mouth one time a day [Hold Losartan if SBP (systolic blood pressure) < (less than) 110].	F 757		

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F 757	Continued From page 86 The surveyor reviewed the February 2019 electronic medication administration record. On 2/10/19 at 0830, Resident #53 was administered the Losartan. The recorded BP was 89/60. Based on the recorded BP and the physician order, the medication Losartan should have been held. The box that indicated a medication had been administered was checked. The surveyor informed the administrator and the director of nursing of the above concern on 5/1/19 at 4:36 p.m. No further information was provided prior to the exit conference on 5/3/19.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, 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;	F 758	F758 Ensuring residents are free of any unnecessary psychotropic medications (or PRN use) is a priority for the team at FMM 1. Resident #13, #43, #16, #27, #61 and #54 received no ill effects from the practice. Behavior observation sheets will be done for each of the residents to ensure psychotropic medication use is still warranted.	

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F 758	Continued From page 87 §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 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 6 of 18 residents were free of an unnecessary psychotropic medication (Resident #13, Resident #43, Resident #16, Resident #27, Resident #54, and Resident #61). The findings included: 1. The facility staff failed to monitor the use of	F 758	2. All residents receiving a psychotropic medication have the potential to be affected by the same practice. An audit will be conducted to ensure all behavior observation summaries are in place to determine if the psychotropic medications being used are needed. 3. Nursing team members will be re-educated to complete the behavior observation weekly summary sheets completely. The care plans will be updated when a medication is started and reviewed on a quarterly basis to ensure identified targeted behaviors and non-pharmacological interventions prior to the use of psychotropic medications are included. 4. The DON or designee will conduct weekly audits of ten records of residents receiving psychotropic medications to ensure the behavior observation weekly summary sheets are	

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F 758	Continued From page 88 Sertraline (an antidepressant) for Resident #13. The clinical record of Resident #13 was reviewed 4/30/19 through 5/3/19. Resident #13 was admitted to the facility 9/5/18 with diagnoses, that included but not limited to end stage renal disease (ESRD), volume overload, hypertension, anemia, hyperphosphatemia, left shoulder arthritis, chronic respiratory failure, type 2 diabetes mellitus, deconditioning, depression, hypothyroidism, peripheral neuropathy, and history of CVA (cerebrovascular accident). Resident #13's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/15/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. No signs or symptoms of delirium, psychosis, or behaviors that affected others were assessed. Section D Mood was assessed with zero on the total severity score. Current comprehensive care plan initiated 5/30/18 and revised on 11/21/18 identified that Resident #13 uses an antidepressant medication to control episodes of depression. His depression is contributed to end stage renal disease. His wife is unable to care for him at home. Interventions: Administer antidepressant medications as ordered by physician, refer to MAR (medication administration record). Observe/document side effects and effectiveness q shift (every shift). Allow him to talk and express his feelings when having s/s (signs/symptoms) of depression. He participates in therapy from a counseling service. Notify physician if current medications are ineffective or if depression worsens.	F 758	completed accurately and that the care plan has been updated to reflect targeted behaviors and non-pharmacological interventions prior to the use of psychotropic medications. Weekly audits for 12 weeks and then ten monthly for 6 months. If variation is found, an investigation will be initiated and corrections made to the process or education given. Audit results will be reported to the QAPI team for further interventions. 5. Corrective action will be complete by 06/07/19. 6. DON or designee	

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F 758	Continued From page 89 Resident #13's May physician orders included the order for Sertraline 75 mg (milligrams) by mouth one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) related to Major Depressive Disorder Order date 10/25/18 Start Date 10/26/18 and Sertraline 75 mg (milligrams) by mouth one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday), Sun (Sunday) related to Major Depressive Disorder Order date 10/25/18 Start Date 10/27/18. The surveyor reviewed the "Behavior Observation Weekly Summary" forms from February 2019 through May 2019. The behavior observation weekly summaries were not done the week of 3/21/19, 3/28/19, 4/4/19, 4/11/19 and 4/18/19. The surveyor reviewed the February 2019 electronic medication administration records (eMAR), the March 2019 eMAR, April 2019 eMAR and May 2019 eMAR and the nurse's progress notes from February 2019 through May 2019 and found no documentation of behavior monitoring to include effects, side effects, and non- pharmacological interventions. The current comprehensive care plan did not identify targeted behaviors or non-pharmacological interventions prior to the use of the medication. The surveyor informed the administrator and the director of nursing of the above concern with failure to monitor the use of Sertraline, identify targeted behaviors and include non-pharmacological interventions on the care plan on 5/3/19 at 3:52 p.m. No further information was provided by the facility prior to the exit conference on 5/3/19.	F 758		

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F 758	Continued From page 90 2. The facility staff failed to monitor the use of Haldol and Ativan (used for anxiety) for Resident #43. The clinical record of Resident #43 was reviewed 4/30/19 through 5/3/19. Resident #43 was admitted to the facility 11/28/18 with diagnoses that included but not limited to DVT (deep vein thrombosis), hyponatremia, thrombocytopenia, leukocytosis, peripheral artery disease, CAD (coronary artery disease), obesity, TIA (transient ischemic attack), BPH (benign prostatic hypertrophy), acute bronchitis, atrial fibrillation, constipation, hypertension, and pacemaker. Resident #43's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/25/19 assessed the resident with a BIMS (brief interview for mental status) as 00/15. Resident #43 had no assessed signs or symptoms of delirium, psychosis, or behaviors that affected others. Section D Mood assessed the resident with a total severity score of 9. Resident #43's current comprehensive care plan (undated) identified the focus area that read the resident uses psychotropic medications-antipsychotic medication r/t (related to) agitation and anxiety. Interventions: Administer psychotropic medications as ordered by physician, observe for side effects and effectiveness, consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate at least quarterly, discuss with MD, family re: ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their	F 758		

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F 758	Continued From page 91 effectiveness. Observe prn (as needed) any adverse reactions of psychotropic medications. The current comprehensive care plan also identified the issue of mood problem r/t disease process of CVA. Interventions: Administer medications as ordered, refer to MAR (medication administration record), encourage him to talk about his thoughts and feelings, and observe/record/report to MD prn mood patterns, s/s (signs/symptoms) of depression, anxiety, and sad mood. Resident #43's May 2019 physician's orders included Ativan tablet 0.5 mg (milligrams) Give 1 tablet by mouth at bedtime for agitation (order date 1/26/19 start date 1/26/19) and Haloperidol Lactate Concentrate 0.25 ml (milliliter) by mouth three times a day for agitation and anxiety and Haloperidol Lactate Concentrate 0.25 ml by mouth at bedtime for agitation and anxiety (order date 1/21/19, start dated 1/21/19). The current comprehensive care plan did not specify targeted behaviors for the use of Haldol and Ativan, non-pharmacological interventions prior to the administration of each, and weekly monitoring of the psychotropic medications per the Behavior Observation Weekly Summary. Only one summary was done from January through May 2019 and that one was done 3/7/19. The surveyor informed the administrator and the director of nursing of the concern with the lack of behavior monitoring and care plan without targeted behaviors for the use of Ativan and Haldol in the end of the day meeting on 5/3/19 at 3:52 p.m.	F 758		

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F 758	Continued From page 92 No further information was provided prior to the exit conference on 5/3/19. 3. The facility failed to document accurately on the behavioral monitor sheets for Resident #16. Resident #16 was readmitted to the facility on 11/14/17 with the following diagnoses of, but not limited to anemia, diabetes, stroke, dementia, seizure disorder, anxiety disorder, depression and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/18/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 4 out of a possible 15. Resident #16 was also coded as requiring extensive assistance of 1-2 staff members for dressing, personal hygiene and coded as being totally dependent on 1 staff member for bathing. During the clinical record review on Resident #16, the surveyor noted the following on the weekly behavioral monitoring sheets: " 4/26/19 and 4/12/19 " ...2. Current MD (medical doctor) order and diagnosis for each psychoactive med (medication) ordered ..." The box under this only has Klonopin listed without a diagnosis. " 4/5/19 and 3/29/19 " ...Current MD order and diagnosis for each psychoactive med ordered ..." The box under this only has Klonopin and Paxil listed. There were no diagnosis listed with these two medications. " 3/22/19 " ...B. Behaviors and Side effects ...7. Paranoia (describe below) ..." was marked by the staff but there was no description of this behavior. " 3/15/19 and 3/1/19 " ...2. Current MD (medical doctor) order and diagnosis for each	F 758		

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F 758	Continued From page 93	F 758		

psychoactive med (medication) ordered ..." The box under this only has Klonopin listed without a diagnosis.

The surveyor reviewed the MAR (medication administration record) for March and April 2019. The resident was receiving Klonopin 0.5 mg (milligram) two times a day for dementia/agitation, Paxil 30 mg two times a day for major depressive disorder and Quetiapine 25 mg at bedtime for dementia with behavioral disturbance.

The surveyor notified the DON (director of nursing) of the above documented findings on 5/2/19 at approximately 11 am. The DON stated, "No they didn't put a diagnosis in that section of the medications."

The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm in the conference room.

No further information was provided to the surveyor prior to the exit conference on 5/3/19.

4. The facility staff failed to document accurately on the behavioral monitor sheets for Resident #27.

Resident #27 was admitted to the facility on 5/18/17 with the following diagnoses of, but not limited to renal failure, neurogenic bladder, diabetes, arthritis, Stage 3 pressure ulcer, high blood pressure and depression. On the quarterly MDS (Minimum Data Set) with an ARD of 3/3/19, the resident's BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #27 was also coded as requiring extensive assistance of 1 staff member for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 94 dressing and personal hygiene and was totally dependent on 1 staff member for bathing. During the clinical record review on 5/1 to 5/3/19, the surveyor noted the following on the weekly behavioral monitoring sheets: " For the dates of 4/23/19, 4/17/19, 4/9/19, 4/1/19, 3/26/19, 3/19/19, 3/12/19 and 3/4/19 " ...2. Current MD (medical doctor) order and diagnosis for each psychoactive med (medication) ordered ..." The box under this only has Zoloft 100 mg (milligram) q (every) day listed without a diagnosis." " Also for the above dates, Under Section "B. Behaviors and Side Effects" Other has been marked but the staff did not describe what Other was. The surveyor reviewed the MAR (medication administration record) for March and April 2019. The resident was receiving Zoloft 100 mg (milligram) one time a day for depression. The surveyor notified the DON (director of nursing) of the above documented findings on 5/2/19 at approximately 11 am. The DON stated, "No they didn't put a diagnosis in that section of the medications." The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm in the conference room. 5. The facility staff failed to document accurately on the behavioral monitor sheets for Resident #54. Resident #54 was admitted to the facility on	F 758		

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F 758	Continued From page 95 7/27/18 with the following diagnoses of, but not limited to dementia, anxiety disorder, depression, psychotic disorder and high blood pressure. On the quarterly MDS (Minimum Data Set) with an ARD of 4/5/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #54 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and being totally dependent on 1 staff member for bathing. During the clinical record review on 5/1 to 5/3/19, the surveyor noted the following on the weekly behavioral sheets: " For the dates of 4/20/19, 4/13/19, 4/5/19, 3/30/19, 3/23/19, 3/16/19, 3/8/19 and 3/2/19 " ...2. Current MD (medical doctor) order and diagnosis for each psychoactive med (medication) ordered ..." The box under this only has Zoloft 50 mg (milligram) daily and Seroquel 25 mg BID (twice a day) listed without a diagnosis." The surveyor also reviewed the MAR (Medication Administration Record) for the months of March and April 2019. The physician had ordered the following for Resident #54 to be given: " Zoloft 50 mg one time a day for depression " Seroquel 25 mg two times a day for psychosis The surveyor notified the DON (director of nursing) of the above documented findings on 5/2/19 at approximately 11 am. The DON stated, "No they didn't put a diagnosis in that section of the medications."	F 758		

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 96 The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 6. For Resident #61 the facility staff failed to monitor behaviors and side effects related to psychotropic medication usage. Resident #61 was admitted to the facility on 06/27/17. Diagnoses included but not limited to anemia, coronary artery disease, congestive heart failure, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, arthritis, cerebrovascular accident, hemiplegia, anxiety and depression. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/13/19 coded the Resident as 15 of 15 in section C, cognitive status. This is an annual MDS. Resident #61's CCP (comprehensive care plan) was reviewed and contained a care plan for " ...uses anti-anxiety medications due to anxiety at times. She is at risk for adverse reaction related to the use of medications". Interventions related to this care plan include "Observe/document/report PRN (as needed) any adverse reaction of anti-anxiety medication: unsteady gait, tardive dyskinesia, EPS ([extra-pyramidal symptoms] shuffling gait, rigid muscles, shaking), frequent falls. Refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting,	F 758		

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F 758	Continued From page 97 behavior symptoms not usual to the person". Resident #61's clinical record was reviewed on 05/02/19. It contained signed physician's order summary for the month of April 2019, which read in part "Lorazepam tablet 1 mg Give 1 tablet by mouth at bedtime related to anxiety disorder, unspecified" and "Paroxetine HCl F/C 20 mg tablet Give by mouth one time a day related to major depressive disorder, recurrent, unspecified". Resident #61's clinical record was reviewed and contained "Behavior Observation Weekly Summary" forms. The surveyor could only locate one weekly form for the month of April 2014. Surveyor spoke with the DON (director of nursing) regarding the missing behavior observation forms. The DON could not locate the forms. The concern of not monitoring the Resident's behavior or side effects of the medication was discussed with the administrative team during a meeting on 05/02/19 at approximately 1625. No further information was provided prior to exit.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 18 residents was free of a significant medication	F 760	F760 Ensuring the residents are free from significant medication errors is a priority for the team at FMM 1. Resident #13 received no ill effects from the practice. The nurse responsible for missing the blood sugar level and medication will be counseled.	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 760	Continued From page 98 error (Resident #13). The findings included: The facility staff failed to follow the physician orders for accuchecks with insulin parameters for Resident #13. The clinical record did not have evidence Resident #13 was administered sliding scale insulin five times (3/5/19, 3/14/19, 3/23/19, 3/28/19 and 4/2/19). The clinical record of Resident #13 was reviewed 4/30/19 through 5/3/19. Resident #13 was admitted to the facility 9/5/18 with diagnoses, that included but not limited to end stage renal disease (ESRD), volume overload, hypertension, anemia, hyperphosphatemia, left shoulder arthritis, chronic respiratory failure, type 2 diabetes mellitus, deconditioning, depression, hypothyroidism, peripheral neuropathy, and history of CVA (cerebrovascular accident). Resident #13's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/15/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Dialysis was marked in Section O Special Treatments, Procedures and Programs. Current comprehensive care plan initiated 5/30/18 and revised on 11/7/18 identified the focus area that read the resident has diabetes mellitus type 2. Interventions: Diabetes medication as ordered by doctor, see MAR (medication administration record), observe for side effects and effectiveness. Resident requests to not be removed from day room/social setting to go to their room for accuchecks and med	F 760	2. All residents receiving a sliding scale insulin dose have the potential to be affected by the same practice. Nursing will be re-educated to follow the sliding-scale orders for residents receiving insulin on a sliding-scale basis and document on the MAR. 3. Nursing will be re-educated to follow the sliding-scale orders for residents receiving insulin on a sliding-scale basis and document on the MAR. 4. The Skilled Nurse or designee will audit records of ten residents who receive sliding scale insulin three times weekly for twelve weeks and then ten residents monthly for six months. The Skilled Nurse will provide education to the team members as needed, if a variance occurs. She will address and monitor for trends. Audit results will be reported to the QAPI team for further interventions.	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 760	Continued From page 99 (medication) administration. Resident #13's March 2019 physician's orders were reviewed. The physician ordered Insulin Lispro Solution 100 unit/ml (milliliter) Inject as per sliding scale: If 151-200=2 unit 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with other diabetic kidney complication. Start date 5/29/18 D/C Date 03/12/2019. The surveyor reviewed the March 2019 electronic medication administration record (eMAR). The medication box for the results of the blood sugar for 3/5/19 at 0600 was blank as well as the staff's initials. The surveyor reviewed the March 2019 blood sugar summary. Resident #13's blood sugar on 3/5/19 at 5:31 a.m. was 174. Based on the sliding scale insulin, Resident #13 should have been administered 2 units of insulin but the clinical record did not reveal insulin was administered on 3/5/19. There was not a progress note written 3/5/19. The sliding scale insulin order changed on 3/12/19 to the following: Lispro Solution 100 units/ml Inject as per sliding scale: If 151-200=1 unit 201-250=2 units 251-300=3 units 301-350=4 units 351-400=15 units, subcutaneously before meals	F 760	5. Corrective action will be complete by 06/07/19. 6. Skilled Nurse or designee	

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F 760	Continued From page 100	F 760		

and at bedtime related to Type 2 Diabetes Mellitus with other diabetic kidney complication. Start date 3/12/19 D/C Date 4/7/12/2019.

The 3/14/19 0600 blood sugar box did not have a recorded blood sugar or the nurse's initials.
The 3/23/19 0600 blood sugar box did not have a recorded blood sugar or the nurse's initials.
The 3/28/19 0600 blood sugar box did not have a recorded blood sugar or the nurse's initials.
The 4/2/19 0600 blood sugar box did not have a recorded blood sugar or the nurse's initials.

The 3/14/19 blood sugar obtained from the blood sugar summary report was done at 6:11 a.m. with a result of 160. Resident # 13 was not administered insulin at 0600 on 3/14/19. There was not a progress note written on 3/14/19. Resident #13 should have been administered 1 unit of sliding scale insulin.

The 3/23/19 0600 blood sugar found on the blood sugar summary report was 160. Resident #13 was not administered the sliding scale insulin. There were 2 progress notes written 3/23/19-one at 0102 and 17:35 (5:35 p.m.). Neither progress note addressed Resident #13's diabetic needs. Resident #13 should have been administered 1 unit of sliding scale insulin.

The 3/28/19 0600 blood sugar was found on the blood sugar summary form and was documented as 156. Based on the sliding scale insulin, Resident #13 should have been administered 1 unit. There was no evidence Resident #13 received sliding scale insulin. A progress note for 3/28/19 was not found in the clinical record.

The 4/2/19 0600 blood sugar was not obtained.

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F 760	Continued From page 101 There was no recorded blood sugar result on the summary form, on the April 2019 eMAR or in the 4/2/19 progress notes. The surveyor informed the administrator and the director of nursing of the above issue with diabetic management on 5/2/19 at 4:32 p.m. and asked for the facility policy on diabetes. No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to label and date opened food items in the facility kitchen.	F 812	F812 Labeling opened spices with an expiration date is important to the team at FMM 1. Dietary team members obtained a Julian calendar which will translate the codes on the labels for the spices. Expiration dates were then placed on every spice. 2. All residents have the potential to be affected by the same practice.	

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F 812	Continued From page 102 The findings included: The facility staff failed to ensure food items in the kitchen that were opened included a date when opened and a label of the package contents. The surveyor toured the kitchen on 4/30/19 at 9:45 a.m. with the food services director (FSD). The following was noted to be opened but not labeled with an expiration or use by date: 18 ounces of Ground Cinnamon, Black Pepper, Garlic Powder and Lemon Pepper. Upon return to the kitchen at 10:45 am, the FSD stated, "The manager has called the company and this code at the bottom of the container can be converted to a date. He is getting it sent to him from the company." The surveyor asked if that they go by the code on the container then what is the expiration date or use by date. FSD stated, "I didn't know what this code was used for." At 11:30 am, FSD returned to surveyor with a page of codes that corresponds with the month the spices would be expired. The surveyor informed the administrative staff of the kitchen concerns during the end of the day meeting on 5/1/19 at 4:45 p.m. and again on 5/3/19 at 3:52 p.m. No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 812	3. Team members were re-educated regarding the use of a Julian calendar. Upon receiving spices, an orange date tag will be placed on incoming spices with the Julian date decoded with the date listed on the product. Information on how to decode the dates is listed in the kitchen area, near the spice holder for easy access. Going forward staff will be educated on the improved process for labeling and dating spices. 4. The Registered Dietitian or designee will audit weekly for twelve weeks and then monthly for six months to ensure all spices are labeled with an expiration date. 5. Corrective action will be complete by 06/07/19. 6. Registered Dietitian or designee	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842	F842 Having resident records with identifiable information is a priority for the team at FMM	

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F 842	Continued From page 103 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	1. Incorrect coding "vitals outside of range" of Hydrocodone did not cause ill effects for resident #28. The staff persons responsible for accurate coding of the MAR on 2/26/19 and on 2/28/19 will be re-educated on accurate use of codes on the MAR. 2. All residents receiving PRN pain medications have the potential to be affected by the same practice. An audit will be conducted for all PRN pain medications given in the month of May, to ensure proper coding. 3. Team members will be re-educated regarding proper coding of the MAR. 4. The DON or designee will conduct an audit to ensure proper coding for 10 PRN pain medications. The audit will be	

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F 842	Continued From page 104 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 1 of 18 residents in the survey sample had a complete and accurate clinical record (Resident #28). The findings included: The facility staff failed to use the proper codes on the MAR (medication administrative record) in the month of February 2019 for Resident #28. Resident #28 was readmitted to the facility on 2/23/19 with the following diagnoses, but not	F 842	done weekly X 12 weeks and monthly X 6 months. Data will be reported to the QAPI team for further recommendations. 5. Corrective action will be complete by 06/07/19. 6. DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 105 limited to atrial fibrillation, coronary artery disease, high blood pressure, renal failure, diabetes and arthritis. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #28 was also coded as only requiring supervision with dressing and limited assistance for personal hygiene and bathing. The surveyor conducted a review of the resident's clinical record, which included the MAR for February 2019. During this review, a physician order for "Hydrocodone 5-325 mg (milligram) by mouth every 8 hours as needed for pain." On 2/26/19, the surveyor noted on MAR as having a code of "4". According to the MAR key, "4" is for "Vitals Outside of Parameters for Administration." On 2/28/19, the MAR had been coded with a "9". According to the MAR key, "9" is for "Other/See Progress Notes." The surveyor did not find any documentation concerning this medication in the progress notes. The surveyor notified the administrative team of the above documented findings on 5/3/19 at 3:52 pm. The surveyor asked the DON (director of nursing) were these the appropriate codes that the staff used. The DON stated, "Those were wrong." No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	F880 Following established infection control procedures is important to the team at FMM	

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	495384	A. BUILDING _____ B. WING _____	C 05/03/2019

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F 880	Continued From page 106 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and 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,	F 880	1. Residents #53, #27, #45 have not received any ill effects from the practice. The team member not washing their hands after caring for #53 was counseled. Team members caring for resident #27 were counseled to keep tubing off the floor and to use proper techniques when cleaning a wound. The nurse was counseled to properly store the nebulizer mask and tubing for resident #45. 2. All residents have the potential to be affected by the same practices. Team members were re-educated regarding following standard infection prevention and control procedures. 3. Team members were re-educated regarding following standard infection prevention and control procedures. Team members are charged with	

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F 880	Continued From page 107 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, and clinical record review, the facility staff failed to follow established infection control procedures for 3 of 18 residents (Resident #53, Resident #27, and Resident #45). The findings included: 1. The facility staff failed to follow infection control procedures for Resident #53. The surveyor observed staff members removing gloves and then not performing hand washing or	F 880	monitoring for compliance with infection prevention procedures. 4. An audit of using appropriate infection prevention/control techniques during wound care will be conducted twice weekly for twelve weeks and then three times monthly for six months, by the Infection Prevention Nurse or designee. If variances occur, the nurse will be counseled at that time. An audit of appropriate storage of nebulizer supplies, positioning of foley tubing and proper handwashing will be done three times weekly for twelve weeks and then ten times a month for six months by the Assistant Nurse Manager or designee. If variances are found, the appropriate team member will be counseled. Audits will be reported to DON for trending and recommendation for additional education, modification of protocols/policy, and / or disciplinary action. Results of the audits will be presented to the QAPI team for further recommendations.	

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F 880	Continued From page 108 hand hygiene. The clinical record of Resident #53 was reviewed 4/30/19-5/3/19. Resident #53 was admitted to the facility 5/22/18 with diagnoses, that included but not limited to sepsis, pneumonia, chronic back pain, dementia, high cholesterol, GERD (gastroesophageal reflux disease), anxiety, hypertension, depression, fatigue, and tiredness. Resident #53's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/5/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #53 was not assessed with any signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #53 required extensive assistance of one person for toilet use. Resident #53 was assessed to be frequently incontinent of bladder and bowel. Current comprehensive care plan was undated but identified a focus area that the resident had ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, impaired balance, fatigue-has chronic intractable pain as well. Interventions: She requires extensive by 1 staff for toileting. A second focus area for incontinence was also undated and read that the resident has incontinence of bladder-dementia, impaired mobility. She has risk for UTI (urinary tract infection) and dx (diagnosis) of chronic kidney disease. Interventions: Clean peri-area with each incontinence episode. If in bed, offer bedpan or BSC (bedside commode), or toilet. She uses disposable diapers. Change prn (as needed). Wash perineum front to back.	F 880	5. Corrective action will be complete by 06/07/19. 6. Infection Prevention Nurse and Assistant Nurse Managers or designee.	

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F 880	Continued From page 109 The surveyor observed incontinence care with certified nursing assistant #1 on 5/2/19 at 7:01 a.m. C.N.A. #1 entered the resident's room without knocking on the door. When the surveyor knocked on the door, C.N.A. #1 turned around and stated to the surveyor she forgot to knock and then apologized. C.N.A. #1 closed the door and donned a pair of gloves. No handwashing observed prior to glove use. The privacy curtain was pulled on both sides of the bed to about mid-bed. When C.N.A. #1 removed the brief, the surveyor observed the resident had been incontinent of urine. C.N.A. #1 removed the brief and placed a clean brief on Resident #53. C.N.A. #1 did not change gloves after removing the soiled brief and failed to provide incontinence care to the resident. C.N.A. #1 then covered the resident up with a blanket and raised the head of the bed. C.N.A. #1 had not changed or removed gloves after changing Resident #53's brief. C.N.A. #1 put the soiled brief in the trashcan and removed the trashcan bag, tied it up, and replaced the liner with a clean one. She removed her gloves, walked down the hall to the soiled utility room, and threw away the trash bag. No handwashing or hand hygiene was observed when C.N.A. #1 left the resident's room. C.N.A. #1 then went into the clean utility, placed her pager in the charger, and then rolled the COW (computer on wheels) to the day room. C.N.A. #1 then went to the break room, got her lunch bag and clocked out. The surveyor informed the administrator at 8:00 a.m. of the above observation. The surveyor observed certified nursing assistant #2 in Resident #53's room on 5/2/19 at 9:36 a.m.	F 880		

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F 880	Continued From page 110 CNA #2 was starting to provide incontinent care. C.N.A. #2 had donned gloves on and removed the brief, which was soiled and placed in trashcan. C.N.A. #2 put a clean pull-up on the resident. No incontinence care was provided. Certified nursing assistant #3 came to assist C.N.A. #2. C.N.A. #3 applied gloves. No hand washing or hand hygiene observed prior to donning gloves. C.N.A. #3 assisted with the pull-up, pants, socks and shoes. The surveyor observed a pad and a towel in Resident #53's wheelchair. A gait belt was placed around the resident, then assisted to the side of the bed by both c.n.a.s, and then transferred to the wheelchair. Resident #53's top was changed. C.N.A. #2 took the trash out to the buggy and removed her gloves. The surveyor did not observe handwashing or hand hygiene after C.N.A. #2's gloves were removed. C.N.A. #3 removed her gloves and then combed the resident's hair and then washed her hands after combing hair and left the room. C.N.A. #2 pushed the resident to the hallway. Mouth care not provided. No hand washing after care. C.N.A. #2 then went to the roommate and was observed touching the over the bed table and conversing with the resident. Before C.N.A. #2 exited the room, hands were washed. The surveyor interviewed certified nursing assistant #2 on 5/2/19 at 10:00 a.m. about the care provided and observations made by the surveyor. C.N.A. #2 stated, "I forgot." The surveyor informed the administrator and the director of nursing (DON) of the above concern on 5/2/19 at 4:34 p.m. and requested information on perineal/incontinence care. The DON was asked if the staff should wash their hands after	F 880		

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F 880	Continued From page 111 removing the soiled gloves. The DON stated yes. The surveyor requested the policy on handwashing and perineal care. The surveyor reviewed the Perineal Care skill sheet on 5/3/19. The skill sheet read "Overview: Perineal care involves a thorough cleansing of the patient's external genitalia and surrounding skin. Gloves must be worn during perineal care because of the risk of contracting an infection. Patients who are incontinent of urine or stool require more frequent perineal care. Perineal cleansing is performed with soap and water. Female Perineal Care 1. Perform hand hygiene and don gloves. 2. Introduce yourself to the patient. 10. b. Using a clean washcloth or perineal wipe, wipe from the perineum to the rectum (front to back). Repeat this process on the opposite side, using a new washcloth or perineal wipe. C. Rinse and dry the area thoroughly. 18. Discard supplies, remove gloves and perform hand hygiene." The facility policy titled "Hand Hygiene" was reviewed 5/3/19. The policy read in part: 2. Hands must be washed with soap and water or alcohol hand gel used a. before and after having direct contact with patients or their surroundings (i.e., before entering the patient's room and upon leaving the patient's room) d. after contact with a patient's skin (i.e., when taking a pulse, blood pressure, lifting a patient) e. after having contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings), f. after removing gloves	F 880		

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F 880	Continued From page 112 g. when moving from a contaminated site to a clean body site h. after contact with inanimate objects (i.e., medical equipment) 4. Glove usage b. Remove gloves after caring for the patient c. Gloves should be changed when moving from a contaminated body site to a clean body site d. Do not wear the same pair of gloves between patients No further information was provided prior to the exit conference on 5/3/19. 2a. The facility staff failed to keep the Foley catheter tubing off the floor for Resident #27. Resident #27 was admitted to the facility on 5/18/17 with the following diagnoses of, but not limited to renal failure, neurogenic bladder, diabetes, arthritis, Stage 3 pressure ulcer, high blood pressure and depression. On the quarterly MDS (Minimum Data Set) with an ARD of 3/3/19, the resident's BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #27 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and was totally dependent on 1 staff member for bathing. During the initial tour of the resident's room on 4/30/19 at 10:30 am, the surveyor noted the Foley catheter tubing was lying on the floor. RN (registered nurse) #1 was asked to come to the resident's room by the surveyor. RN #1 went to the side of the bed and found the Foley catheter tubing lying the floor. She proceeded to hang the Foley catheter bag on the side of the bed so that the tubing was not in the floor. RN #1 stated,	F 880		

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F 880	Continued From page 113 "The Foley catheter tubing shouldn't had been in the floor." The surveyor notified the administrative team of the above documented findings on 5/1/19 at 4:45 pm and again on 5/3/19 at 3:52 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/3/19. 2b. The facility staff failed to follow infection control guidelines during a dressing change observation on Resident #27. Resident #27 was admitted to the facility on 5/18/17 with the following diagnoses of, but not limited to renal failure, neurogenic bladder, diabetes, arthritis, Stage 3 pressure ulcer, high blood pressure and depression. On the quarterly MDS (Minimum Data Set) with an ARD of 3/3/19, the resident's BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #27 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and was totally dependent on 1 staff member for bathing. During the wound dressing change observation on 5/2/19 at 10:25 am, the surveyor observed the wound care nurse cleaning the wound with a clean 4 x 4. She proceeded to wipe the wound from side to side. The same 4 X 4 was not discarded and she used the same one all over the resident's wound. The surveyor notified the administrative team of the above documented findings on 5/2/19 at approximately 4 pm in the conference room.	F 880		

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F 880	Continued From page 114 The administrator and wound care nurse came back to the conference room and the surveyor notified the wound care nurse of the infection control issue that was observed by the surveyor. The wound care nurse stated, "I just got so nervous." No further information was provided to the surveyor prior to the exit conference on 5/3/19. 3. The facility staff failed to follow infection control guidelines in regards to the storage of the nebulizer mask when it was not in use for Resident #45. Resident #45 was admitted to the facility on 1/22/19 with the following diagnoses, but not limited to anemia, high blood pressure, diabetes, dementia and anxiety disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/19/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #45 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and is totally dependent on 1 staff member for bathing. During the initial tour of the resident's room on 4/30/19 at approximately 11 am, the surveyor noted that the resident's nebulizer mask was lying on the bedside table. The mask was out in the open and not stored in a plastic bag. On 5/1/19 at 3 pm, the surveyor requested and received a copy of the facility's policy on the storage of a nebulizer mask when not in use. The policy titled " ...Disposable Nebulizers ..."	F 880		

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F 880	Continued From page 115 which read in part, " ...Rinse all parts thoroughly with water and air dry or hand dry with a lint free cloth. Reassemble and store in clean equipment bag ..." The surveyor notified the administrative team of the above documented finding on 5/3/19 at 3:52 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/3/19.	F 880		