STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/12/19 through 3/14/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.	E 004		4/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/04/2019

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E 004	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that the Emergency Preparedness Plan (EP) was updated annually. The facility staff failed to update the Emergence Preparedness plan since November, 2017. The Findings included: On 3/14/19 a review was conducted of the Emergency Preparedness Plan along with the facility Administrator (Employee B). The EP had not been updated since November, 2017. Each page, including the cover page was undated. In addition, the Administrator was unable to describe the identified necessary updates. No further information was received.	E 004	The statements contained in this Plan of Correction do not constitute an admission of, or agreement with, the deficiencies alleged herein. To remain in compliance with all Federal and State regulations, Beth Sholom has taken, or will take, the actions set forth in the following Plan of Correction (POC). The following POC constitutes the facility□s allegation of compliance, that all alleged deficiencies cited have been or will be corrected by the date indicated. E004 It is the intended practice of this facility to develop an EP plan and review and update it annually. Criterion 1 The Emergency Plan (EP) has been reviewed and updated. Criterion 2 All residents have the potential to be affected. Criterion 3 Facility will update the EP book annually and as needed, and will evidence this with dates and signatures. The Administrator/designee will be re-educate facility staff on EP procedures Criterion 4 The signature page of the EP Book will be	

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E 004	Continued From page 2	E 004	checked quarterly by the Administrator or designee, to verify that all policies. Information collected will be submitted to QA&A committee for further review and recommendation. and procedures are current with review. Criterion 5 Date of compliance is April 28, 2019.	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures	E 013		4/28/19

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E 013	Continued From page 3 must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that the Policies and Procedures were updated annually. The facility staff failed to update the Policies and Procedures since November, 2017. The Findings included: On 3/14/19 a review was conducted of the Policies and Procedures along with the facility Administrator (Employee B). The P&P had not been updated since November, 2017. The Administrator was unable to show that any of the aforementioned specific policy updates had been completed. In addition, the Administrator was unable to describe the identified necessary updates. No further information was received.	E 013	E013 It is the practice of this facility to develop EP policies and procedures. Criterion 1 The Emergency Plan (EP) has been reviewed and updated. Criterion 2 All residents have the potential to be affected. Criterion 3 The signature page of the EP Book will be checked quarterly by the Administrator or designee, to verify that all policies and procedures are current with review. Criterion 4	

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E 013	Continued From page 4	E 013	The signature page of the EP Book will be checked quarterly by the Administrator or designee, to verify that all policies and procedures are current with review. Information collected will be submitted to QA&A committee for further review and recommendation. Criterion 5 Date of compliance is April 28, 2019.	
E 032 SS=F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that alternate means for communication were available communicate with facility staff,	E 032	E032 . It is the practice of the facility to have an	4/28/19

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E 032	Continued From page 5 Federal, State, regional and local emergency management agencies The facility staff failed to ensure that alternate communications equipment or communications systems were available for use in an emergency. The Findings included: On 3/14/19 a review was conducted of the Communications Plan along with the facility Administrator (Employee B). When asked to see the communications equipment, the Administrator stated that the facility did not have any, but that they planned to have a satellite phone installed. No further information was received.	E 032	alternate means of communication for emergencies. Criterion 1 The satellite telephone for the purpose of communicating with outside parties during an emergency, was installed on 3/26/19. Criterion 2 All residents have the potential to be affected. Criterion 3 The Administrator and Director of Maintenance have been educated on how to use the facility satellite phone in an emergency. The facility staff will be educated on location and how to use the phone Criterion 4 Testing of the satellite phone will be done monthly by the Director of Maintenance. Information collected will be submitted to QA&A committee for further review and recommendation. . Criterion 5 Date of compliance is April 28, 2019.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication	E 035		4/28/19

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E 035	Continued From page 6 plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that the Communications Plan included a method for sharing information from the emergency plan. The facility staff failed to ensure that the Communications Plan included a method for sharing information from the emergency plan with staff, residents, and families. The Findings included: On 3/14/19 a review was conducted of the Emergency Preparedness Plan along with the facility Administrator (Employee B). The Communications Plan did not address how the facility would share information with the staff, families or residents. In addition, the Administrator was unable to describe the information sharing process. No further information was received.	E 035	E035 It is the practice of the facility to share EP with residents. Criterion 1 The facility has developed a plan for communicating with resident, families and staff during an emergency using the newly installed Emergency phone system. This information will be communicated with current residents and or their legal representatives and with all new admissions. Criterion 2 All residents have the potential to be affected. Criterion 3 Administrator/designee will educate all staff on the emergency communication plan Criterion 4 Administrator or designee will conduct a random audit of 5 residents and 5 staff to validate their understanding of communication plan weekly for 4 weeks and monthly X2. Information collected will be submitted to QA&A committee for	

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E 035	Continued From page 7	E 035	further review and recommendation. Criterion 5 Date of compliance is April 28, 2019.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this	E 036		4/28/19

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E 036	Continued From page 8 section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to ensure that the Emergency Preparedness (EP) plan included a written training and testing program. The facility staff failed to have a written training and testing program. The Findings included: On 3/14/19 a review was conducted of the Emergency Preparedness Plan along with the facility Administrator (Employee B). The EP did not include a written training and testing program. In addition, the Administrator was unable to describe the written training and testing that staff receives or when the training took place. The Administrator submitted an undated inservice sign in sheet, which was signed by only 35 people. The Administrator stated that the facility had 79 employees. No further information was received.	E 036	E036 It is the practice of this facility to provide training and testing in the EP. Criterion 1 the facility has developed written and testing program for the emergency preparedness plan. Criterion 2 All residents have the potential to be affected. Criterion 3 Education regarding the emergency preparedness plan will be provided to current staffs, and during new hire Orientation. The Administrator will be responsible for scheduling emergency preparedness training at least annually. Criterion 4 Human Resources or the Education Coordinator will audit staff training records to ensure staff are trained monthly x 3 and annually. Information collected will be submitted to QA&A committee for further review and recommendation.	

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E 036	Continued From page 9	E 036	Criterion 5 Date of compliance is April 28, 2019.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/12/19 through 3/14/19. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 101 certified bed facility was 96 at the time of the survey. The survey sample consisted of 45 resident reviews.	F 000		
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. §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	F 550		4/28/19

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F 550	Continued From page 10 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 resident interview, staff interview, clinical record review, and facility documentation the facility staff failed to ensure the Resident right to dignified existence for 1 Resident (#76) in a survey sample of 45 Residents. For Resident #76, the facility staff pulled the resident backwards down the hallway in his Broda Chair. The findings include: Resident # 76, a 79-year-old man admitted to the facility on 3/11/14 with diagnoses of but not limited to Unspecified Dementia with behavioral disturbances, Diabetes Type 2, Lewy Body	F 550	F550 It is the practice of the facility to ensure residents have the right to exercise their rights. Criterion 1 Resident #76 suffered no adverse outcomes related to being transported backwards in his Broda chair. Upon notification from the surveyor, resident #76 unit staff were educated on the proper way to transport resident. The resident□s care plan has been updated to reflect measures to transport him both safely and with dignity.	

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F 550	Continued From page 11 Dementia and Insomnia. Resident #76 resides on the memory care unit of the facility due to his advanced Dementia. Resident #76's last (Minimum Data Set) MDS (screening tool) was an annual with an (Assessment Reference Date) of 1/11/19, which coded the Resident as having a (Brief Interview of Mental Status) BIMS score of 99 which indicates severe cognitive impairment / unable to complete assessment. He was also coded as being a two-person physical assist with bed mobility, incontinence care, transfers and he uses a Broda Chair for mobility. On 3/12/19, at 8:15 AM, during the initial tour of the facility it was observed that Resident # 76 was being pulled backwards down the hallway in his Broda Chair from his room to the dining room by CNA H. On 3/12/19 at 8:25 AM, CNA H was asked why she pulled Resident backward down the hall. The CNA stated: "So he can't put his feet down and stop the chair." On 3/13/19 at 8:35 AM, an interview was conducted with LPN B. LPN B was asked about why the resident was pulled backward, in the Broda Chair. LPN B stated that normally it's not the way he is transported to breakfast. On 3/13/19 at 9:15 AM, an interview was conducted with the PT director (employee J). The PT director stated that although it's not ideal we have to pull him backward in his Broda Chair, he (the resident) will plant his feet so we cannot push him forward. When asked about the foot pedals that come with the Broda chair the PT	F 550	Criterion 2 Residents who sit in Broda chairs have the potential to be affected. Criterion 3 Licensed nurses and CNA□s will be re-educated on properly transporting residents in a manner that preserves their dignity and safety. Criterion 4 The DON or designee will conduct random audits of properly transporting residents, in a manner that is both safe and dignified. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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F 550	Continued From page 12	F 550		

director stated: "If we put those on then he tries to stand up and it becomes a safety issue." When asked what the concern was associated with pulling a Resident backward in the hall the PT Director stated, "Dignity". When asked what effect on a cognitively impaired Resident being pulled backward could have, the PT director stated, it could increase confusion or disorientation.

On 3/13/19 at 10:45 AM, a clinical review of the care plan showed that there was no mention of pulling the chair backward down the hall.

On 3/13/19 at approximately 3:00 PM, Unit Manager (LPN D) was asked to show where transporting in Broda Chair backward was addressed and she stated it was not in the care plan.

On 3/13/19 at approximately 5:00 PM, the facility produced a new care plan which stated:

Category: Falls
[Resident name redacted] is at risk for falling R/T impaired cognition, Diabetes, Wandering, unsteady gait, medication side effects, and requiring staff assistance with transfers. He will get up unassisted at times despite redirection. He is up much during the night, related to past habits/history.

Goal:
[Resident name redacted] will remain free from injury thru next review.

Approach:
Approach Start Date: 3/13/19

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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 550	Continued From page 13 [Resident name redacted] will plant feet or attempt to stand when being moved in Broda Chair, safest manner of mobility is to move backward. Inform [Resident name redacted] you will be moving him backward. At the end of day meeting on 3/13/19 and 3/14/19, the Administrator and DON were made aware but no further information was provided.	F 550		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to assess and determine that residents are safe and appropriate to self administer medications for 4 residents (Resident #87, 21, 11, and 26) in a survey sample of 45 residents. 1. For Resident #87, the facility failed to assess that the resident was safe to self administer medications that she had access to her room. 2. For Resident #21 the facility failed to assess that the resident was safe to self administer medications that he had immediate access to. 3. For Resident #11 the facility failed to assess that she was safe to self administer medications that she had immediate access to.	F 554	F554 It is the practice of the facility to allow residents to administer medication in a safe manner. Criterion 1 Upon notification from surveyors, medication was removed from the rooms and resident #87 was assessed and found to not have any ill effect from medication left in room. resident #21 was assessed and found to not have any ill effect from medication left in room, resident #11 was assessed and found to not have any ill effect from medication left in room. resident #26 was assessed and found to not have any ill effect from medication left	4/28/19

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F 554	Continued From page 14 4. For Resident #26 the facility failed to assess that he was safe to self administer medications that he had immediate access to. The findings included: 1. For Resident #87, the facility failed to assess that the resident was safe to self administer medications that she had access to her room. Resident #87, an 78 year old female, was admitted to the facility on 9/18/17, with her most recent readmission being on 12/7/18. Her diagnosis included but were not limited to: unspecified dementia with behavioral disturbance, urinary tract infection, nausea with vomiting, cellulitis, pain in right wrist, osteoarthritis of left knee and failure to thrive. Resident #87's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/25/19 was coded as a quarterly assessment. Resident #87 was coded as having a BIMS (Brief interview for mental status) score of 3 indicating severe cognitive impairment. She was also coded as requiring supervision of one staff member for her activities of daily living to include, bed mobility, walking in and out of room, locomotion on and off unit and eating. She was coded as requiring extensive assistance of one staff member for dressing, toilet use and personal hygiene. During initial observation and facility tour of the locked dementia unit, on 3/12/19 at approximately 8:30am in the bathroom of Resident #87 there was 3 containers of Greer's Goo (a barrier cream consisting of a mixture containing nystatin	F 554	in room. Criterion 2 All residents have the potential to be affected. An inspection of all resident rooms was conducted to ensure there were no other residents with medications or treatment supplies available to them, who had not been assessed to safely self-administer. Criterion 3 Licensed nurses and direct care staff will be re-educated on ensuring residents do not have immediate access to medications or topical treatments. If residents wish to administer their own medication an assessment will be completed and medication properly stored. Criterion 4 The DON or designee will conduct random audits of 5 resident□s rooms. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28th, 2019.	

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powder, hydrocortisone powder and zinc oxide paste) accessible to the resident in the bathroom cabinet.

Review of Resident #87's nursing notes, careplan, physician orders, nursing assessments and MDS revealed that no type of assessment had been conducted to determine if she was safe to self administer this medication.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #87 "is ambulatory" and therefore would have access to items within her room, bathroom and on the unit.

Review of the facility policy and procedure titled "Self-Administration of Medications" reads, "If a resident requests to self-administer medication medications, it is the responsibility of the interdisciplinary team to determine that it is clinically appropriate for the resident to self-administer the medications, before the resident may exercise that right. The interdisciplinary team must also determine who will be responsible [the resident or nursing staff] for storage and documentation of the administration of the medication, as well as the location of the medication administration. Appropriate notation of these determinations will be maintained in the resident's clinical record. The decision that it is clinically appropriate for a resident to self-administer medication is subject to periodic re-evaluation based on change in the resident's condition or a change in the medications. The attending physician must approve a recommendation from the interdisciplinary team prior to being permitted to self-administer medications." [sic]

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The Administrator and Interim Director of Nursing were made aware of the lack of assessment to self administer medications on 3/13/19.

No further information was provided.

2. For Resident #21 the facility failed to assess that the resident was safe to self administer medications that he had immediate access to.

Resident #21, an 97 year old male, was admitted to the facility on 11/20/18. His diagnosis included but were not limited to: Dementia, anemia, anxiety, hypertension and benign prostatic hyperplasia.

Resident #21's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/27/19 was coded as a quarterly assessment. Resident #21 was coded as having a BIMS (Brief interview for mental status) score of 3 indicating severe cognitive impairment. He was also coded as requiring supervision of one staff member for eating. Other activities of daily living to include, walking in his room, locomotion on and off unit, dressing, personal hygiene he requires extensive assistance of one staff member.

During initial observation and facility tour of the locked dementia unit, on 3/12/19 at approximately 8:30am in the bathroom of Resident #21 there was a container of Tera Tears eye drops accessible to the resident in the bathroom cabinet. The bottles read, "if swallowed get medical help or contact poison control right away." During an observation on 3/14/19 at

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approximately 1:58pm the Tera Tears were still present in the bathroom cabinet.

Review of Resident #21's nursing notes, careplan, physician orders, nursing assessments and MDS revealed that no assessment had been conducted to determine if he was safe to self administer this medication.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #21 "is ambulatory at times and self propels his wheelchair at other times" and therefore would have access to items within his room, bathroom and on the unit.

Review of the facility policy and procedure titled "Self-Administration of Medications" read, "If a resident requests to self-administer medication medications, it is the responsibility of the interdisciplinary team to determine that it is clinically appropriate for the resident to self-administer the medications, before the resident may exercise that right. The interdisciplinary team must also determine who will be responsible [the resident or nursing staff] for storage and documentation of the administration of the medication, as well as the location of the medication administration. Appropriate notation of these determinations will be maintained in the resident's clinical record. The decision that it is clinically appropriate for a resident to self-administer medication is subject to periodic re-evaluation based on change in the resident's condition or a change in the medications. The attending physician must approve a recommendation from the interdisciplinary team prior to being permitted to self-administer medications." [sic]

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The Administrator and Interim Director of Nursing were made aware of the lack of assessment to self administer medications on 3/13/19.

No further information was provided.

3. For Resident #11 the facility failed to assess that she was safe to self administer medications that she had immediate access to.

Resident #11, an 89 year old female, was admitted to the facility on 7/21/14, with her most recent readmission being on 5/8/18. Her diagnosis included but were not limited to: unspecified dementia with behavioral disturbance, hyperlipidemia, anxiety disorder, schizophrenia, hypothyroidism and paranoid schizophrenia.

Resident #11's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/13/18 was coded as a quarterly assessment. Resident #11 was coded as having a BIMS (Brief interview for mental status) score of 7 indicating severe cognitive impairment. She was also coded as requiring supervision of one staff member for her activities of daily living to include eating. Other activities of daily living, such as bed mobility, transfers, ambulation in and out of her room and locomotion on and off of the unit required limited assistance of one staff member. She was coded as requiring extensive assistance of one staff member for dressing, personal hygiene and bathing.

During an initial observation and facility tour of the

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locked dementia unit, on 3/12/19 at approximately 8:30am, in the bathroom of Resident #11, there was a container of Gold Bond Medicated Powder accessible to the resident in the bathroom cabinet.

Review of Resident #11's nursing notes, careplan, physician orders, nursing assessments and MDS revealed that no assessment had been conducted to determine if she was safe to self administer this medication.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #11 "is able to self propel her wheelchair" and therefore would have access to items within her room, bathroom and on the unit.

Review of the facility policy and procedure titled "Self-Administration of Medications" reads, "If a resident requests to self-administer medication medications, it is the responsibility of the interdisciplinary team to determine that it is clinically appropriate for the resident to self-administer the medications, before the resident may exercise that right. The interdisciplinary team must also determine who will be responsible [the resident or nursing staff] for storage and documentation of the administration of the medication, as well as the location of the medication administration. Appropriate notation of these determinations will be maintained in the resident's clinical record. The decision that it is clinically appropriate for a resident to self-administer medication is subject to periodic re-evaluation based on change in the resident's condition or a change in the medications. The attending physician must approve a recommendation from the

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interdisciplinary team prior to being permitted to self-administer medications." [sic]

The Administrator and Interim Director of Nursing were made aware of the lack of assessment to self administer medications on 3/13/19.

No further information was provided.

4. For Resident #26 the facility failed to assess that he was safe to self administer medications that he had immediate access to.

Resident #26, an 98 year old male, was admitted to the facility on 12/21/18. His diagnosis included but were not limited to: unspecified dementia with behavioral disturbance, metabolic encephalopathy, vomiting, dry eye syndrome, urinary tract infection, frequency of micturition, unspecified mood disorder, insomnia and overactive bladder.

Resident #26's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/28/18 was coded as an admission assessment. Resident #26 was coded as having a BIMS (Brief interview for mental status) score of 5 indicating severe cognitive impairment. He was also coded as being independent with set up assistance only for eating. Other activities of daily living to include, bed mobility, transfers, dressing, toilet use and personal hygiene he requires extensive assistance of one staff member. He is coded as needing only limited assistance of one staff member for walking in corridor.

During an initial observation and facility tour of the

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locked dementia unit, on 3/12/19 at approximately 8:30am in the bathroom of Resident #26 there was a container of Tera Tears eye drops accessible to the resident in the bathroom cabinet. The bottles read, "if swallowed get medical help or contact poison control right away." During an observation on 3/14/19 at approximately 1:58pm the Tera Tears were still present in the bathroom cabinet.

Review of Resident #26's nursing notes, careplan, physician orders, nursing assessments and MDS revealed that no assessment had been conducted to determine if he was safe to self administer this medication.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #26 "is ambulatory" and therefore would have access to items within his room, bathroom and on the unit.

Review of the facility policy and procedure titled "Self-Administration of Medications" read, "If a resident requests to self-administer medication medications, it is the responsibility of the interdisciplinary team to determine that it is clinically appropriate for the resident to self-administer the medications, before the resident may exercise that right. The interdisciplinary team must also determine who will be responsible [the resident or nursing staff] for storage and documentation of the administration of the medication, as well as the location of the medication administration. Appropriate notation of these determinations will be maintained in the resident's clinical record. The decision that it is clinically appropriate for a resident to self-administer medication is subject

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F 554	Continued From page 22 to periodic re-evaluation based on change in the resident's condition or a change in the medications. The attending physician must approve a recommendation from the interdisciplinary team prior to being permitted to self-administer medications." [sic] The Administrator and Interim Director of Nursing were made aware of the lack of assessment to self administer medications on 3/13/19. No further information was provided.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, family interviews, resident interviews and clinical record review, the facility staff failed to ensure reasonable accommodation of resident needs and preferences for one Resident (Resident # 36 and # 86) in a survey sample of 45 residents. 1. For Resident # 86, the facility staff failed to get the resident up early for breakfast as desired. Findings included: 1. For Resident # 86, the facility staff failed to get the resident up early for breakfast as desired.	F 558	F558 It is the practice of the facility to allow residents the right to reside and receive services with reasonable accommodation of the residents□ needs and preferences. Criterion 1 Resident #86 suffered no adverse outcomes related to not being assisted up early for breakfast. Nursing staff will be reeducated on ensuring resident is up for breakfast as desired. No information provided for resident #36	4/28/19

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F 558	Continued From page 23 Resident # 86, a 90 year old female was admitted to the facility on 12/1/2018. Diagnoses included but were not limited to: Chronic Obstructive Pulmonary Disease, Acute and chronic respiratory failure with hypercapnia, Heart Failure, Hypertension, anemia, Abdominal Aortic Aneurysm, and Osteoporosis. Resident # 86's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/22/2019. The MDS coded Resident # 86 with a BIMS (Brief Interview for Mental Status) score of "13" out of 15, indicating no cognitive impairment. Resident # 86 was coded as requiring extensive assistance of one staff person for Activities of Daily Living and occasionally incontinent of bowel and bladder. On 3/12/2019 at 9:40 AM, an interview was conducted with the daughter of Resident # 86 who stated there was a problem of the facility staff not getting her mother (Resident # 86) ready for breakfast early like she desired. Resident # 86's daughter stated that when her mother ate breakfast late, it meant she had decreased socialization with others. She stated there were times that breakfast was eaten so late that there were only a couple of hours between breakfast and lunch. She stated Resident # 86 did not want to eat lunch when breakfast was eaten so late. She also stated she was concerned because she did not want her mother to lose weight. She stated she had several discussions with the facility staff to express her desire to have her mother eat breakfast early in the dining room. Resident # 86's daughter stated changes were made to the care plan to help make sure her	F 558	Criterion 2 All residents have the potential to be affected. Criterion 3 Nursing staff will be re-educated on ensuring residents are up for meals based on their preferences. Resident preferences for meal times will be assessed by the IDT at each care plan review; where a resident has a specific preference, it will be noted to their care plan and profile. Criterion 4 The DON or designee will conduct audits at meal times, weekly x four (4) and monthly x two (2) to ensure resident□s preferences are being followed. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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needs were met.

Review of the clinical record was conducted on 3/12/2019.

Review of care plan revealed:

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Problem Start Date 3/4/2019 Resident is at risk for compromised quality of life secondary to cognitive deficits/memory loss
Goal: Resident will receive assistance with daily routine with support and guidance from staff and need will be met thru [sic] next review
Approach Start Date: 3/4/2019
Maintain consistency in daily routine as much as possible

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Problem...
requires multiple reminders of programs of interest. has some short term memory loss and poor vision. Requires 1:1 asst (assistance) during sight related programs to maximize participation
Approaches included:
Involve ____(Resident # 86) with those who have shared interests, seat next to during programs and encourage meals in the dining room."

On page 22 of 35-
Problem: ...Is at nutritional risk due to decreased and variable P.O. (by mouth) intake, refusing nutritional supplements.....
Approach Start Date: 03/04/2019-Encourage _____ (Resident # 86) to eat meals in the unit DR (Dining Room)

On 3/13/2019 at 8:30 AM, Resident # 86 was

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observed lying in bed. Resident # 86 told the surveyor she was waiting to get up so she could go to breakfast.

On 3/13/2019 at 9:30 AM, Resident # 86's daughter was observed walking in the hallway toward Resident # 86's room. Resident # 86's daughter asked "Hi Mom, have you had breakfast yet? Let's get ready to go to the Dining Room" Resident # 86's daughter helped Resident # 86 wash her face and hands, get dressed and wheeled her to the dining room.

On 3/13/2019 at 9:40 AM, Resident # 86's daughter retrieved the breakfast tray from the ledge on the kitchen counter and at 9:42 AM, Resident # 86 began eating breakfast, her daughter was sitting beside her, talking to her.

On 3/13/2019 at 9:55 AM, an interview was conducted with Resident # 86's daughter who stated "now this means there would be less than 3 hours between breakfast and lunch! " The daughter stated the other residents who sit at the table with her mother were finished eating. The daughter stated meal time is a time for socialization and not going to breakfast on time meant very little time for socialization.

On 3/13/2019 at 12:07 PM, Resident # 86 was observed being wheeled by her daughter into the dining room for lunch. Resident # 86's daughter sat beside her. There were two other residents at the table eating lunch with Resident # 86.

On 3/13/2019 at 2:10 PM, an interview was conducted with Registered Nurse (RN B) who stated the facility staff was working short and had not gotten Resident # 86 up for breakfast prior to

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BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(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 558	Continued From page 26 when the daughter arrived. On 3/13/2019 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The Administrator stated the facility had ample staff of 3 to 4 Certified Nursing Assistants on each unit. The DON stated the facility staff were expected to get the residents ready for breakfast at the time they desired. No further information was provided.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		4/28/19

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F 561	Continued From page 27 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation, the facility staff failed to ensure a resident's right to self-determination for 1 Resident (#75) in a survey sample of 45 Residents For Resident #75 the Physical Therapy staff faxed over a letter to his surgeon without first allowing the Resident to view it or have input in the content. The Resident is his own Responsible Party. The findings include: Resident # 75 a 70-year-old man admitted to the facility on 2/7/19 with diagnoses of but not limited to (Peripheral Vascular Disease) PVD, Orthopedic Surgical aftercare for (Below Knee Amputation) BKA of Left lower leg. Most recent (Minimum Data Set) MDS (an assessment tool) with an (Assessment Reference Date) ARD of 2/27/19 codes Resident as having a (Brief Interview of Mental Status) BIMS of 15 indicating No Cognitive Impairment. On 3/12/19, during an initial tour, Resident # 75 asked to have the door closed to discuss some issues he was not happy with. He stated that he felt there was incorrect information in his medical record and that the staff had sent erroneous information to his doctor by fax without first	F 561	F561 It is the practice of the facility to ensure residents have the right to self-determination. Criterion 1 Following receipt of the resident□s concern from the surveyors, the facility informed the resident that it was his right to amend his own medical record. The progress notes sent to the physician were redacted in accordance with his wishes, and provided to the resident. Criterion 2 All residents for whom progress notes are shared with other caregivers / providers have the potential to be affected. Criterion 3 This citation has been reviewed with the rehabilitation team members, who are responsible for providing copies of progress notes and other skilled rehabilitation information to other providers, such as orthopedists and surgeons. The facility notifies residents at admission of their rights under HIPAA, and their rights to make decisions regarding their	

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F 561	Continued From page 28 having let him have input into the document. He stated on 3/6/19 the Physical therapist had faxed a letter to his doctor without his knowledge. He stated that he usually brings the updates from the physical therapy dept to the doctor. He stated this time they faxed it without even letting me see it first. Resident # 75 stated that when he read the follow up to the doctor he objected to the terms "Noncompliant with wearing [device]" and "CGA [Contact Guard Assist] due to decreased safety awareness." He stated that he felt this implied he was somehow cognitively deficient. He stated, " I am not an Alzheimer's Patient, just because I am 70 doesn't mean I'm nuts..." Resident #75 further went on to say that he did not want the doctor to get the wrong impression of his therapy sessions, he stated that he was progressing well in therapy. He went on to state that the [device] was cracked anyway and uncomfortable. (A crack was observed in the lower half of the device in question.) He stated they did not get him a new one when this one broke and that his doctor had told him that wearing the [device] was at his discretion. He stated he felt like they were telling on him behind his back to the doctor as if he were a child. On 3/13/19 at 4:45 an interview was conducted with Employee J the Director of Physical Therapy (PT) who submitted a written statement about the interactions with Resident# 75 as it relates to herself and another PT (Employee K) in her department. The statement dated 3/13/19 read: RE: Statement regarding therapy interaction with [Resident#75 name redacted] on 3/5/19.	F 561	treatment and services. The facility will include, (in the admission package), a statement that the referring or consulting physician may request copies of their rehabilitative progress notes as part of their ongoing care. The resident will be provided the opportunity to decide whether or not they permit the facility to share this information, if they want to review their records, prior to sending to an outside provider, or if they wish to arrange transport of the records themselves. The resident may change their mind at any time regarding how their information is routinely shared, and the facility will communicate this to the involved provider. Rehabilitation staffs will be reeducated regarding the above policy and procedures and resident□s rights to choose after providing them with education on risk and benefits and including notification of their choice to the interprofessional team involved with their care. Criterion 4 Rehab Director/designee will complete random audit of 5 residents progress note to validate resident education and notification has been completed before communicating their information with their care team weekly X5 and monthly X2. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5	

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F 561	Continued From page 29 [PT name redacted -Employee K] prepared a letter to send with [Resident name redacted] to his MD [Medical Doctor] appointment with [Surgeon name redacted] regarding progress in therapy as well as current status. She discussed her concern with me regarding his [condition]. She prepared the letters as follows: Date: 3/5/19 Sub: Update of functional progress To: Respected Sir, [Resident name redacted] has been progressing well with therapy. He recently demonstrates [description of condition] which may lead to hindrance with future [device] management. Patient demonstrates non-compliance with respect to wearing the [device] which may contribute to [description of condition] Reports pain in L middle finger and L posterior deltoid about 10+ pain with weight bearing for transfer and gait. Reports 1-4/10 at rest for L posterior deltoid. Hence unable to perform ambulation today due to pain. Pt has contacted [name of clinic] regards new [device] as current [device] needs repair as lower portion dysfunctional. Informed them regards recent [description of condition]. . He is mod 1 for rolling, supine, and sit to supine. Requires CGA [contact guard assist] for transfers due to impulsivity and decreased safety	F 561	Date of compliance is April 28, 2019.	

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F 561	Continued From page 30	F 561		

awareness.

He was able to do hopping on RLE with front wheeled walker with contact guard assist for 120 feet last week with the wheelchair to follow closely.

Thanks
[PT name redacted]

Employee J's written statement then goes on to read:

"She and I discussed delivery of information to [Surgeon's name redacted] and I suggested that given [Resident#75's name redacted] known history of non compliance that the letter should be faxed to his office and a phone call be made to insure [sic] delivery to [Surgeon's name redacted] in time for the afternoon appointment. This was done."

The statement continues on to say that just prior to leaving for appointment Resident #75 was given a copy of the note and he became upset about the contents of the note at which point the Employee J offered to strike out the offending statements however the Resident stated " It was too late by then it had already been faxed and I had to leave for my appointment."

On 3/12/19, it appears that the facility staff faxed the Resident's Surgeon at the [redacted] Clinic to get clarification on when he should wear the [device] and they received a fax and showed it to the Resident. Once again the Resident had no knowledge of the contact between the two parties prior to the facility sending the document.

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F 561	Continued From page 31 The Resident stated that the nurse who wrote the clarification is not his doctor's nurse. The nurse wrote in her letter that the Resident is to wear the [device] and take it off three times per day for air. The clarification does not specify times or state if it must be worn a prescribed number of hours and it does not address the fact it is broken. Also the letter states that the resident is to " Ambulate with walker" Resident stated "It's clear that nurse has never seen me I cannot ambulate with a walker I have [condition] and have not even been fitted [device] yet how can I ambulate?" The resident produced a copy of the faxed letter from the nurse at the [redacted] Clinic. This sparked an argument between the Resident and the physical therapy assistant (Employee L) as Resident stated he felt as if the physical therapy staff were excluding him from treatment decisions. On 3/12/19 at the end of day conference the Administrator and the DON were made aware and no new information was submitted.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.	F 565		4/28/19

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F 565	Continued From page 32 (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview, the facility staff did not allow a private Resident council meeting with state agency surveyors for 7 Resident attendees. Staff entered the Private group council meeting, while in progress, to interrupt the proceedings on 4 occasions during the hour long meeting. This staff intrusion in a confidential meeting, made Residents feel uncomfortable, and fearful of retaliation, should they share complaints with surveyors.	F 565	F565 It is the practice of this facility to allow residents the right to organize and participate in resident groups in the facility. Criterion 1 The seven residents in attendance suffered no adverse outcomes related to the resident meeting with state surveyors being interrupted. An apology for staff interrupting the meeting will be provided at	

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F 565	Continued From page 33 The findings included; A Resident council private session with state agency surveyors commenced on 3-13-19 at 11:00 a.m. In attendance were 7 members of the resident population. The Resident council President was not in attendance, however, was interviewed prior to the meeting, and previous minutes from meetings were reviewed. Approximately 20 minutes into the session, and during Resident disclosure of grievances, a private duty sitter for a Resident entered the room, and was told this was a private meeting and please to place signs on the door to restrict access to all staff while the private meeting was being held, and to let the unit manager know of this. She stated she would do so, and proceeded out of another door after greeting several Residents. The meeting continued, and in approximately 10 minutes more, A laundry staff member entered the room with a laundry cart full of clean linen. The Laundry staff member was told a meeting was being held, and the same instructions were given to her as she exited the room. In 10 to 15 minutes more 2 staff CNA's (certified nursing assistants) entered the room to obtain a weight scale, and were told the same information, with the addition of asking for the unit managing nurse to come to the room to make sure staff entry was restricted. In approximately 10 minutes more another CNA entered the room, and simply walked through without speaking to anyone. At this point the	F 565	the next Resident Council Meeting. Criterion 2 All residents have the potential to be affected by meeting interruptions. Criterion 3 A private area has been identified for future meetings. Facility staff will be re-educated by the facility Resident Services Director on ensuring privacy during resident□s council meetings. Criterion 4 Administrator/design will randomly audit resident□s council meetings from a distance to ensure that privacy is maintain during meetings monthly X3. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is April 28, 2019.	

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F 565	Continued From page 34 Residents refused to speak further as they divulged they were afraid if they shared any negative information they would be retaliated against, and stated that they were "being watched." At this time the meeting was adjourned, as the Residents were not being afforded their right to a private meeting with surveyors. The unit manager nurse never responded to the request of her presence at the meeting. The Administrator and Director of Nursing were made aware of the incident at the end of day meeting on 3-13-19. No further information was supplied by the facility.	F 565		
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)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		4/28/19

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F 583	Continued From page 35 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (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 failed to ensure resident privacy and confidentiality of his or her personal medical records for one resident in a survey sample of 45 residents. For Resident #62, the facility staff failed to ensure the confidentiality of medical records by leaving resident information visible on the computer in the hallway while other residents, staff and visitors were in the hallway. The findings included: Resident #62, a 79 year old female, was admitted to the facility on 5/7/18. Her diagnosis included but were not limited to: presence of right artificial hip joint, mood disorder, mild cognitive impairment, anxiety disorder, suicidal ideation's, primary insomnia, repeated falls, and overactive bladder. Resident #62's most recent MDS (minimum data	F 583	F583 It is the practice of this facility to ensure the residents privacy and confidentiality is maintained at all times. Criterion 1 Resident #62 suffered no adverse outcomes related to the confidential information reported to be visible in the resident hallway. Upon notification, resident #62□s nurse was immediately reeducated on maintaining confidentiality of resident□s records Criterion 2 All residents have the potential to be affected. Criterion 3 Nursing staff will be re-educated on ensuring resident medical information remains confidential at all times and this includes computer screens and kiosks.	

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F 583	Continued From page 36 set) (an assessment tool) with an ARD (assessment reference date) of 2/13/19 was coded as a quarterly assessment. Resident #62 was coded as having a BIMS (Brief Interview for Memory Status) score of 13 indicating cognitively intact. She was also coded as requiring limited assistance with assistance of one staff member for walking in her room and corridor. She was coded as requiring extensive assistance of one staff member for bed mobility, dressing, toileting and personal hygiene. Requires supervision with setup help only for eating. She was coded as frequently incontinent of bowel and bladder. On 3/13/19 at 12:02pm, it was observed that the wall mounted computer beside the 200 hall clean utility room door, Resident #62's information to include MDS data, bowel incontinence, and code (CPR- Cardiopulmonary resuscitation) status. There was no staff member in sight but other residents and visitors were observed in the hallway and the information was visible to other residents and visitors who were present in the hallway. On 3/13/19 at 12:04pm, an interview with CNA D, whose name was listed as being logged onto the computer, stated "she called me real quick" referencing RN B. She acknowledged she had walked away leaving the resident medical record visible to persons walking by. The Administrator and DON were informed of the failure of the staff to ensure resident privacy and confidentiality of medical records on 3/13/19. No further information was provided. COMPLAINT DEFICIENCY	F 583	Following this observation, the facility has shortened the time out period on the direct care charting kiosks from 3 minutes to 1 minute. Criterion 4 The DON or designee will conduct audits weekly x four (4) and monthly x two (2) on each unit to monitor staff protection of resident information. These audit results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance April 28, 2019.	

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to implement the abuse policy for 3 resident (Resident #3, # 27, and # 85) of 45 residents in the survey sample and they failed to ensure the abuse policy was accurate. 1. For Resident #3, the facility did not implement the abuse policy after discovery of an injury of unknown origin described as an unwitnessed fall with injury. 2. The abuse policy did not clearly state that injuries of unknown origin will be reported to the State Agency and thoroughly investigated. The policy did not state the final report of the investigation would be provided to the State Agency within 5 business days. 3. For Resident #27, the facility failed to implement their abuse protocol policy for an injury of unknown origin.	F 607	F607 It is the practice of this facility to have abuse/neglect policies and implement them. Criterion 1 Residents # 3, 27 and 85 suffered no adverse outcomes related to facility deviation from mandatory reporting of injuries of unknown origin. Criterion 2 All residents have the potential to be affected. Criterion 3 The facility□s Abuse Prevention and Reporting Policy has been revised to identify that all injuries of unknown origin will be reported, prior to investigation of such injury and a final report submitted to	4/28/19

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F 607	Continued From page 38 4. For Resident #85, the facility failed to implement their abuse protocol policy for an injury of unknown origin. The findings included: 1. For Resident #3, the facility did not implement the abuse policy after discovery of an injury of unknown origin described as an unwitnessed fall with injury. Resident #3, an 98 year old female, was admitted to the facility on 11/5/18. Her diagnoses included but were not limited to: Vascular Dementia, Hypokalemia, Osteoarthritis, Anorexia, Repeated falls, Hypertension, and Anxiety. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date (ARD) of 11/12/18. Resident # 3 was coded with a Brief Interview of Mental Status (BIMS) score of "5" indicating severe cognitive impairment. Resident # 3 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except she required total assistance of one staff person for bathing. Resident # 3 was coded to need extensive assistance of one staff person for ambulation. During the initial tour of the facility on 3/12/2019 at 10:45 AM, Resident # 3 was observed sitting in a wheelchair at the nurses station. There was a bruise over her left eye and steri strips covering a wound. On 3/12/19 at 2 PM, an interview was conducted with LPN (Licensed Practical Nurse) E who stated	F 607	the state agencies within 5 business days. Facility staff will be reeducated on the facility□s Abuse prevention and reporting policy to include that all injury of unknown origin will be immediately reported to their supervisor for further investigation. . Criterion 4 The DON or designee will conduct audits of resident injuries weekly X4 and Monthly X2 to identify those of unknown origin, verify that reporting and investigating requirements were met. The results of these audits will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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Resident # 3 fell and sustained the injury the night before on 3/11/2019 on the 3-11 shift. LPN E stated the CNA found the resident on the floor according to the report.

Review of the progress notes revealed no documentation of the unwitnessed fall on 3/11/2019.

On 3/12/19 at 4:30 PM, an interview was conducted with the Director of Nursing (DON) who stated she was informed that Resident # 3 fell on the 3-11 shift on 3/11/2019. The DON stated the injury over Resident # 3's eye was the result of the fall. When asked to see a copy of the investigation, the DON stated no investigation was done because the nurse determined the resident had fallen. The DON stated the nurse filled out a fall investigation form but no further investigation was conducted. The DON was asked to submit a copy of the fall investigation.

Review of the Fall investigation Report dated 3/11/19 at 8:40 PM Under Initial Investigation:
Documented the fall occurred in the resident's room.
List all witnesses to the fall (staff, residents, visitors) "None."
What was the resident observed doing immediately before the fall? " in bed asleep"
What does the resident say they were doing before the fall "no explanation"
Is there any reason to believe that another person was involved in the fall? If , so why and who[sic]:" No"

Review of the "Fall Investigation Report" dated 3/11/2019 revealed no documentation of any injuries. There was no mention of the bruise or

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injury above the left eye.

On 3/14/2019 at 10:36 a.m., an interview was conducted with the Administrator and Director of Nursing regarding the process regarding any Unwitnessed falls and injuries of unknown origin. The Director of Nurses stated the expectation is: the nurse would assess the resident for injuries, if they look like they are not seriously injured, move them, start neuro (neurological) checks, notify the md (medical doctor), and rp (responsible party), apply first aid if necessary, nurse on unit is responsible for starting the fall investigation including interviewing resident if possible, interviewing staff, inspect to make sure the equipment is operating properly, bed brakes, alarm, putting appropriate interventions in place, example, use non skid socks, if incontinent, look at toileting patterns, care plan updates. The fall investigation form is reviewed by the unit manager who makes sure it is completed accurately or if it needs any more information. It was reviewed with the DON and Administrator that an allegation should be reported before it is investigated. The Administrator and DON stated the facility would not report an unwitnessed fall with injury to the State Agency.

When asked to describe the process for a resident who had an unwitnessed fall with an injury in the cognitively impaired resident, the DON stated "we do not report unwitnessed falls to the state." The Administrator stated "we ask the resident what happened." The surveyor asked how the facility would determine what happened if the resident had cognitive impairment. The Administrator and DON stated the nurses were "able to determine if there was a need for an investigation based on the assessment of the

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situation." Both stated that the facility did not need to report the unwitnessed fall with injury as an injury of unknown origin because the nurse would be able to look at the situation and determine if it looked like the injury was the result of a fall.

The DON was interviewed regarding abuse. She was the Abuse Coordinator at the facility. The DON was asked to explain her process. She stated that once an allegation was made, she would investigate. If the allegation was an issue, then she would report.

The Administrator, Director of Nursing and Chief Executive Officer were asked to come to the conference room to discuss the abuse policies with the entire survey team.

On 3/14/2019 at 10:50 a.m., the administrator, DON and CEO came to the conference room to continue the conversation regarding the definition of an injury of unknown origin, the need to report injuries of unknown origin, unwitnessed falls with injury in the cognitively impaired and implementation of the abuse policies. The DON stated "we would immediately report any suspected abuse if we thought that was a problem." The DON stated the facility was aware of the 24 hour and two hour reporting requirement for suspected abuse but the injury for Resident # 3 "was not considered possible abuse." The DON stated the CNA (Certified Nursing Assistant) reported she found the resident had fallen on the floor and the nurse determined the injury was the result of the fall.

After a lengthy discussion, the Administrator stated he understood the definition of and the

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need to report injuries of unknown origin to the State Agency prior to investigating. The DON stated the facility would "be submitting lots of FRIs (Facility Reported Incidents) as a result of this interpretation." The DON also stated she was going to have to figure out how to educate the nursing staff on reporting injuries of unknown origin. The DON stated she thought the nurses would "have a hard time understanding because they know the residents and would be able to figure out how the injuries happened."

When asked again about abuse allegations, the DON stated that she would report to the state agency with in 24 hours. The DON was asked if she was aware of the new two hour rule. This rule required allegations of abuse to be reported immediately but not later that two hours after the allegation is made. She stated that she had read about it in the new regulation and would read the regulation again. It was reviewed with the DON that the facility abuse policy did not reflect the new reporting time frame required for the final report within 5 days. The CEO (Chief Executive Officer) stated the current facility policy stated the final report would be provided to the agencies with the timeframes required by regulations. The CEO was informed that the policy needed to be specific to state the final report would be submitted with 5 working days.

The facility abuse policy "Abuse: Prevention, Investigation and Reporting, Revision date 2/13/18 was reviewed.

Policy
Section VII (7) Reporting and follow up Response

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B. The Administrator (or designee) will report all alleged violations to the state survey agency and to all other required agencies: Adult Protective Services, the Ombudsman (DARS) and where applicable, the Board of Nursing and law enforcement. The initial report is made as soon as possible:

a. Allegations involving abuse, neglect, or exploitation of a resident must be reported within two hours (first report), in the event that there has been serious bodily injury to a resident.

b. Allegations that have resulted in no serious harm to the resident are reported as soon as is possible, and within 24 hours.

C. If the allegation will require additional time for thorough investigation, the initial report will indicate this and the final report (a summary of the conclusion) will be provided to the same agencies within the timeframes required by regulations.

On 3/14/19 at 5:00 p.m., the Administrator and DON were asked to submit any information they would like to have reviewed regarding the issue. The DON stated the facility did not submit a report to the State Agency for Resident # 3.

No further information was provided.

2. The abuse policy did not clearly state that injuries of unknown origin will be reported to the State Agency and thoroughly investigated. The policy did not state the final report of the investigation would be provided to the State Agency within 5 business days.

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On 3/14/19 at 10:36 AM., The DON was interviewed regarding abuse. She was the Abuse Coordinator at the facility. The DON was asked to explain her process. She stated that once an allegation was made, she would investigate. If the allegation was an issue, then she would report. It was reviewed with the DON that an allegation should be reported before it is investigated.

The DON and Administrator stated an unwitnessed fall with injury in a resident with cognitive impairment did not indicate an injury of unknown origin because they would ask the resident what happened. Both stated the facility staff would do the investigation and then report if there was abuse.

The Administrator and Director of Nursing again stated the facility would investigate the unwitnessed fall with injury and report to the State Agency if it was determined there was abuse. It was reviewed with the Administrator and DON that the injury should be reported to the State Agency and then thoroughly investigated.

When asked again about abuse allegations, the DON stated that she would report to the state agency with in 24 hours. The DON was asked if she was aware of the new two hour rule. This rule required allegations of abuse to be reported immediately but not later that two hours after the allegation is made. She stated that she had read about it in the new regulation and would read the regulation again. It was reviewed with the DON that the facility abuse policy did not reflect the new reporting time frame required for the final report within 5 days. The CEO (Chief Executive Officer) stated the current facility policy stated the

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final report would be provided to the agencies with the timeframes required by regulations." The CEO was informed that the policy needed to be specific to state the final report would be submitted with 5 working days.

The facility abuse policy "Abuse: Prevention, Investigation and Reporting, Revision date 2/13/18 was reviewed.

Policy
Section VII (7) Reporting and follow up Response

B. The Administrator (or designee) will report all alleged violations to the state survey agency and to all other required agencies: Adult Protective Services, the Ombudsman (DARS) and where applicable, the Board of Nursing and law enforcement. The initial report is made as soon as possible:

a. Allegations involving abuse, neglect, or exploitation of a resident must be reported within two hours (first report), in the event that there has been serious bodily injury to a resident.

b. Allegations that have resulted in no serious harm to the resident are reported as soon as is possible, and within 24 hours.

C. If the allegation will require additional time for thorough investigation, the initial report will indicate this and the final report (a summary of the conclusion) will be provided to the same agencies within the timeframes required by regulations.

On 3/14/19 at 5:00 PM., the findings were reviewed with the Administrator, DON and Chief Executive Officer. They were asked to submit any

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information they would like to have reviewed regarding the issue. The Administrator stated the facility policy would be updated to include reporting injuries of unknown origin and requirements of investigation reporting times. The DON stated injuries of unknown origin would be reported to the State Agency as required.

No further information was provided.

3. For Resident #27, the facility failed to implement their abuse protocol policy for an injury of unknown origin.

Resident #27, an 86 year old male, was admitted to the facility on 4/26/16. His diagnosis included but were not limited to: aphasia, nontraumatic intracerebral hemorrhage, facial weakness, dysphagia, hypothyroidism, hyperlipidemia, compression of brain and hypertension .

Resident #27's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 1/3/19 was coded as a quarterly assessment. Resident #27 was coded as having a BIMS (Brief interview for mental status) score of 3, indicating severe cognitive impairment. He was also coded as requiring extensive assistance of one staff member for transfers, locomotion on and off unit, dressing, toileting and personal hygiene. He required supervision with setup assistance for eating. The MDS stated that he did not have any physical or verbal behavioral symptoms or any other behaviors directed toward others.

During record review of nursing notes, Resident

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#27 was documented on 2/21/19 as having a 0.5 x 0.5 cm skin tear to the right wrist. The resident's record including nursing notes, physician notes and nursing assessments; make no indication of how the skin tear occurred.

The DON was requested to provide any and all investigation on this particular injury of unknown source. The facility provided the survey team a two page document entitled "Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries." This document entailed a series of check boxes that were checked for the following three items; 1. observed thrashing limbs in bed or chair, 2. observed scratching or picking at skin, 3. demonstrate combative behavior with caregivers."

It was also noted on the Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries form that this information was "described in the chart 2/21/19". However, there was no evidence in Resident #27's clinical chart, nursing notes, physician notes, careplan, nursing assessments or MDS, from 1/1/19-3/14/19 that the resident exhibited any of these behaviors. Accompanying this document, was an unsigned and undated statement allegedly from a CNA stating that Resident #27 "was resisting getting up and yank his hand away from us a couple of times." [sic]

The facility had no formal investigation of the injury of unknown source. The facility didn't have statements from all staff members involved in the care of the individual when the injury was identified. No report was made to the state agency regarding the injury of unknown source and no corrective action nor protection of the

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resident during an investigation was performed by the facility, which are the parts of the Abuse protocol mandated by Federal regulation.

Review of the facility Policy and Procedure titled: "Abuse Prevention, Investigation and Reporting" states the facility is "committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of allegations of activities or situations that may constitute abuse." This policy further states that the procedure for Investigation includes: "A. Designated staff will review and investigate all reports of incidents and occurrences that may represent abuse or neglect. C. Investigations may include, but are not limited to: a. assessment of the resident and nature of any injuries b. interviews of the resident, potential witnesses and staff c. assessment of the environment where the incident occurred and any physical factors d. evaluation by a physician or other licensed health professional where indicated e. utilizing available resources in the low enforcement community where applicable f. review of the medical record g. analysis of staffing reports and assignments."

The facility failed to implement their abuse policy in regard to investigating and reporting allegations of alleged abuse. The facility Administrator, Director of Nursing and CEO were made aware of these findings on 3/13/19.

No additional information was provided.

4. For Resident #85, the facility failed to implement their abuse protocol policy for an injury of unknown origin.

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Resident #85, a 91 year old female, was admitted to the facility on 5/1/12. Her diagnosis included but were not limited to: Alzheimer's disease, dementia, Hypertension, unspecified diastolic heart failure, hypothyroidism, generalized anxiety, and type 2 diabetes.

Resident #85's most recent MDS (minimum data set) (an assessment) with an ARD (assessment reference date) of 2/22/19 was coded as an annual assessment. Resident #85 was coded as having a BIMS (Brief Interview for Mental Status) score of 5, indicating severe cognitive impairment. She was also coded as requiring extensive assistance with two staff members for her activities of daily living to include transfers and bed mobility. She required extensive assistance with one staff member for locomotion on unit and dressing. Was totally dependent with assistance of one staff member for eating, toileting, personal hygiene and bathing. Further, her MDS is coded as her not having any behavioral symptoms.

During record review the nursing notes revealed Resident #85 had "a irregularly shaped 6 x 6 cm bruise to the back of her left hand. The color is noted to be purplish-black and reddish black." "Aide made writer aware that resident had two combative episodes one on 12/31/18 where the resident struck out at the aides with both hands and feet. One earlier on 7-3." There was no further documentation recorded in the resident's record of her being combative during care. Resident #85 careplan doesn't indicate she is resistive to or combative during care that would indicate this is routine behavior for this resident.

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The facility provided the survey team with a document titled "Initial QA Report of Bruises, Skin Tears, Scratches or other skin injuries" which states the bruise was noted when CNA was "ready to do pm care." The facility concludes: "writer notes that resident had x 2 combative episodes and noted to thrash in bed. Resident is also on ASA (aspirin). Writers think resident received bruise during combative episode." There is no evidence in the clinical chart other than the note the day the bruise was noted for combativeness. There are no witness statements obtained to identify if the bruise had been present previously.

Review of the facility Policy and Procedure titled: "Abuse Prevention, Investigation and Reporting" states the facility is "committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of allegations of activities or situations that may constitute abuse." This policy further states that the procedure for Investigation includes: "A. Designated staff will review and investigate all reports of incidents and occurrences that may represent abuse or neglect. C. Investigations may include, but are not limited to: a. assessment of the resident and nature of any injuries b. interviews of the resident, potential witnesses and staff c. assessment of the environment where the incident occurred and any physical factors d. evaluation by a physician or other licensed health professional where indicated e. utilizing available resources in the low enforcement community where applicable f. review of the medical record g. analysis of staffing reports and assignments."

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F 607	Continued From page 51 The facility failed to implement their abuse policy in regard to investigating and reporting allegations of alleged abuse. The resident's incident/injury was not reported to the State Survey Agency nor the results of the investigation of this injury of unknown origin. The facility Administrator, Director of Nursing and CEO were made aware of these findings on 3/13/19. No additional information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		4/28/19

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BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

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F 609	Continued From page 52 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to report an injury of unknown origin for 3 residents (Resident # 3, # 27, and # 85) of 45 residents in the survey sample. 1. For Resident #3, the facility did not report to the State Agency the discovery of an injury of unknown origin from 3/11/2019 at 8:40 PM which was described as an unwitnessed fall with injury. 2. For Resident #27, the facility failed to report an injury of unknown origin and failed to report investigation results. 3. For Resident #85, the facility failed to report an injury of unknown origin and failed to report investigation results. The findings included: 1. For Resident #3, the facility did not report to the State Agency the discovery of an injury of unknown origin from 3/11/2019 at 8:40 PM described as an unwitnessed fall with injury. Resident #3, an 98 year old female, was admitted to the facility on 11/5/18. Her diagnoses included but were not limited to: Vascular Dementia, Hypokalemia, Osteoarthritis, Anorexia, Repeated	F 609	F609 It is the practice of this facility to report all alleged violations. Criterion 1 Resident numbers 3, 27 and 85 suffered no adverse outcomes related to facility staff failing to report injuries of unknown origin. Completed facility reports of incidents and results of investigations for these residents will be transmitted to the Office. Criterion 2 All residents have the potential to be affected. The facility will review medical record information from the previous 30 days to identify residents that had unwitnessed falls resulting in injury or other injuries of unknown origin, and identify any that were not reported as injuries of unknown origin to the Office, for reporting as part of this Plan of Correction. Criterion 3 The facility□s Abuse Prevention and	

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F 609	Continued From page 53 falls, Hypertension, and Anxiety. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date (ARD) of 11/12/18. Resident # 3 was coded with a Brief Interview of Mental Status (BIMS) score of "5" indicating severe cognitive impairment. Resident # 3 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except she required total assistance of one staff person for bathing. Resident # 3 was coded to need extensive assistance of one staff person for ambulation. Review of the clinical record revealed no documentation of an injury of unknown origin being reported to the State Agency. On 3/14/2019 at 10:36 a.m., an interview was conducted with the Administrator and Director of Nursing regarding the process regarding any Unwitnessed falls. The Director of Nurses stated the expectation is: the nurse would assess the resident for injuries, if they look like they are not seriously injured, move them, start neuro (neurological) checks, notify the md (medical doctor), and rp (responsible party), apply first aid if necessary, nurse on unit is responsible for starting the fall investigation including interviewing resident if possible, interviewing staff, inspect to make sure the equipment is operating properly, bed brakes, alarm, putting appropriate interventions in place, example, use non skid socks, if incontinent, look at toileting patterns, care plan updates. The fall investigation form is reviewed by the unit manager who makes sure it is completed accurately or if it needs any more information. It	F 609	Reporting Policy has been revised to identify that all injuries of unknown origin will be reported, prior to investigation of such injury and a final report submitted to the state agencies within 5 business days. Facility staff will be reeducated on the facility□s Abuse prevention and reporting policy to include that all injury of unknown origin will be immediately reported to their supervisor for further investigation. Criterion 4 The DON or designee will conduct audits of resident injuries weekly X4 and Monthly X2 to identify those of unknown origin, verify that reporting and investigating requirements were met. The results of these audits will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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was reviewed with the DON and Administrator that an allegation should be reported before it is investigated. The Administrator and DON stated the facility would not report an unwitnessed fall with injury to the State Agency.

When asked to describe the process for a resident who had an unwitnessed fall with an injury in the cognitively impaired resident, the DON stated "we do not report unwitnessed falls to the state." The Administrator and DON stated the nurses were "able to determine if there was a need for an investigation based on the assessment of the situation." Both stated that the facility did not need to report the unwitnessed fall with injury as an injury of unknown origin because the nurse would be able to look at the situation and determine if it looked like the injury was the result of a fall.

The DON was interviewed regarding abuse. She stated that once an allegation was made, she would investigate. If the allegation was an issue, then she would report it to the State Agency. It was reviewed with the DON that an allegation should be reported before it is investigated.

The Administrator, Director of Nursing and Chief Executive Officer were asked to come to the conference room to discuss the abuse policies with the entire survey team. On 3/14/2019 at 10:50 a.m., the administrator, DON and CEO came to the conference room to continue the conversation regarding the definition of an injury of unknown origin, the need to report injuries of unknown origin, unwitnessed falls with injury in the cognitively impaired and implementation of the abuse policies. The DON stated "we would immediately report any suspected abuse if we

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thought that was a problem." The DON stated the facility was aware of the two hour and 24 hour reporting requirement for suspected abuse but the injury for Resident # 3 was not considered possible abuse. The DON stated the CNA (Certified Nursing Assistant) reported she found the resident had fallen on the floor and the nurse determined the injury was the result of the fall.

On 3/14/2019 at 3:15 PM, the DON presented another copy of the Abuse Policy which included 7 pages. The DON stated the previous copy she presented was missing two pages since both sides of each page had not been copied.

Review of the facility abuse policy "Abuse: Prevention, Investigation and Reporting, Revision date 2/13/18 was reviewed.

Policy
Section VII (7) Reporting and follow up Response

B. The Administrator (or designee) will report all alleged violations to the state survey agency and to all other required agencies: Adult Protective Services, the Ombudsman (DARS) and where applicable, the Board of Nursing and law enforcement. The initial report is made as soon as possible:

a. Allegations involving abuse, neglect, or exploitation of a resident must be reported within two hours (first report), in the event that there has been serious bodily injury to a resident.

b. Allegations that have resulted in no serious harm to the resident are reported as soon as is possible, and within 24 hours.

C. If the allegation will require additional time for

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thorough investigation, the initial report will indicate this and the final report (a summary of the conclusion) will be provided to the same agencies within the timeframes required by regulations.

On 3/14/19 at 5:00 p.m., the Administrator and DON were asked to submit any information they would like to have reviewed regarding the issue. The DON stated the facility did not submit a report to the State Agency for the injury of unknown origin over the left eye of Resident # 3 on 3/11/2019.

No further information was provided.

2. For Resident #27, the facility failed to report an injury of unknown origin and failed to report investigation results.

Resident #27, an 86 year old male, was admitted to the facility on 4/26/16. His diagnosis included but were not limited to: aphasia, nontraumatic intracerebral hemorrhage, facial weakness, dysphagia, hypothyroidism, hyperlipidemia, compression of brain and hypertension .

Resident #27's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 1/3/19 was coded as a quarterly assessment. Resident #27 was coded as having a BIMS (Brief interview for mental status) score of 3, indicating severe cognitive impairment. He was also coded as requiring extensive assistance of one staff member for transfers, locomotion on and off unit, dressing, toileting and personal hygiene. He

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requires supervision with setup assistance for eating. It states that he doesn't have any physical or verbal behavioral symptoms or any other behaviors directed toward others.

During record review of nursing notes, Resident #27 was documented on 2/21/19 as having a 0.5 x 0.5 cm skin tear to the right wrist. The resident's record including nursing notes, physician notes and nursing assessments; make any indication of how the skin tear occurred.

The DON was requested to provide any and all investigation on this particular injury of unknown source. The facility provided the survey team a two page document entitled "Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries." This document entailed a series of check boxes that were checked for the following three items; 1. observed thrashing limbs in bed or chair, 2. observed scratching or picking at skin, 3. demonstrate combative behavior with caregivers."

It was also noted on the Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries form that this information was "described in the chart 2/21/19". There was no evidence in Resident #27's clinical chart, nursing notes, physician notes, careplan, nursing assessments or MDS, from 1/1/19-3/14/19 that the resident exhibited any of these behaviors. Accompanying this document, was an unsigned and undated statement allegedly from a CNA stating that Resident #27 "was resisting getting up and yank his hand away from us a couple of times." [sic]

The facility had no formal investigation of the injury of unknown source. The facility didn't have

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statements from all staff members involved in the care of the individual when the injury was identified. No report was made to the state agency regarding the injury of unknown source and no corrective action nor protection of the resident during an investigation was performed by the facility, which are the parts of the Abuse protocol mandated by Federal regulation.

Review of the facility Policy and Procedure titled: "Abuse Prevention, Investigation and Reporting" states "outside entities, including regulatory agencies, ombudsmen, protective services, and legal investigators will be notified and involved as appropriate to the situation." It further states "the facility will investigate and report all observations, allegation, incidents or occurrences that may indicate abuse or neglect to the state survey and other interested agencies in accordance with federal and state regulations."

The facility Administrator, Director of Nursing and CEO were made aware of these findings on 3/13/19.

No additional information was provided.

3. For Resident #85, the facility failed to report an injury of unknown origin and failed to report investigation results.

Resident #85, an 91 year old female, was admitted to the facility on 5/1/12. Her diagnosis included but were not limited to: Alzheimer's disease, dementia, Hypertension, unspecified diastolic heart failure, hypothyroidism, generalized anxiety, and type 2 diabetes.

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Resident #85's most recent MDS (minimum data set) (an assessment) with an ARD (assessment reference date) of 2/22/19 was coded as an annual assessment. Resident #85 was coded as having a BIMS (Brief Interview for Mental Status) score of 5, indicating severe cognitive impairment. She was also coded as requiring extensive assistance with two staff members for her activities of daily living to include transfers and bed mobility. She requires extensive assistance with one staff member for locomotion on unit and dressing. Is totally dependent with assistance of one staff member for eating, toileting, personal hygiene and bathing. Further, her MDS is coded as her not having any behavioral symptoms.

During record review the nursing notes revealed Resident #85 had "a irregularly shaped 6 x 6 cm bruise to the back of her left hand. The color is noted to be purplish-black and reddish black." "Aide made writer aware that resident had two combative episodes one on 12/31/18 where the resident struck out at the aides with both hands and feet. One earlier on 7-3."

There was no further documentation recorded in the resident's record of her being combative during care. Resident #85 careplan did not indicate that she is resistive to or combative during care.

The DON was requested to provide any and all investigation on this particular injury of unknown source. The facility provided the survey team an "Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries" which indicates that "resident might have strach hand causing a skin tear." [sic]

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F 609	Continued From page 60 The facility had no formal investigation of the injury of unknown source. The facility didn't have statements from staff members involved in the care of the individual when the injury was identified. No report was made to the state agency regarding the injury of unknown source and no corrective action nor protection during an investigation was performed by the facility, which are the parts of the Abuse protocol mandated by Federal regulation. Review of the facility Policy and Procedure titled: "Abuse Prevention, Investigation and Reporting" states "outside entities, including regulatory agencies, ombudsmen, protective services, and legal investigators will be notified and involved as appropriate to the situation." It further states "the facility will investigate and report all observations, allegation, incidents or occurrences that may indicate abuse or neglect to the state survey and other interested agencies in accordance with federal and state regulations." The facility Administrator, Director of Nursing and CEO were made aware of these findings on 3/13/19. No additional information was provided.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		4/28/19

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F 610	Continued From page 61 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed for 3 residents (Resident #3, # 27 and # 85) of 45 residents in the survey sample to investigate an injury of unknown origin. 1. For Resident #3, the facility staff failed to investigate an incident of the resident being found on the floor with an injury of her left eye as an injury of unknown origin. The incident was documented as an unwitnessed fall. 2. For Resident #27, the facility failed to protect the resident, conduct an investigation of an injury of unknown origin and did not provide corrective action for an injury of unknown origin. 3. For Resident #85, the facility failed to protect the resident, conduct an investigation of an injury of unknown origin and did not provide corrective action for an injury of unknown origin. The findings included:	F 610	F610 It is the practice of this facility to investigate/prevent and correct any alleged violations. Criterion 1 Resident #□s 3, 27 and 85 suffered no adverse outcomes related to the facility allegedly not completing investigations related to injuries of unknown origin. To the extent possible, investigations have been made into the etiology of their injuries. Criterion 2 All residents have the potential to be affected. Criterion 3 The facility tool / guide for investigating injuries of unknown origin will be revised to prompt staff in obtaining relevant information. Licensed nurses will receive	

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F 610	Continued From page 62 1. For Resident #3, the facility staff failed to investigate an incident of the resident being found on the floor with an injury of her left eye as an injury of unknown origin. The incident was documented as an unwitnessed fall. Resident #3, an 98 year old female, was admitted to the facility on 11/5/18. Her diagnoses included but were not limited to: Vascular Dementia, Hypokalemia, Osteoarthritis, Anorexia, Repeated falls, Hypertension, and Anxiety. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date (ARD) of 11/12/18. Resident # 3 was coded with a Brief Interview of Mental Status (BIMS) score of "5" indicating severe cognitive impairment. Resident # 3 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except she required total assistance of one staff person for bathing. Resident # 3 was coded to need extensive assistance of one staff person for ambulation. During the initial tour of the facility on 3/12/2019 at 10:45 AM, Resident # 3 was observed sitting in a wheelchair at the nurses station. There was a bruise over her left eye and steri strips covering a wound. Review of the clinical record was conducted on 3/12/2019. On 3/12/19 at 2 PM, an interview was conducted with LPN (Licensed Practical Nurse) E who stated Resident # 3 fell and sustained the injury the night before on 3/11//2019 on the 3-11 shift. LPN E stated the CNA found the resident on the floor	F 610	Inservice training in conducting investigations into injuries of unknown origin, as well as the use of the new investigative tool. Criterion 4 The DON or designee will conduct audits of resident injuries weekly X4 and Monthly X2 to identify those of unknown origin, verify that reporting and investigating requirements were met. The results of these audits will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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according to the report.

On 3/12/19 at 4:30 PM, an interview was conducted with the Director of Nursing (DON) who stated she was informed that Resident # 3 fell on the 3-11 shift on 3/11/2019. The DON stated the injury over Resident # 3's eye was the result of the fall. When asked to see a copy of the investigation, the DON stated no investigation was done because the nurse determined the resident had fallen. The DON stated the nurse filled out a fall investigation form but no further investigation was conducted. The DON was asked to submit a copy of the fall investigation form.

Review of the Fall investigation Report dated 3/11/19 at 8:40 PM documented the fall occurred in the resident's room. The form read:

List all witnesses to the fall (staff, residents, visitors) "None."
What was the resident observed doing immediately before the fall? " in bed asleep"
What does the resident say they were doing before the fall "no explanation"
Is there any reason to believe that another person was involved in the fall? If, so why and who[sic]:" No"

Review of the "Fall Investigation Report" dated 3/1/2019 revealed no documentation of any injuries. There was no mention of the bruise or injury above the left eye.

On 3/14/19 at 5:00 p.m., the Administrator and DON were asked to submit any information they would like to have reviewed regarding failure to thoroughly investigate the injury of unknown

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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 610	Continued From page 64 origin to the State Agency. The DON stated injuries of unknown origin would be reported to the State Agency prior to investigating and a final report would be submitted within 5 days as required in the future. No further information was provided. 2. For Resident #27, the facility failed to protect the resident, conduct an investigation of an injury of unknown origin and did not provide corrective action for an injury of unknown origin. Resident #27, an 86 year old male, was admitted to the facility on 4/26/16. His diagnosis included but were not limited to: aphasia, nontraumatic intracerebral hemorrhage, facial weakness, dysphagia, hypothyroidism, hyperlipidemia, compression of brain and hypertension . Resident #27's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 1/3/19 was coded as a quarterly assessment. Resident #27 was coded as having a BIMS (Brief interview for mental status) score of 3, indicating severe cognitive impairment. He was also coded as requiring extensive assistance of one staff member for transfers, locomotion on and off unit, dressing, toileting and personal hygiene. He requires supervision with setup assistance for eating. The MDS stated that he did not have any physical or verbal behavioral symptoms or any other behaviors directed toward others. During a record review of nursing notes, Resident #27 was documented on 2/21/19 as having a 0.5	F 610		

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	495291	A. BUILDING _____ B. WING _____	C 03/14/2019

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x 0.5 cm skin tear to the right wrist. The resident's record including nursing notes, physician notes and nursing assessments did not make any indication of how the skin tear occurred.

The DON was requested to provide any and all investigation on this particular injury of unknown source. The facility provided the survey team a two page document entitled "Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries." This document entailed a series of check boxes that were checked for the following three items; 1. observed thrashing limbs in bed or chair, 2. observed scratching or picking at skin, 3. demonstrate combative behavior with caregivers."

It was also noted on the Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries form that this information was "described in the chart 2/21/19". However, there is no evidence in Resident #27's clinical chart, nursing notes, physician notes, careplan, nursing assessments or MDS, from 1/1/19-3/14/19 that the resident exhibited any of these behaviors. Accompanying this document, was an unsigned and undated statement allegedly from a CNA stating that Resident #27 "was resisting getting up and yank his hand away from us a couple of times." [sic]

The facility had no formal investigation of the injury of unknown source. The facility didn't have statements from all staff members involved in the care of the individual when the injury was identified nor protection of the resident during an investigation was performed by the facility.

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Review of the facility Policy and Procedure titled: "Abuse Prevention, Investigation and Reporting" states "outside entities, including regulatory agencies, ombudsmen, protective services, and legal investigators will be notified and involved as appropriate to the situation." It further states "the facility will investigate and report all observations, allegation, incidents or occurrences that may indicate abuse or neglect to the state survey and other interested agencies in accordance with federal and state regulations."

The facility Administrator, Director of Nursing and CEO were made aware of these findings on 3/13/19.

No additional information was provided.

3. For Resident #85, the facility failed to protect the resident, conduct an investigation of an injury of unknown origin and did not provide corrective action for an injury of unknown origin.

Resident #85, an 91 year old female, was admitted to the facility on 5/1/12. Her diagnosis included but were not limited to: Alzheimer's disease, dementia, Hypertension, unspecified diastolic heart failure, hypothyroidism, generalized anxiety, and type 2 diabetes.

Resident #85's most recent MDS (minimum data set) (an assessment) with an ARD (assessment reference date) of 2/22/19 was coded as an annual assessment. Resident #85 was coded as having a BIMS (Brief Interview for Mental Status) score of 5, indicating severe cognitive impairment. She was also coded as requiring extensive assistance with two staff members for

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her activities of daily living to include transfers and bed mobility. She required extensive assistance with one staff member for locomotion on unit and dressing. Was totally dependent with assistance of one staff member for eating, toileting, personal hygiene and bathing. Further, her MDS is coded as her not having any behavioral symptoms.

During record review the nursing notes revealed Resident #85 had "a irregularly shaped 6 x 6 cm bruise to the back of her left hand. The color is noted to be purplish-black and reddish black." "Aide made writer aware that resident had two combative episodes one on 12/31/18 where the resident struck out at the aides with both hands and feet." "One earlier on 7-3 (shift)."

There was no further documentation recorded in the resident's record of her being combative during care. Resident #85 careplan did not indicate she is resistive to or combative during care or that it was routine behavior for this resident.

The DON was requested to provide any and all investigation on this particular injury of unknown source. The facility provided the survey team an "Initial QA Report of Bruises, Skin Tears, Scratches or Other Skin Injuries" which indicates that "resident might have strach hand causing a skin tear." [sic]

The facility had no formal investigation of the injury of unknown source. The facility didn't have statements from staff members involved in the care of the individual when the injury was identified.

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F 610	Continued From page 68 Review of the facility Policy and Procedure titled: "Abuse Prevention, Investigation and Reporting" states "outside entities, including regulatory agencies, ombudsmen, protective services, and legal investigators will be notified and involved as appropriate to the situation." It further states "the facility will investigate and report all observations, allegation, incidents or occurrences that may indicate abuse or neglect to the state survey and other interested agencies in accordance with federal and state regulations." The facility Administrator, Director of Nursing and CEO were made aware of these findings on 3/13/19. No additional information was provided.	F 610		
F 622 SS=D	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	F 622		4/28/19

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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 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

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F 622	Continued From page 70 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: (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, clinical record review, and facility documentation review, the facility staff failed for 1 residents (Resident #33) of 45 sampled residents to ensure that necessary discharge documentation was completed and sent to the receiving facility. The facility staff failed to ensure that physician documentation, care plan goals, etc. were completed and sent to the receiving facility.	F 622	F622 The statement made in this plan of It is the practice of this facility to ensure transfer and discharge requirements are followed in accordance with the regulation. Criterion 1 Resident # 33 is identified in the statement of deficiency, but the facility	

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F 622	Continued From page 71 The Findings included: Resident # 145 was a 89 year old who was admitted to the facility on 10/19/18. Resident #145's diagnoses included Heart Failure, Hypertension, Diabetes Mellitus, Dementia, and Depression. The Minimum Data Set, which was an Admission Assessment, with an Assessment Reference Date of 10/26/18 was reviewed. Resident #145 was coded as having a Brief Interview of Mental Status score of 8, indication severe cognitive impairment. On 3/14/19, a review was conducted of Resident #145's clinical record, revealing the following nurse's note: "11/13/18. Skilled rehab for weakness. Alert and oriented x 2, confused. Vitals wni (within normal limits). Patient anxious and upset this shift due to being discharged today and time. Lungs clear, no sob (shortness of breath) noted. No pain. No bowel movement (BM) x 3 days. Patient refused Sorbitol-no BM this shift. Patient is discharging to (Nursing Facility) and was evaluated today by hospice nurse. Patient to be transported via ambulance at 5 PM. No additional concerns." The clinical record did not contain documentation that the following written documentation was sent to the receiving facility: Discharge Summary, Comprehensive Care plan goals, Advance Directives, Physician documentation of the basis for the transfer, list of medications, and contact information of the practitioner responsible for the care of the resident.	F 622	believes that the content refers to resident #145, and offers corrections for these residents: Resident #145 was discharged successfully with the paperwork sent to the receiving facility, and not retained by our staff. It is not possible to retrieve this documentation, from her discharge in November. Criterion 2 All residents discharging from the facility are potentially affected. Criterion 3 Licensed nurses and Social worker will be re-educated on the documentation that is required upon discharge, as well as retaining a copy of all documents to evidence what was communicated to the receiving facility. Policy and procedure will be revised to reflect the retention of specific documentation and incorporation into the resident□s record. . Criterion 4 The facility social worker or designee will audit all transfers and discharges weekly X4 and monthly X2. The audit results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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F 622	Continued From page 72 On 3/14/19 at 2:45 P.M., an interview was conducted with the Discharge Licensed Practical Nurse (LPN B), who was asked for copies of the above-mentioned documents, and proof that the documents had been sent to the receiving facility. LPN B stated, "We don't have a copy of the paperwork, we sent it off." On 3/14/19 at 4:00 P.M. the Administrator was notified of the findings. No further information was received.	F 622		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure a Quarterly Minimum Data Set was completed at least every 92 days for two residents (Resident # # 2 and # 3) in a survey sample of 45 residents. 1. For Resident #2, the facility staff failed to complete a (Minimum Data Set) MDS since the Significant Change MDS with and (Assessment Reference Date) ARD of 11/6/18. There are 128 days between 11/6/18 and 3/14/18 (the end of survey). 2. For Resident #3, the facility staff failed to complete a Minimum Data Set (MDS) since the Admission MDS with an Assessment Reference	F 638	F638 It is the practice of this facility to complete quarterly assessments every 3 months. Criterion 1 Resident #2□s MDS was completed when brought to the attention of the facility. Resident #3□s quarterly assessment was located in the facility database as completed on 2/11/2019. She will be assessed again in May. Criteria 2	4/28/19

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F 638	Continued From page 73 Date (ARD) of 11/12/2018. There are 122 days between 11/12/2018 and 03/14/2019 (the end of survey). The findings include: 1. For Resident #2, the facility staff failed to complete a (Minimum Data Set) MDS since the Significant Change MDS with and (Assessment Reference Date) ARD of 11/6/18. There are 128 days between 11/6/18 and 3/14/18 (the end of survey). Resident #2 an 89-year-old female was admitted to the facility on 9/24/19 with diagnoses of but not limited to (Coronary Artery Disease) CAD, Hypertension, Dementia, Arthritis, Anxiety, and Depression. On 3/14/19 at 6:45 PM, the ASPEN system identified Resident #2 as not having a Quarterly Assessment as required. On 3/14/19 at 6:50 PM, an interview was conducted with the DON who stated that Resident #2 must have had a Quarterly MDS assessment. She looked in her computer and found that the Resident had the following listed: 09/24/18 - Entry Tracking 10/4/18- OBRA Assessment 11/6/18 - OBRA Significant Change It had been 128 days since the last MDS assessment. The DON then stated, "I don't know how it got missed."	F 638	All residents have the potential to be affected. Criteria 3 MDS coordinators has been reeducated on timely completing all scheduled assessments. MDS Coordinators have developed a tickler file to use in addition to the software reporting, to determine the due date for all scheduled assessments. The Coordinators will use this tickler in addition to the software scheduler to do a backup verification that all residents scheduled assessment are completed timely Criteria 4 The QA nurse will be provided a schedule of each month□s upcoming assessments, for the purpose of doing a monthly audit against the quarterly completions. Any pattern of omissions will be reported to the QA Committee for further action if necessary. Criteria 5 Date of compliance is April 28, 2019.	

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On 3/14/19 at 7: 45 PM during the end of day meeting the Administrator and the DON were made aware of the issue with the MDS and no further information was provided.

2. For Resident #3, the facility staff failed to complete a Minimum Data Set (MDS) since the Admission MDS with an Assessment Reference Date (ARD) of 11/12/2018. There are 122 days between 11/12/2018 and 03/14/2019 (the end of survey).

Resident #3, a 98 year old female, was admitted to the facility on 11/5/18. Her diagnoses included but were not limited to: Vascular Dementia, Hypokalemia, Osteoarthritis, Anorexia, Repeated falls, Hypertension, and Anxiety.

The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date (ARD) of 11/12/18. Resident # 3 was coded with a Brief Interview of Mental Status (BIMS) score of "5" indicating severe cognitive impairment. Resident # 3 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except she required total assistance of one staff person for bathing. Resident # 3 was coded to need extensive assistance of one staff person for ambulation.

Review of the clinical record was conducted on 3/12/19 and 3/13/19.

Review of the MDS assessments revealed the only assessment was done on 11/12/2018. A

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F 638	Continued From page 75 Quarterly Assessment was due by 2/12/19. The facility staff did not complete a quarterly assessment since the Admission Assessment on 11/12/2019. On 3/14/2019 at 6:50 PM, an interview was conducted with the Director of Nursing who stated she did not know why the MDS was not done. No further information was provided.	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		4/28/19

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F 656	Continued From page 76 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed for 2 residents (Resident #29 and #76) of 45 sampled residents to develop and implement a comprehensive care plan. 1. For Resident #29, the facility staff failed to develop and implement a comprehensive care plan to include a specialized High-Back Reclining wheelchair for fall prevention. 2. For Resident # 76 the facility failed to address transporting Resident in Broda Chair. The Findings included: 1. Resident #29 was a 79 year old who had been admitted to the facility on 6/28/18. Resident #29's diagnoses included Dementia, Parkinson's Disease, Urinary Tract Infection, Hypertension and Neurogenic Bladder.	F 656	F656 It is the practice of this facility to develop/implement comprehensive care plans. Criterion 1 Resident #29 suffered no adverse outcomes related to facility allegedly failing to implement a comprehensive care plan to include a specialized High-back reclining wheelchair for fall prevention. His care plan has been updated to include his seating interventions, including the high back chair. Resident #76 suffered no adverse outcomes related to facility□s alleged failure to address transporting resident in Broda chair in his care plan. Licensed nurses will be re-educated on how to	

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F 656	Continued From page 77 The Minimum Data Set, which was a Significant Change Assessment with an Assessment Reference Date of 1/7/19 was reviewed. It coded Resident #29 as having a Brief Interview of Mental Status score of 5, indicating severe cognitive impairment. In addition, Resident #29 was coded as having Inattention and Disorganized thinking. On 3/13/19 at approximately 11:15 A.M., an observation was conducted of Resident #29 sitting upright in his wheelchair at the nurse's station. He was observed bending forward a few times and touching his shoes. Nursing staff were observed to walk past the nurse's station, and occasionally sit at the nursing station. On 3/13/19 at 11:31 A.M., an interview was conducted with the Certified Nursing Assistant (CNA A) who was assigned to work with Resident #29. She stated that she had worked with Resident #29 for approximately 8 months. When asked why Resident #29 had not been put in a reclining position prior to his fall, CNA A stated, "He's supposed to be in that broda chair because he leans and has a bruise on his lower back from leaning. If he's leaning a lot, we put him in a broda chair. There is a broda chair on Unit 1. No one else is using it. That's the only broda chair. This morning I kept hearing the nurse saying to him "sit back and keep on your shoes." She stated that facility staff were aware that Resident #29 had been leaning forward to try to take off his shoes several times. When asked if she had received any training on when, how, and to what degree to recline Resident #29's wheelchair, CNA A stated "No. I just use common sense."	F 656	enter and use the interventions on care plans. Criterion 2 All residents have the potential to be affected and all are included in this plan of correction. Criterion 3 Interdisciplinary team and licensed nurses will receive in-service training on identifying measures (beyond those developed through the RAI process) that should be included in the comprehensive care plan, how to access the care plan, and how to revise care plans to reflect the resident□s changing condition and orders. The care planning library has been expanded to include specific types of chair seating, which can be used in individualizing interventions for residents with special seating needs. Criterion 4 DON or designee will complete five (5) random audits of residents□ charts to ensure that each comprehensive care plan has been developed/implemented and followed. These audits will be done weekly for four weeks and monthly thereafter for two months. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5	

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F 656	Continued From page 78 On 3/13/19 a review was conducted of Resident #29's clinical record, revealing his care plan. The care plan did not address the use of his specialized wheelchair for fall prevention or other use. On 3/13/19 at 2:41 P.M., an interview was conducted with the Director of Rehabilitation (Employee J). When asked if the facility had provided staff training on the use of Resident #29's High Back Reclining Wheelchair, The Director of Rehabilitation stated, "We didn't provide a training on the use of the reclining chair." When asked about the degree of decline that should be used, she stated, "The degree of decline varies according to how he's feeling. She acknowledged that Resident #20's wheelchair had not been reclined on 3/12/19 and 3/13/19. When asked about the purpose of Resident #29 having a reclining wheelchair, the Director of Rehabilitation stated, "If the chair is reclined it helps with facilitating rest. If he's leaning forward it's reclined for safety and redirection." On 3/14/19 at 3:41 P.M., the facility Administrator (Employee B, and Director of Nursing (Employee C) were notified of the findings. No further information was received. 2. For Resident # 76 the facility failed to address transporting the resident in Broda Resident # 76, a 79-year-old man admitted to the facility on 3/11/14 with diagnoses of but not limited to Unspecified Dementia with behavioral disturbances, Diabetes Type 2, Lewy Body Dementia and Insomnia.	F 656	Date of compliance is April 28, 2019.	

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Resident #76's last (Minimum Data Set) MDS (screening tool) was an annual with an (Assessment Reference Date) of 1/11/19, which coded the Resident as having a (Brief Interview of Mental Status) BIMS score of 99 which indicates severe cognitive impairment / unable to complete assessment. He was also coded as being a two-person physical assist with bed mobility, incontinence care, transfers and he uses a Broda Chair for mobility.

On 3/12/19, at 8:15 AM, during the initial tour of the facility Resident # 76 was observed being pulled backward down the hallway in his Broda Chair from his room to the dining room by CNA H.

On 3/12/19 at 8:25 AM, CNA H was asked why she pulled Resident backward down the hall. CNA H stated: "So he can't put his feet down and stop the chair."

On 3/13/19 at 8:35 AM, LPN B was asked about why the resident was pulled backward in the Broda Chair the day before. LPN B stated that normally it's not the way he is transported to breakfast.

On 3/13/19 at 9:15 AM, the PT director (employee J) stated that although it's not ideal, we have to pull him backward in his Broda Chair because he will plant his feet so we cannot push him forward. When asked about the foot pedals that come with the Broda chair she stated: "If we put those on then he tries to stand up and it becomes a safety issue."

On 3/13/19 at 10:45 AM, Upon clinical review of the care plan it was noted that there is no

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mention of pulling the chair backward down the hall.

On 3/13/19 at approximately 3:00 PM, Unit Manager (LPN D) was asked to show where transporting in Broda Chair backward was addressed in the care plan. LPN D stated it was not in the care plan.

On 3/13/19 at approximately 5:00 PM, the facility produced a new care plan which stated:

Category: Falls
[Resident name redacted] is at risk for falling R/T impaired cognition, Diabetes, Wandering, unsteady gait, medication side effects, and requiring staff assistance with transfers. He will get up unassisted at times despite redirection. He is up much during the night, related to past habits/history.

Goal:
[Resident name redacted] will remain free from injury thru next review.

Approach:
Approach Start Date: 3/13/19

[Resident name redacted] will plant feet or attempt to stand when being moved in Broda Chair, safest manner of mobility is to move backward. Inform [Resident name redacted] you will be moving him backward.

At the end of day meeting on 3/13/19 the DON was and 3/14/19 the Administrator and DON were made aware but no further information was provided.

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F 657	Continued From page 81	F 657		
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 observation and resident record review the facility failed to review and revise the careplan for one resident in a sample of 45 residents. 1. For Resident #62, the facility staff failed to review and update the careplan to remove the 15 minute checks/observations after being cleared	F 657	F657 It is the practice of this facility to ensure care plan timing and revisions are complete. Criterion 1	4/28/19

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F 657	Continued From page 82 by psychiatric services to no longer be suicidal. The Findings include: Resident #62, a 79 year old female, was admitted to the facility on 5/7/18. Her diagnosis included but were not limited to: presence of right artificial hip joint, mood disorder, mild cognitive impairment, anxiety disorder, suicidal ideation, primary insomnia, repeated falls, and overactive bladder. Resident #62's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/13/19 was coded as a quarterly assessment. Resident #62 was coded as having a BIMS (Brief Interview for Memory Status) score of 13, indicating cognitively intact. She was also coded as requiring limited assistance with assistance of one staff member for walking in her room and corridor. She is coded as requiring extensive assistance of one staff member for bed mobility, dressing, toileting and personal hygiene. Requires supervision with setup help only for eating. She is frequently incontinent of bowel and bladder. During clinical record review of nursing notes, physician progress notes and careplan, on 3/13/19 it was noted in the nursing notes that Resident #62 verbalized thoughts of suicide on 2/11/19 and again on 2/15/19. The facility implemented 15 minute checks on the resident on each occasion and ordered psychiatric consult. She was seen by psychiatric services on 2/12/19 and they indicated no need for suicide precautions to continue. Resident #62 again on 2/15/19 verbalized suicidal thoughts and the facility again placed her on 15 minute checks.	F 657	Resident # 62 suffered no adverse outcomes related to the continuation of 15-minute checks on her care plan. The care plan has been updated to reflect current resident status. . Criterion 2 All residents have the potential to be affected. Criterion 3 Interdisciplinary team and licensed nurses will be re-educated on removing discontinued interventions, or no longer relevant information from care plans. Criterion 4 DON or designee will complete five (5) random audits of residents charts to ensure that each comprehensive care plan has been developed/implemented and followed. These audits will be done weekly for four weeks and monthly thereafter for two months. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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F 657	Continued From page 83 Resident #62's careplan still has listed that she is on 15 minute checks as of record review on 3/13/19 and 15 minute checks were not being done at the present time. The careplan had not been reviewed/updated to reflect the discontinuance of the 15 minute safety checks. The Administrator and Director of Nursing were made aware of these findings on 3/13/19. No further information was provided.	F 657		
F 658 SS=D	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 staff interview, Resident interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of practice for medication and treatment administration for 1 Resident (Residents #75) in a survey sample of 45 Residents. For Resident #75 facility staff failed to administer medications and change dressing to the Left Stump as ordered by the physician. The findings include: Resident # 75, a 70-year-old man admitted to the	F 658	F658 It is the practice of this facility to follow professional standards. Criteria 1 Resident #75□s medications are being administered as ordered by the physician, allowing for refusals. He requested and has been allowed to perform his own stump treatments , although the facility stocks and provides him with supplies, including Mepilex. Criteria 2 All residents has the potential to be	4/28/19

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F 658	Continued From page 84 facility on 2/7/19 with diagnoses of but not limited to (Peripheral Vascular Disease) PVD, Orthopedic Surgical aftercare for (Below Knee Amputation) BKA of Left lower leg. Most recent (Minimum Data Set) MDS (an assessment tool) with an (Assessment Reference Date) ARD of 2/27/19 codes Resident as having a (Brief Interview of Mental Status) BIMS of 15 indicating No Cognitive Impairment. On 3/12/19 at 10:00 AM, during an initial tour the Resident removed his sock covering his stump to the left leg and a dressing was observed to be dated 3/10/19. During this same interaction, Resident #75 provided a copy of the follow-up report from the Surgeon dated 3/6/19 with orders for dressing changes that read: Result Type: Orthopedic Surgery OP Established Visit Date: March 5, 2019 16:23 [4:23 PM] Author: [Surgeon Name Redacted] F/u Left BKA [follow up Left below Knee Amputation] Patient [Resident #75 name and medical record information redacted] Chief Complaint: Follow- up Left BKA History of Present Illness 70 Year old male status post left below knee amputation. Date of surgery was January 16, 2018. Comes in today for follow up visit. Denies fevers chills chest pain shortness of breath. However, he does have some erythema [redness] and drainage from the medial aspect of the incision. He states that it started a couple of	F 658	affected. Criterion 3 The delay in administering the resident□s antibiotic occurred when there was a delay in order approval; facility policy requires that when a consulting physician or outside provider gives new orders or changes in orders, the attending physician is required to review and approve the orders. The orders are initiated as soon as possible after approval. To expedite this process, the facility will change policy to request that outside or consulting providers fax new orders directly to the facility, in addition to giving them to the resident, so that the attending physician may be contacted and approval obtained as quickly as possible. Criterion 4 DON or designee will run a weekly report of any missing treatments or medications, to identify any delays in treatment, which will be investigated and appropriate action taken. The results of the weekly review will be forwarded to the QA committee, to determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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weeks ago. He was seen last week and started on Keflex. He feels like it is better.

Plan:
We will add Doxycycline to the antibiotic regimen because of him being in a facility and cover MRSA. We will do Keflex and Doxycycline. We will have him do DAILY Mepilex AG dressing changes to leg. Once it heals up we will give him a prescription for a temporary prosthesis. We will see the stump shape is an issue. If it is we may have to consider revision surgery to reshape it. In terms of wound care change the Mepilex AG dressing one a day. Just cover the medial aspect of the incision where it is draining. Continue with the antibiotics follow up in 2 weeks. On follow up we will get x-rays of the left tibia stump.

According to the facility (Treatment Administration Record), the new treatment with Mepilex was not initiated until 3/9/19.

During interview with the Resident on 3/12/19 the Resident stated that he had been given the Mepilex by the staff at the hospital on his follow up on 3/5/19 and told "Mepilex is very expensive this box costs about $600.00 keep it in your room and cut off a piece every day to give to the treatment nurse to do your dressing changes. The facility may use it for someone else if you give it to them to hold."

When asked when he gave the information about the new orders to the facility staff he stated when he got back from the doctor he made copies and gave to the nursing staff. He did not recall which nurse was working at the time. He stated that the nurse told him she couldn't start the new antibiotic until the facility doctor sees the new orders. The

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Resident admits to being upset by this but states that the new Antibiotic was started the next evening.

According to the (Medication Administration Report) MAR, the antibiotic ordered by the Surgeon on 3/5/19 was initiated on 3/6/19 at 5:00 PM.

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

1. The right medication

2. The right dose

3. The right client

4. The right route

5. The right time

6. The right documentation

Administrator and DON were made aware during the end of day meeting on 3/13/19 at 6:00 PM no further information was provided.

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F 688	Continued From page 87	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review and facility documentation the facility failed to ensure one Resident received equipment ordered to maintain Range of Motion in survey sample of 45. For Resident #12 the facility staff failed to apply palm guard, foot box and leg rests to the wheelchair. The findings include: Resident # 12 an 81-year-old woman admitted to the facility on 6/08/18 with diagnoses of but not limited to Dementia with Behavioral Disturbance,	F 688	F688 It is the practice of this facility to increase/prevent decrease in ROM/mobility Criterion 1 Upon notification from surveyors of their findings, resident # 12□s palm guard, footbox and leg rests were applied. Criteron 2 All residents with orders for adaptive equipment to maintain range of motion are potentially affected.	4/28/19

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F 688	Continued From page 88 Pain in left hand, Contracture of Left Hand, Edema (swelling) to the left hand, Edema to Bilateral Legs, Hypertension, Depression, and Hip joint Replacement. Resident #12's most recent (Minimum Data Set) MDS (a screening tool) was coded as a Quarterly with an (Assessment Reference Date) ARD of 12/14/19 codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 0 indicating a severe cognitive impairment. On 3/12/19 at 8:25 AM, during initial tour Resident #12 had a notice posted on the wall in the room. The notice stated as follows: [Resident #12] Positioning and Palm Protector [In the center was a picture of Resident sitting in her wheelchair with her adaptive equipment in place, the Resident's face was not shown in the picture.] 1. Gently stretch the hand and place Palm Protector in left hand 2. Position hips all the way back in the wheelchair 3. Affix foot box to leg rests. 4. Place left elbow on arm lateral support rest. *Hung with permission of family 06/11/18 by [name redacted] OTR/L* On 3/12/19 at 8:33 AM ,Resident #12 was observed in the common area eating breakfast. The Palm Guard was hanging on the back of wheelchair and there was no foot rest or foot box, and no left lateral support rest. On 3/12/19 at 12:35 PM, the Resident was observed again without the footrest or the foot	F 688	Criterion 3 License nurses will be reeducated on updating resident profile with all adaptive equipment orders with instructions on when to apply and remove device Criterion 4 DON and/or designee will complete audits weekly x four (4) and monthly x two (2), to validate that each resident has the devices or equipment and applied as ordered. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action Criteria 5 Date of compliance is April 28, 2019.	

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F 688	Continued From page 89 box. However she did have the left lateral support. On 3/13/19 at 8:15 AM, Resident #12 was observed again without the foot box or footrest, or Palm guard. On 3/13/19 at 8:20 AM, LPN B was asked about the missing adaptive equipment and she stated that she thought perhaps it was with PT being cleaned. On 3/13/19 at 8:35 AM, Employee I (PT Assistant) was observed carrying foot pedals out of the Resident's room. When asked if those were for Resident #12 she stated that they did not fit the Residents wheelchair. Employee I also stated she did not know where they came from but they were not for Resident # 12's chair. Employee I stated she was going to go to the gym to see if the foot pedals were there. On 3/13/19 at 9:10 AM, Employee J (Dir. of PT) stated that she did not know how long the Residents wheelchair legs were in the gym but they were found there along with the foot box. Facility staff then applied them to the chair for the Resident. She further stated the wheelchair legs that Employee I removed was "probably from her old chair." On 3/14/19 at 6:00 PM during the end of day meeting the Administrator and the DON were made aware of the issues and no further information was provided.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		4/28/19

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F 689	Continued From page 90 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed for 8 residents (Resident #29, #87, #21, #345, #11, #26, #62, #27) in a sample of 45 residents to prevent accident hazards. 1. For Resident #29, the facility staff failed to recline a specialized High-Back Reclining wheelchair for fall prevention. 2. For Resident #87, the facility failed to ensure the environment is free of accident hazards by allowing resident access to medications, sharps and trip hazards. 3. For Resident #21 the facility failed to provide a safe environment by allowing resident access to medications, sharps and trip hazards. 4. For Resident #345 the facility failed to provide a safe environment by allowing resident access to medications, a disposable razor, and trip hazards. 5. For Resident #11 the facility failed to provide a safe and accident free environment by allowing resident access to medications, sharps and trip hazards.	F 689	F689 It is the intended practice of this facility to be free of accident hazards/supervision/devices. Criterion 1 Resident number #29, suffered no adverse outcomes related to the alleged deficiency. Upon notification from surveyor regarding resident #29 facility staff immediately reclined the high-back reclining wheelchair and provided reeducation to the staff. Residents #87, #21, #345, #11, #26 suffered no adverse outcomes related to the alleged deficiency. Upon notification from surveyors regarding resident #87, #21, #345, #11 and #26, all medications, sharps and trip hazards were removed and proper stored. Resident #62 suffered no adverse outcomes related to the related deficiency. Nursing staff will be re-educated regarding following protocol for 15 minute safety checks and resolve	

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F 689	Continued From page 91 6. For Resident #26 the facility failed to provide a safe environment by allowing the resident access to medications, sharps and trip hazards. 7. For Resident #62 the facility failed to provide a safe environment by failing to provide 15 minute checks for safety after she verbalized suicidal thoughts. 8. For resident #27 the facility failed to provide an environment free of accident hazards due to the water barrier strip at the base of the shower being unsecured and creating a trip hazard and access to medications. The Findings included: 1. For Resident #29, the facility staff failed to recline a specialized High-Back Reclining wheelchair for fall prevention. Resident #29 was a 79 year old who had been admitted to the facility on 6/28/18. Resident #29's diagnoses included Dementia, Parkinson's Disease, Urinary Tract Infection, Hypertension and Neurogenic Bladder. The Minimum Data Set, which was a Significant Change Assessment with an Assessment Reference Date of 1/7/19 was reviewed. It coded Resident #29 as having a Brief Interview of Mental Status score of 5, indicating severe cognitive impairment. In addition, Resident #29 was coded as having Inattention and Disorganized thinking. On 3/13/19 at approximately 11:15 A.M., an observation was conducted of Resident #29	F 689	intervention when appropriate from care plan Resident #27 suffered no adverse outcomes related to the alleged deficiency. Upon notification from surveyors regarding resident #27, the water barrier strip at the base of the shower was secured and medications were removed. Nursing staff will be re-educated regarding ensuring that resident□s areas are free of accident hazards/supervision/devices. Criterion 2 All residents have the potential to be affected. Criterion 3 Nursing staff will be re-educated on ensuring resident areas are free of accident hazards/supervision/devices. Inservice training will focus on the various types of accidents or hazards that could be present in the facility, including but not limited to: trip hazards, sharps, medications or ointments that are accessible to residents, and positioning in specialized chairs. Criterion 4 The DON and/or designee will complete five (5) random audits of resident areas and bathing units to ensure areas are free of accidental hazards/supervision/devices. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the	

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F 689	Continued From page 92 sitting upright in his wheelchair at the nurse's station. He was observed bending forward a few times and touching his shoes. Nursing staff were observed to walk past the nurse's station, and occasionally sit at the nursing station. On 3/13/19 at 11:31 A.M., an interview was conducted with the Certified Nursing Assistant (CNA A) who was assigned to work with Resident #29. She stated that she had worked with Resident #29 for approximately 8 months. When asked why Resident #29 had not been put in a reclining position prior to his fall, CNA A stated, "He's supposed to be in that broda chair because he leans and has a bruise on his lower back from leaning. If he's leaning a lot, we put him in a broda chair. There is a broda chair on Unit 1. No one else is using it. That's the only broda chair. This morning I kept hearing the nurse saying to him "sit back and keep on your shoes." CNA A stated that facility staff were aware that Resident #29 had been leaning forward to try to take off his shoes several times. When asked if she had received any training on when, how, and to what degree to recline Resident #29's wheelchair, CNA A stated "No. I just use common sense." On 3/13/19 a review was conducted of Resident #29's clinical record, revealing his care plan. The care plan did not address the use of his specialized wheelchair for fall prevention or other use. On 3/13/19 at 2:41 P.M., an interview was conducted with the Director of Rehabilitation (Employee J). When asked if the facility had provided staff training on the use of Resident #29's High Back Reclining Wheelchair, The Director of Rehabilitation stated, "We didn't	F 689	need for further audits and/or action. Criteria 5 Date of compliance is April 28, 2019.	

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provide a training on the use of the reclining chair." When asked about the degree of recline that should be used, she stated, "The degree of recline varies according to how he's feeling. She acknowledged that Resident #20's wheelchair had not been reclined on 3/12/19 and 3/13/19. When asked about the purpose of Resident #29 having a reclining wheelchair, the Director of Rehabilitation stated, "If the chair is reclined it helps with facilitating rest. If he's leaning forward it's reclined for safety and redirection."

On 3/14/19 at 3:41 P.M., the facility Administrator (Employee B, and Director of Nursing (Employee C) were notified of the findings. No further information was received.

2. For Resident #87, the facility failed to ensure the environment is free of accident hazards by allowing resident access to medications, sharps and trip hazards.

Resident #87, an 78 year old female, who resides in a secure memory care unit, was admitted to the facility on 9/18/17, with her most recent readmission being on 12/7/18. Her diagnosis included but were not limited to: unspecified dementia with behavioral disturbance, urinary tract infection, nausea with vomiting, cellulitis, pain in right wrist, osteoarthritis of left knee and failure to thrive.

Resident #87's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/25/19 was coded as a quarterly assessment. Resident #87

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was coded as having a BIMS (Brief interview for mental status) score of 3 indicating severe cognitive impairment. She was also coded as requiring supervision of one staff member for her activities of daily living to include, bed mobility, walking in and out of room, locomotion on and off unit and eating. She was coded as requiring extensive assistance of one staff member for dressing, toilet use and personal hygiene.

During initial observation and facility tour of the locked dementia unit, on 3/12/19 at approximately 8:30am in the bathroom of Resident #87 there was 3 containers of Greer's Goo (a barrier cream consisting of a mixture containing nystatin powder, hydrocortisone powder and zinc oxide paste) accessible to the resident in the bathroom cabinet. Also in the bathroom cabinet was a disposable razor without a cover/safety cap. During observation on 3/13/19 at 9:32am the razor and Greer's Goo was still present.

During facility tour and observation of the locked dementia unit, on 3/12/19 at 8:30am, other medications to include Gold Bond Medicated powder with the label reading "for external use only. In case of accidental ingestion get medical help or contact a poison control center right away" Tera Tears with a label reading "if swallowed get medical help or contact poison control right away" was noted on the unit and accessible to residents during observation on 3/12/19, 3/13/19 and again on 3/14/19. On 3/12/19 during observation in room 408 there was a water barrier strip at the base of the shower unsecured, which created a trip hazard. During observation on 3/14/19 Resident #87 was observed to be independently walking on the unit.

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An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #87 "is ambulatory" and therefore would have access to items within her room, bathroom and on the unit.

The Administrator and Interim Director of Nursing were made aware of the safety hazards on 3/13/19.

No further information was provided.

3. For Resident #21 the facility failed to provide a safe environment by allowing resident access to medications, sharps and trip hazards.

Resident #21, an 97 year old male, who resides in a secure memory care unit, was admitted to the facility on 11/20/18. His diagnosis included but were not limited to: Dementia, anemia, anxiety, hypertension and benign prostatic hyperplasia.

Resident #21's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/27/19 was coded as a quarterly assessment. Resident #21 was coded as having a BIMS (Brief interview for mental status) score of 3 indicating severe cognitive impairment. He was also coded as requiring supervision of one staff member for eating. Other activities of daily living to include, walking in his room, locomotion on and off unit, dressing, personal hygiene he requires extensive assistance of one staff member.

During initial observation and facility tour of the locked dementia unit, on 3/12/19 at approximately

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8:30am in the bathroom of Resident #21 there was a container of Tera Tears eye drops accessible to the resident in the bathroom cabinet. The bottles reads "if swallowed get medical help or contact poison control right away." Also during observation on 3/12/19 at approximately 8:30am multiple items were noted throughout the unit that Resident #21 would have access to which included, a disposable razor without a cover, Gold Bond Medicated Powder, Greer's Goo (a barrier cream consisting of a mixture containing nystatin powder, hydrocortisone powder and zinc oxide paste). On 3/12/19 during observation in room 408 there was a water barrier strip at the base of the shower, unsecured which created a trip hazard. Observation of the locked dementia unit, on 3/13/10 at 9:32am revealed the razor, Greer's Goo, Tera Tears and Gold Bond Medicated Powder still present and accessible. During observation of the locked dementia unit, on 3/14/19 at approximately 1:58pm the Tera Tears were still present in the bathroom cabinet and Gold Bond Medicated Powder was present in another room. Resident #21 was propelling himself without any assistance down the hallway to his room.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #21 "is ambulatory at times and self propels his wheelchair at other times" and therefore would have access to items within his room, bathroom and on the unit.

The Administrator and Interim Director of Nursing were made aware of the accident hazards on the unit on 3/13/19.

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No further information was provided.

4. For Resident #345 the facility failed to provide a safe environment by allowing resident access to medications, a disposable razor, and trip hazards.

Resident #345, an 84 year old female, resides in the secure memory care unit, was admitted to the facility on 3/11/19. Her diagnosis included but are not limited to: vitamin deficiency, hyperlipidemia, hypokalemia, unspecified dementia without behavioral disturbance, anxiety disorder, confusional arousals, and other specified rheumatic heart disease.

Resident #345 doesn't have a MDS (minimum data set) (an assessment tool) due to being a new admission to the facility. Facility records to include Physician Visit- Admission dated 3/11/19 indicates Resident #345 has significantly impaired cognitive impairment and is ambulatory.

During initial observation and facility tour of the locked dementia unit, on 3/12/19 at approximately 8:30am on the memory care unit Resident #345 had access to multiple hazardous items. Observation noted a container of Gold Bond Medicated Powder in a bathroom cabinet; label read "for external use only. In case of accidental ingestion get medical help or contact a poison control center right away." Tera Tears eye drops were also noted on the unit, accessible to the resident. The bottles reads "if swallowed get medical help or contact poison control right away." Also during observation of the locked dementia unit, on 3/12/19 at approximately 8:30am a disposable razor without a cover, Greer's Goo (a barrier cream consisting of a

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mixture containing nystatin powder, hydrocortisone powder and zinc oxide paste) was observed and in room 408 there was a water barrier strip at the base of the shower, unsecured and created a trip hazard.

During observation of the locked dementia unit, on 3/13/19 at 9:29am Resident #345 was observed walking in the hallway of rooms 409-421 without any staff assistance. Observations on 3/13/19 at 9:32am revealed the Gold Bond Medicated Powder, Tera Tears, razor and Greer's Goo were still present and accessible. Observation on 3/14/19 at approximately 1:58pm the Gold Bond Medicated power and Tera Tears were still on the unit and accessible to Resident #345.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #345 "is able to ambulate" and therefore would have access to items within her room, bathroom and on the unit.

The Administrator and Interim Director of Nursing were made aware of the safety hazards on 3/13/19.

No further information was provided.

5. For Resident #11 the facility failed to provide a safe and accident free environment by allowing resident access to medications, sharps and trip hazards.

Resident #11, an 89 year old female, resides in the secure memory care unit, was admitted to the facility on 7/21/14, with her most recent

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readmission being on 5/8/18. Her diagnosis included but were not limited to: unspecified dementia with behavioral disturbance, hyperlipidemia, anxiety disorder, schizophrenia, hypothyroidism and paranoid schizophrenia.

Resident #11's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/13/18 was coded as a quarterly assessment. Resident #11 was coded as having a BIMS (Brief interview for mental status) score of 7 indicating severe cognitive impairment. She was also coded as requiring supervision of one staff member for her activities of daily living to include eating. Other activities of daily living, such as bed mobility ,transfers, ambulation in and out of her room and locomotion on and off of the unit required limited assistance of one staff member. She was coded as requiring extensive assistance of one staff member for dressing, personal hygiene and bathing.

During initial observation of the locked dementia unit, and facility tour on 3/12/19 at approximately 8:30am in the bathroom of Resident #11 there was a container of Gold Bond Medicated Powder in the cabinet; label read "for external use only. In case of accidental ingestion get medical help or contact a poison control center right away." Tera Tears eye drops were also noted on the unit, accessible to the resident. The bottles reads "if swallowed get medical help or contact poison control right away." Also during observation of the locked dementia unit, on 3/12/19 at approximately 8:30am multiple items were noted throughout the unit that Resident #11 would have access to which included, a disposable razor without a cover, Greer's Goo (a barrier cream

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consisting of a mixture containing nystatin powder, hydrocortisone powder and zinc oxide paste). On 3/12/19 during observation in room 408 there was a water barrier strip at the base of the shower unsecured and creating a trip hazard. During observation of the locked dementia unit, on 3/13/19 at 9:32am the Gold Bond Medicated Powder, Tera Tears, razor and Greer's Goo were still present and accessible. Observation on 3/14/19 at approximately 1:58pm the Gold Bond Medicated power was still present in the bathroom cabinet and Tera Tears was present in another room.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #11 "is able to self propel her wheelchair" and therefore would have access to items within her room, bathroom and on the unit.

The Administrator and Interim Director of Nursing were made aware of the safety hazards on 3/13/19.

No further information was provided.

6. For Resident #26 the facility failed to provide a safe environment by allowing the resident access to medications, sharps and trip hazards.

Resident #26, an 98 year old male, who resides in a secure memory care unit, was admitted to the facility on 12/21/18. His diagnosis included but were not limited to: unspecified dementia with behavioral disturbance, metabolic encephalopathy, vomiting, dry eye syndrome, urinary tract infection, frequency of micturition, unspecified mood disorder, insomnia and

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overactive bladder.

Resident #26's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/28/18 was coded as an admission assessment. Resident #26 was coded as having a BIMS (Brief interview for mental status) score of 5 indicating severe cognitive impairment. He was also coded as being independent with set up assistance only for eating. Other activities of daily living to include, bed mobility, transfers, dressing, toilet use and personal hygiene he requires extensive assistance of one staff member. He is coded as needing only limited assistance of one staff member for walking in corridor.

During initial observation and facility tour of the locked dementia unit, on 3/12/19 at approximately 8:30am in the bathroom of Resident #26 there was a container of Tera Tears eye drops accessible to the resident in the bathroom cabinet. The bottles reads "if swallowed get medical help or contact poison control right away." On 3/14/19 at approximately 1:58pm observations of the locked dementia unit, noted the Tera Tears were still present in the bathroom cabinet.

During observation of the locked dementia unit, on 3/12/19 at approximately 8:30am Gold Bond Medicated Powder, label reading "for external use only. In case of accidental ingestion get medical help or contact a poison control center right away"; was accessible to the resident in another room's bathroom cabinet. Also during observation on 3/12/19 at approximately 8:30am multiple items were noted throughout the unit that Resident #26 would have access to which

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included, a disposable razor without a cover, Greer's Goo (a barrier cream consisting of a mixture containing nystatin powder, hydrocortisone powder and zinc oxide paste). On 3/12/19 during observation in room 408 there was a water barrier strip at the base of the shower unsecured, which created a trip hazard. During observation of the locked dementia unit, on 3/13/19 at 9:32am the Tera Tears, Gold Bond Medicated Powder, Greer's Goo and razor were still present and accessible. During observation of the locked dementia unit, again on 3/14/19 at approximately 1:58pm the Tera Tears were still present in the bathroom cabinet and the Gold Bond Medicated Powder was present in another room.

An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #26 "is ambulatory" and therefore would have access to items within his room, bathroom and on the unit.

The Administrator and Interim Director of Nursing were made aware of the lack of assessment to self administer medications on 3/13/19.

No further information was provided.

7. For Resident #62 the facility failed to provide a safe environment by failing to provide 15 minute checks for safety after she verbalized suicidal thoughts.

Resident #62, a 79 year old female, was admitted to the facility on 5/7/18. Her diagnosis included but were not limited to: presence of right artificial hip joint, mood disorder, mild cognitive

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impairment, anxiety disorder, suicidal ideation's, primary insomnia, repeated falls, and overactive bladder.

Resident #62's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/13/19 was coded as a quarterly assessment. Resident #62 was coded as having a BIMS (Brief Interview for Memory Status) score of 13 indicating cognitively intact. She was also coded as requiring limited assistance with assistance of one staff member for walking in her room and corridor. She is coded as requiring extensive assistance of one staff member for bed mobility, dressing, toileting and personal hygiene. Requires supervision with setup help only for eating. She is frequently incontinent of bowel and bladder.

Review of Resident #62's nurses notes from 1/30/19-2/27/19 indicate that on 2/15/19 at 11:33am Resident #62 "stated that she had thoughts of suicide but with no plan. Patient stated she wanted to end it all. Writer offered encouragement and support. Resident was assisted with hygiene and is sitting near nursing station Patient is also on 15 minute checks." Facility Administration provided survey team with Safety Rounds for Resident #62 dated 2/16/19 which covered from 12 midnight until 7:30pm. An additional sheet was attached that is unlabeled, listing times from 7:45pm-10:45pm stating "calm EB"[sic]. There is no resident name or date on the paper provided. Nursing notes continue to state resident is on 15 minute checks through 2/19/19, no evidence of the 15 minute checks was provided beyond 2/16/19. Survey team asked Director of Nursing if they had any additional safety checks for Resident #62 on

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3/14/19 and no additional information was provided. The facility failed to provide a safe environment and/or monitoring for Resident #62 who was verbalizing feelings of suicide.

Facility Administrator and Director of Nursing were notified of safety concerns for Resident #62 on 3/14/19.

No further information was provided.

8. For resident #27 the facility failed to provide an environment free of accident hazards due to the water barrier strip at the base of the shower being unsecured and creating a trip hazard and access to medications.

Resident #27, an 86 year old male, was admitted to the facility on 4/26/16. His diagnosis included but were not limited to: aphasia, nontraumatic intracerebral hemorrhage, facial weakness, dysphagia, hypothyroidism, hyperlipidemia, compression of brain and hypertension .

Resident #27's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 1/3/19 was coded as a quarterly assessment. Resident #27 was coded as having a BIMS (Brief interview for mental status) score of 3, indicating severe cognitive impairment. He was also coded as requiring extensive assistance of one staff member for transfers, locomotion on and off unit, dressing, toileting and personal hygiene. He requires supervision with setup assistance for eating.

On 3/12/19 during observation of the locked

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F 689	Continued From page 105 dementia unit, in Resident #27's room there was a water barrier strip at the base of the shower unsecured and creating a trip hazard. An interview with LPN D was conducted on 3/14/19 at approximately 3:20pm. LPN D stated that Resident #27 "self propels" and therefore would have access to items within his room, bathroom and on the unit. The Administrator and Interim Director of Nursing were made aware of the safety concerns on 3/13/19. No further information was provided.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		4/28/19

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F 690	Continued From page 106 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation the facility staff failed to provide appropriate treatment to prevent urinary tract infection for 1 Resident in a survey sample of 45 Residents. For Resident #48 the facility staff failed to ensure proper catheter care by allowing the catheter tubing to drag on the floor while transporting Resident in a wheelchair and while sitting in the hall. The findings include: Resident # 48, a 79-year-old woman was admitted to the facility on 6/30/12 with diagnoses of but not limited to Dementia, abnormal weight loss, history of stroke, history of pneumonia, anxiety disorder, and urinary retention related to Neurogenic Bladder. Most recent (Minimum Data Set) MDS (an assessment tool) was an annual with an (Assessment Reference Date) ARD of 1/16/19 codes Resident as being unable to	F 690	F690 It is the intent of this facility to ensure bowel/bladder incontinence, catheter, UTI are cared for in accordance with the regulation. Criterion 1 Resident #48 suffered no adverse outcomes related to the alleged deficiency. Upon notification from surveyor regarding resident #48 staff adjusted the catheter tubing so that it did not have contact with the floor. Criterion 2 Residents who use catheters are potentially affected. Criterion 3 Nursing staff will be re-educated regarding catheter care, including ensuring that catheters tubing does not	

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F 690	Continued From page 107 assess using the (Brief Interview of Mental Status) BIMS tool. The Resident is coded as not being understood and unable to screen indicating severe cognitive impairment. On 3/13/19 at 10:30 AM Resident #48 was observed being propelled in the wheelchair to the nurse's station. The catheter bag was placed in a dignity bag however the tubing was dragging on the floor under the wheelchair. The resident was observed sitting in her wheelchair at the nurse's station for over an hour. On 3/14/19 at 11:50, an interview was conducted with LPN C. LPN C was asked if she saw a problem with the way Resident #48 was dozing in her wheelchair at the nurses' station. LPN C stated, "oh she needs to be repositioned." She then realized the Resident's glasses were on the floor and knelt down to pick them up. LPN C was then asked what about her catheter? Is it supposed to be dragging on the ground under her chair? LPN C stated, "no I will take her to fix it" and proceeded to wheel Resident down the hall. When asked what would be the potential problem with the catheter dragging the floor, LPN C stated contamination with germs and it could get caught on something. On 3/14/19 at 1:00 PM, an interview was conducted with the DON about catheter care. She stated that the catheter should be in a drainage bag and neither should be touching the floor. On 3/14/19 the facility's catheter care policy/procedure was reviewed but it did not address the tubing being kept off of the floor.	F 690	touch the floor. Criterion 4 DON and/or designee will complete five (5) random audits of residents using catheters to ensure tubing is not in contact with the floor. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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F 690	Continued From page 108 On 3/14/19 during the end of day meeting, the DON and Administrator were made aware and no further information was provided.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, clinical record review and facility documentation review, the facility staff failed to administer oxygen in a manner to prevent the spread of infection for two Residents (Residents #70 and # 86) in a survey sample of 45 Residents. 1. For Resident #70, the nebulizer tubing was not dated. 2. For Resident # 86, there were two different dates on the oxygen humidifier bottle. The finding include: 1. For Resident #70, the nebulizer tubing was not dated. Resident #70, a 96 year old woman who was	F 695	F695 It is the intended practice of this facility to ensure respiratory/tracheostomy care and suctioning is done in accordance with the regulation. Criterion 1 Resident #70 suffered no adverse outcomes related to the nebulizer tubing allegedly not being dated. The tubing was changed and dated when brought to facility□s attention. Resident #86 suffered no adverse outcomes related to allegedly having two different dates on the oxygen humidifier bottle, which was changed and dated when brought to the facility□s attention. Criterion 2	4/28/19

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F 695	Continued From page 109 admitted to the facility on 12/9/09 with diagnoses of but not limited to Hemiparesis following stroke affecting right (dominant) side, anemia, history of heart attack, long term use of inhaled steroids, osteo arthritis and dementia without behavioral disturbance. On 3/12/19, upon initial tour, it was observed that Resident #70 had a nebulizer in her room with tubing that was not dated. On 3/12/19 at 11:50 AM, an interview with the DON was conducted and she was asked about the policy for oxygen and Nebulizer tubing. The DON stated " It is changed and dated weekly on Wednesday night shift." The facility Oxygen and Respiratory care policy (provided by the DON) reads: Related Supplies and Storage 5. Oxygen tubing, nebulizers, masks and humidifier bottles will be dated when changed. Changing of the oxygen tubing and related supplies will be done weekly by night shift. On 3/13/19 the Administrator and the DON were made aware during the end of day meeting and no additional information was provided. 2. For Resident # 86, there were two different dates on the oxygen humidifier bottle. Resident # 86, a 90 year old female was admitted to the facility on 12/1/2018. Diagnoses included but were not limited to: Chronic Obstructive	F 695	Residents receiving respiratory care have the potential to be affected. Criterion 3 Nursing staff will be re-educated on ensuring accurate dates are on respiratory materials, including tubing, masks and humidifier bottles. Criterion 4 DON and/or designee will complete five (5) random audits of residents using respiratory equipment to ensure they□re properly dated. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is April 28, 2019.	

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Pulmonary Disease, Acute and chronic respiratory failure with hypercapnia, Heart Failure, Hypertension, anemia, Abdominal Aortic Aneurysm, and Osteoporosis.

Resident # 86's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/22/2019. The MDS coded Resident # 86 with a BIMS (Brief Interview for Mental Status) score of "13" out of 15, indicating no cognitive impairment. Resident # 86 was coded as requiring extensive assistance of one staff person for Activities of Daily Living and occasionally incontinent of bowel and bladder.

On 3/12/19 at 9:40 AM during the initial tour of the facility, Resident # 86 was observed sitting in a chair in her room with oxygen via nasal cannula at 2 liters per minute. The oxygen humidifier bottle had a date of 3/5/2019 written in fine point black ink and the top of the bottle had the date 3/9/19. The "9" was visibly written on top of another date that was illegible. There was a red "Oxygen in Use" sign on the door frame.

On 3/12/2019 at 9:45 AM , an observation of a visitor enter Resident # 86's room. The visitor identified herself as Resident # 86's daughter.

On 3/12/2019 at 9:50 AM, an interview was conducted with the daughter of Resident # 86 who stated the "oxygen is an issue" She stated the facility staff often put the nasal cannula upside down in the resident's nose. The daughter stated the oxygen tubing and humidifiers were not changed weekly as they were supposed to be changed. Daughter stated she saw there was no date on the oxygen humidifier, so on 3/5/2019,

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she put the date 3/5/2019 on the label on the front of the humidifier bottle in pen to see if it was going to be changed., Daughter stated she noticed that someone wrote a different date written on top of the bottle in magic marker and that it was in conflict with when the bottle was put in her mother's room.

Review of the Care Plan on Page 8 of 35 revealed
"problem: start date 3/4/2019, Category: Respiratory ____(Resident # 86) has a diagnosis of exacerbation of COPD and chronic respiratory failure.
Approach: Start date: 3/4/2019
Oxygen as ordered: use concentrator when resident is seated or in bed in room,, oxygen tanks to chair when mobile and in activity and dining areas.

Resident is to take concentrator out of room to dinning [sic] room for meals per RP (Responsible Party) request."

On Page 31 of 35 Problem start date 3/4/2019 "____(Resident # 86) is on oxygen therapy as ordered for SOB (Shortness of Breath):
Approaches included: Oxygen administered as ordered"

During the end of day debriefing on 3/1/19 at approximately 5:00 PM, the Administrator and Director of Nursing were informed of the different dates on the humidifier bottle. The Director of Nursing stated the oxygen tubing and supplies were expected to be changed weekly on night shift every Wednesday night.

On 3/13/2019 at 6:15 PM, the Director of Nursing

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F 695	Continued From page 112 and surveyor went to Resident 86's room to inspect the oxygen equipment. The Director of Nursing inspected the oxygen equipment and stated she could not explain the different dates on the humidifier bottle. Review of the Facility Policy on Oxygen administration storage and maintenance, Date 9/1/2015 revealed: "Related supplies and storage 5. Oxygen tubing, nebulizers, masks and humidifier bottles will be dated when changed. Changing of oxygen tubing an related supplies is done weekly by night shift." No further information was provided.	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on facility documentation review and staff interview the facility failed to provide regular in-service education based on the outcome of performance reviews at least every 12 months for one employee in a survey sample of 6 employees. The facility failed to ensure CNA F was provided a minimum of 12 hours of in-service training	F 730	F730 It is the intended practice of this facility to perform nurse aide performance review-12hr/yr in-service in accordance with the regulation. Criterion 1	4/28/19

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F 730	Continued From page 113 annually. The findings include: Employee records were reviewed with the HR Director on 3/14/19 at 2:19pm. Those records indicated that CNA F, with a hire date of 8/17/11, had attended several training's in December 2018. She stated "they usually last 15-20 minutes each." A total of 1.25 hours of inservice hours were recorded for CNA F for 2018. There was no evidence of receiving the required 12 hours of in-service training, based on performance reviews for 2017 or 2018. Interview with Employee K, HR Generalist on 3/14/19 at approximately 2:50pm indicated she had no further information she could afford to the survey team. The Administrator was made aware of the findings during the end of day meeting on 3/14/19. No additional information was provided.	F 730	Facility residents suffered no adverse outcomes related to CNA F allegedly not receiving a minimum of 12 hours of in-service training. Criterion 2 All residents are potentially affected when CNAs do not meet training requirements. An audit of all training records will be used in identifying staff who are delinquent and put systems in place to ensure that training is completed Criterion 3 C.N.A. will be reeducated on completing all scheduled in-services timely. Criterion 4 HR/designee will complete a random audit of C.N.A. training weekly to ensure timely completion. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in	F 809		4/28/19

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F 809	Continued From page 114 the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interviews and facility documentation review, the facility staff failed to provide meals at regular times for five residents (Residents # 46, # 62, # 40, # 48, # 34 and # 86) in the survey sample of 45 residents. 1. For Resident # 46, breakfast was not served until 10:05 AM on 3/12/2019. 2. For Resident # 62, breakfast was not served until 9:46 AM on 3/13/19 3. For Resident # 40, breakfast was not served until 9:48 AM on 3/13/19. 4. For Resident # 48, breakfast was not served until 9:58 AM on 3/13/19. 5. For Resident # 34, breakfast was not served until 10:08 AM on 3/13/19.	F 809	F809 It is the intended practice of this facility to ensure the frequency of meals and snacks is followed in accordance with the regulation. Criterion 1 Residents #46, #62, #40, #48, #34 and 86 suffered no adverse outcomes related to allegedly being served breakfast later than the scheduled meal time. Criteria 2 All residents have the potential to be affected Criteria 3 Nursing staff will be re-educated on adhering to facility meal times, unless the resident has a known and care planned	

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F 809	Continued From page 115 6. For Resident # 86, breakfast was not served until 9:42 AM on 3/13/2019. Findings included: On 3/12/2019, the following observations were made concerning breakfast being served in the Second Floor Dining Room Unit 2. 3/12/2019 at 10:00 AM, Observed CNA J sitting at table with two residents helping them finish the last of their meal. 3/12/2019 at 10:05 AM, observed CNA (Certified Nursing Assistant) D go to the counter for a tray and gave to Resident # 46. 3/12/2019 at 10:10 AM, observed Resident # 46 being fed by CNA (Certified Nursing Assistant) D. On 3/13/2019 at 9:42 AM an interview was conducted with dining staff (Employee G) who showed the meal cards still on the counter waiting for breakfast to be prepared. There were cards still waiting for four residents. (Residents # 40, # 62, # 34, and # 48). Employee G explained the process for dining services in the dining rooms on each unit. Employee G stated the Dietary Staff serve a hot meal from the steam tables on each unit. The meal tray tickets are placed on the counter. The nursing staff pick up the meal tray ticket and give to the Dietary Staff when the resident is ready to be served the meal. Breakfast is from 8:00 am -9:30 am each day.	F 809	preference for early or late meals. Staff will also be informed that when unexpected incidents or resident needs result in a need for additional staff in the dining room, they are to inform the DON/Sup, or Administrator, who will assist them by obtaining other staff members who are trained or licensed to assist in the dining room. Criteria 4 DON and/or designee will complete five (5) random audits of resident meals services to ensure residents are eating during scheduled meal times. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is April 28, 2019.	

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F 809	Continued From page 116 Lunch is 12:00 pm -1:30 pm Dinner is 5:45 pm - 7:15 pm On 3/13/2019, the following observations were made concerning breakfast being served in the Second Floor Dining Room Unit 2. 9:44 AM: CNA G went to the pantry window, requested the breakfast for Resident # 40. Dietary staff prepared tray, pureed diet-eggs, pancakes with syrup, cream of wheat, and placed on counter 9:46 AM: RN (Registered Nurse) B, unit manager, wheeled Resident # 62 in Dining Room, sat her at a table with two residents who were already finishing their meals. RN B retrieved the breakfast tray for Resident # 62 from the dining counter. 9:48 AM: CNA G retrieved Resident # 40's tray from counter and took to Resident # 40's room. 9:50 AM: two tickets were still on counter- One for Resident # 34 and one for Resident # 48. RN B stated the staff was getting Resident # 48 up now and Resident # 34 went somewhere this morning. 9:58 AM: Resident # 48 was wheeled into the dining room, sat at table by herself, nurse put on apron, retrieved her tray from the ledge and sat down to feed her. 10:06 AM: CNA D wheeled Resident # 34, into dining room and told dining staff to prepare her breakfast tray. 10:07 AM: CNA D poured orange juice into a glass and gave it to Resident # 34.	F 809		

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10:08 AM: CNA D retrieved the breakfast tray from the ledge and placed it in front of the Resident # 34.

10:24 AM: Resident # 34 still eating breakfast, feeding self with cueing from CNA D

10:30 AM: Resident # 34 finished eating breakfast, CNA D wheeled Resident # 34 out of the dining room.

10:35 AM: Dining room staff finished cleaning the dining area and took food cart to kitchen along with another staff person.

12:07 PM: staff wheeling residents into the dining room for lunch.

On 3/14/2019 at 9:00 AM, An interview with Employee G from Dietary was conducted. Employee G stated if the nursing staff has not brought the residents to the dining room by the time she leaves, she wraps the plate in plastic, puts it in the refrigerator and the nursing staff will use the microwave to heat it. Employee G stated there are alcohol wipes and a thermometer left on the counter for the staff to make sure the food is at the right temperature. Employee G stated she waits as long as she cans before leaving the dining room to go back to the kitchen. Employee G stated she has to wash dishes to prepare for the next meal after leaving the dining room. Employee G stated the dining room could not be cleaned until the residents finished eating.

On 3/14/2019 at 12:05 PM, an interview with the Dietary Manager was conducted. The Dietary Manager state that the dining services are

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delivered on time and they are dependent on nursing staff to get the food to resident. The Dietary Manager stated she was concerned about the quality of the food after 2 hours. Dietary Manager stated the facility administrative staff have a "stand up meeting" every morning where they discuss issues with the managers of each department. The Dietary Manager stated they discuss ways to problem solve any issues presented. The Dietary Manager stated when the nursing staff worked short of staff, it affected the times the meals were finished on each unit. The Dietary Manager stated snacks were available on each unit and the nursing staff had access to the pantry.

On 3/14/2019 at 5:10 PM, an interview was conducted with LPN (Licensed Practical Nurse) C who stated the nursing staff was responsible for getting residents to the dining room to eat meals. LPN C stated Resident # 34 typically ate her meals in the dining room. LPN C stated on the 3-11 shift, all of the residents usually have been served their meals and the kitchen area is cleaned.

Review of the Healthcare Center Meal Delivery Log for March 2019 revealed documentation of breakfast times for the last resident served varied from 8:45 AM to 10:00 AM. The times the server and hot box left the pantry varied from 9:15-10:15 and the times the pantry and dining room were cleaned varied from 10:15-11:30.

Residents in the survey sample who were observed to receive breakfast late listed below:

1. For Resident # 46, breakfast was not served

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until 10:05 AM on 3/12/2019.

Resident # 46, a 95 year old male, was admitted to the facility on 6/22/18. His diagnosis included but were not limited to: Hypertension, Diabetes, Dementia, and Depression

Resident # 46's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/31/19 was coded as a quarterly assessment. Resident #46 was coded as having a BIMS (Brief Interview for Memory Status) score of 10 indicating moderate cognitive impairment. He was also coded as requiring extensive assistance with assistance of one to two staff members for bed mobility, dressing, toileting and personal hygiene. Resident # 46 required supervision with setup help only for eating. He was always incontinent of bowel and bladder.

On 3/12/2019 at 10:00 AM, Resident # 46 was observed sitting in a wheelchair at a table with two other residents. The other residents were finishing their breakfast.

3/12/2019 at 10:05 AM, observed CNA (Certified Nursing Assistant) D go to the counter for a tray and gave to Resident # 46.

3/12/2019 at 10:10 AM, observed Resident # 46 being fed by CNA (Certified Nursing Assistant) D.

During the end of day debriefing on 3/13/2019, the Administrator and Director of Nursing were informed of the findings.

No further information was provided.

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2. For Resident # 62, breakfast was not served until 9:46 AM on 3/13/19.

Resident #62, a 79 year old female, was admitted to the facility on 5/7/18. Her diagnosis included but were not limited to: presence of right artificial hip joint, mood disorder, mild cognitive impairment, anxiety disorder, suicidal ideation's, primary insomnia, repeated falls, and overactive bladder.

Resident #62's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/13/19 was coded as a quarterly assessment. Resident #62 was coded as having a BIMS (Brief Interview for Memory Status) score of 13 indicating cognitively intact. She was also coded as requiring limited assistance with assistance of one staff member for walking in her room and corridor. She is coded as requiring extensive assistance of one staff member for bed mobility, dressing, toileting and personal hygiene. Requires supervision with setup help only for eating. She is frequently incontinent of bowel and bladder.

On 3/13/19 at 9:46 AM, RN (Registered Nurse) B, unit manager, wheeled Resident # 62 in Dining Room, sat her at a table with two residents who were already finishing their meals. RN B retrieved the breakfast tray for Resident # 62 from the dining counter.

3. For Resident # 40, breakfast was not served until 9:48 AM on 3/13/19.

Resident # 40, a 79 year old female, was

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admitted to the facility on 5/7/18. Her diagnosis included but were not limited to: presence of right artificial hip joint, mood disorder, mild cognitive impairment, anxiety disorder, suicidal ideation's, primary insomnia, repeated falls, and overactive bladder.

Resident # 40's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/13/19 was coded as a quarterly assessment. Resident # 40 was coded as having a BIMS (Brief Interview for Memory Status) score of 13 indicating cognitively intact. She was also coded as requiring limited assistance with assistance of one staff member for walking in her room and corridor. She is coded as requiring extensive assistance of one staff member for bed mobility, dressing, toileting and personal hygiene. Requires supervision with setup help only for eating. She is frequently incontinent of bowel and bladder.

On 3/13/19 at 9:44 AM, CNA G went to the pantry window, requested the breakfast for Resident # 40. Dietary staff prepared tray, pureed diet-eggs, pancakes with syrup, cream of wheat, and placed the tray on the counter

9:48 AM: CNA G retrieved Resident # 40's tray from counter and took it to Resident # 40's room.

10:20 AM: Observed CNA G bringing the tray out of Resident # 40's room.

During the end of day debriefing on 3/13/2019, the Administrator and Director of Nursing were informed of the findings.

No further information was provided.

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4. For Resident # 48, breakfast was not served until 9:58 AM on 3/13/19.

Resident # 48, a 79 year old woman was admitted to the facility on 6/30/12 with diagnoses of but not limited to Dementia, abnormal weight loss, history of stroke, history of pneumonia, anxiety disorder, and urinary retention related to Neurogenic Bladder.

The most recent (Minimum Data Set) MDS (an assessment tool) was an annual assessment with an (Assessment Reference Date) ARD of 1/16/19 coded Resident# 48 as being unable to assess using the (Brief Interview of Mental Status) BIMS tool. The Resident was coded as not being understood and unable to screen indicating severe cognitive impairment.

On 3/13/2019, breakfast meal was observed in the dining room on Unit 2.

9:50 AM: two tickets were observed still on counter and one was for Resident # 48. RN B stated the staff was getting Resident # 48 up now.

9:58 AM: Resident # 48 was wheeled into the dining room, sat at table by herself. Licensed Practical Nurse, LPN K, put on apron, retrieved her tray from the ledge and sat down to feed her.

On 3/13/19 at 10:26 AM, Resident # 48 was finished with the meal. LPN (Licensed Practical Nurse) C wheeled Resident # 48 out of the dining room.

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During the end of day debriefing on 3/13/2019, the Administrator and Director of Nursing were informed of the findings.

No further information was provided.

5. For Resident # 34, breakfast was not served until 10:08 AM on 3/13/19.

Resident # 34, a 84 year old female was admitted to the facility on 10/21/2015. Diagnoses included but were not limited to: Diabetes, Hypertension, Parkinson's Dementia and Depression .

Resident # 34's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/22/2019. The MDS coded Resident # 34 as having severe cognitive impairment. Resident # 34 was coded as requiring extensive assistance of one staff person. for Activities of Daily Living and always incontinent of bowel and bladder.

On 3/13/2019 at 10:06 AM, staff member, CNA (Certified Nursing Assistant) D, wheeled Resident # 34, into dining room. CNA D told the dining staff to prepare breakfast tray for Resident # 34.

On 3/13/2019 at 10:07 AM, CNA D poured orange juice into a glass and gave it to Resident # 34.

On 3/13/2019 at 10:08 AM, CNA D retrieved the breakfast tray from the ledge and placed it in front of the resident.

On 3/13/2019 at 10:24 AM, Resident # 34 still eating breakfast, feeding self with cueing from

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CNA D.

On 3/13/2019 at 10:30 AM, Resident # 34 finished eating breakfast. CNA D wheeled Resident # 34 out of the dining room.

On 3/13/2019 at 10:35 AM, Dining room staff finished cleaning the dining area and took food cart to kitchen along with another staff person.

On 3/13/2019 at 12:07 PM, staff wheeling residents into the dining room for lunch.

During the end of day debriefing on 3/13/2019, the Administrator and Director of Nursing were informed of the findings.

No further information was provided.

6. For Resident # 86, breakfast was not served until 9:40 AM on 3/13/2019.

Resident # 86, a 90 year old female was admitted to the facility on 12/1/2018. Diagnoses included but were not limited to: Chronic Obstructive Pulmonary Disease, Acute and chronic respiratory failure with hypercapnia, Heart Failure, Hypertension, anemia, Abdominal Aortic Aneurysm, and Osteoporosis.

Resident # 86's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/22/2019. The MDS coded Resident # 86 with a BIMS (Brief Interview for Mental Status) score of "13" out of 15, indicating no cognitive impairment. Resident # 86 was coded as requiring extensive assistance of one staff person. for Activities of Daily Living

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and occasionally incontinent of bowel and bladder.

On 3/12/2019 at 9:40 AM, an interview was conducted with the daughter of Resident # 86 who stated there was a problem of the facility staff not getting her mother (Resident # 86) ready for breakfast early like she desired. Resident # 86's daughter stated that when her mother ate breakfast late, it meant she had decreased socialization with others. She stated there were times that breakfast was eaten so late that there were only a couple of hours between breakfast and lunch. She stated Resident # 86 did not want to eat lunch when breakfast was eaten so late. She also stated she was concerned because she did not want her mother to lose weight. She stated she had several discussions with the facility staff to express her desire to have her mother eat breakfast early in the dining room. Resident # 86's daughter stated changes were made to the care plan to help make sure her needs were met.

On 3/13/2019 at 8:30 AM, Resident # 86 was observed lying in bed. Resident # 86 told the surveyor she was waiting to get up so she could go to breakfast.

On 3/13/2019 at 9:30 AM, Resident # 86's daughter was observed walking in the hallway toward Resident # 86's room. Resident # 86's daughter asked "Hi Mom, have you had breakfast yet? Let's get ready to go to the Dining Room" Resident # 86's daughter helped Resident # 86 wash her face and hands, get dressed and wheeled her to the dining room.

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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 809	Continued From page 126	F 809		

On 3/13/2019 at 9:40 AM, Resident # 86's daughter retrieved the breakfast tray from the ledge on the kitchen counter and at 9:42 AM, Resident # 86 began eating breakfast, her daughter was sitting beside her, talking to her.

On 3/13/2019 at 9:55 AM, an interview was conducted with Resident # 86's daughter who stated "now this means there would be less than 3 hours between breakfast and lunch! " The daughter stated the other residents who sit at the table with her mother were finished eating. The daughter stated meal time is a time for socialization and not going to breakfast on time meant very little time for socialization.

On 3/13/2019 at 12:07 PM, Resident # 86 was observed being wheeled by her daughter into the dining room for lunch. Resident # 86's daughter sat beside her. There were two other residents at the table eating lunch with Resident # 86.

On 3/13/2019 at 2:10 PM, an interview was conducted with Registered Nurse (RN B) who stated the facility staff was working short and had not gotten Resident # 86 up for breakfast prior to when the daughter arrived.

On 3/13/2019 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The Administrator stated the facility had ample staff of 3 to four Certified Nursing Assistants on each unit. The DON stated the facility staff were expected to get the residents ready for breakfast at the time they desired.

No further information was provided.

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F 812	Continued From page 127	F 812		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed to store and serve food in accordance with professional standards for food service safety. 1. Facility staff failed to ensure an air gap was in place between the ice machine drainage pipe and floor drain for the ice machine in the main kitchen. 2. Nursing staff CNA (Certified Nursing Assistant) D was observed entering the kitchen without a hair net on Unit 2.	F 812	F812 It is the intended practice of this facility to ensure food is stored, prepared and served in a sanitary manner in accordance with the regulation. Criterion 1 Upon notification from the surveyor regarding the air gap placement under the ice machine. The Maintenance Director immediately fixed the gap. Upon notification from surveyor regarding CNA entering kitchen without a hairnet,	4/28/19

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F 812	Continued From page 128 The findings included: 1. Facility staff failed to ensure an air gap was in place between the ice machine drainage pipe and floor drain for the ice machine in the main kitchen. A tour of the main kitchen took place on 3/12/19 at 8:10 a.m. with the Dietary Manager. Upon inspection of the ice machine, it was observed that one of the two drainage pipes from the ice machine was flush against the floor drain cover plate. There was no air gap in place to allow for back flow from the drain. After looking at the drainage pipe, the Dietary Manager stated that both pipes should be elevated off the drain. She stated that it looked like the weight of one pipe was pressing against the other and caused one pipe to hang too low. The Dietary Manager stated the Maintenance Director would be notified immediately of the problem. On 3/12/2019 at 1:10 PM, during another inspection of the kitchen, it was observed that both pipes were elevated off the drain cover plate. On 3/12/2019 at 3:05 PM, the administrator was informed of no air gap on the ice machine in the main kitchen. The administrator stated he would make sure the problem was corrected. During the end of day debriefing on 3/13/2019, the facility administrator and Director of Nursing were informed of the findings of the drainage pipe from the ice machine in the main kitchen was flush against the floor drain. There was no air gap in place. The Administrator stated the	F 812	CNA was re-educated on wearing a hairnet in the kitchen. Criterion 2 All residents have the potential to be affected. Criterion 3 Dietary staff will be reeducated on checking the air gap under the ice machine, and report inadequate gap. to Maintenance for immediate action. Staff will be re-educated on wearing hairnets in the kitchen / pantry area. Criterion 4 Dietary director/designee will check air gap on ice machine, document by the submitted to the Administrator for review. The Administrator or designee will complete five (5) random audits of kitchens to ensuring staff is wearing hairnets. These audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is April 28, 2019.	

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F 812	Continued From page 129 problem had been corrected immediately by Maintenance. No further information was provided. 2. Nursing staff, CNA (Certified Nursing Assistant) D, was observed entering the kitchen without a hair net on Unit 2. On 3/14/2019 at 9:30 AM, CNA (Certified Nursing Assistant) D, was observed entering the kitchen without a hairnet on. Employee G turned around to see who entered the kitchen. CNA D was going to the ice machine with a large plastic drinking cup in her hand. CNA D was interviewed immediately. CNA D stated she was sorry and stated she thought the dining services were finished. CNA D stated she should have had a hairnet on before entering the kitchen. Employee G stated all staff should have on hairnets before entering the kitchen. Employee G showed the surveyor that hairnets were available in the kitchen. On 3/14/2019 during the end of day debriefing, the Administrator and Director of Nursing (DON) were informed that facility nursing staff did not wear a hairnet when she entered the kitchen. The DON stated all staff should wear hairnets in the kitchen. No further information was provided.	F 812		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance.	F 868		4/28/19

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F 868	Continued From page 130 §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on facility records and staff interview the facility failed to ensure the minimum staff were part of the facility quality assessment and assurance committee. The facility failed to ensure the director of nursing services and medical director attended the quality assurance meetings. The findings included: Review of the facility quality assurance meeting held on 1/16/19 sign in sheet, showed that the Director of Nursing failed to attend the meeting. During interview with interim Director of Nursing on 3/14/19 at approximately 3:40pm regarding the absence of the director of nursing, the interim Director of Nursing (DON) acknowledged the DON had not been present for at least 50% of the meeting. She stated, "She must have forgot to sign in, I know she was there because we were	F 868	F868 It is the intended practice of this facility to have a QAA committee in accordance with the regulation. Criterion 1 No resident suffered any adverse outcomes related to the Director of Nursing (DON) not signing the QA sign-in sheet. DON no longer the DON at Beth Sholom Home. She was in attendance at the January meeting, but did not sign. The Medical Director and two other physicians signed attendance the 3rd quarter QA meeting, which was held on October 24, 2018. Criterion 2 All residents are potentially affected by the presence of minimum staff at the QA	

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F 868	Continued From page 131 half way through the meeting when she came in." Quality Assurance meeting held 9/25/18 sign in sheet showed that the Medical Director did not attend the meeting. The facility Administrator was made aware of the findings on 3/14/19 at approximately 3:45pm. No further documents were provided.	F 868	Meeting. Criterion 3 The new Director of Nursing is aware of her duty to attend and sign for attendance at each meeting. The sign in sheet for all QA Meetings will be passed TWICE at each meeting, once at the beginning and again at the conclusion, to assure that all attendees have been given the opportunity to sign. Criterion 4 The Administrator or designee will audit all QA meetings going forward to ensure all required parties are in attendance and sign the sign-in sheet. Criterion 5 Date of compliance is April 28, 2019	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/28/19

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F 880	Continued From page 132 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 133 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, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide Linens, Oxygen, and Activities of Daily Living (ADL) care supplies in a manner to prevent the spread of infection, in the general environment, laundry, in the unit 2 clean utility room, on medication carts in unit 1, and in the shower room of unit 2. In addition, the facility failed to develop and implement a water management plan for Legionella. Dust and mildew were on ventilation areas. Clean Linens were left uncovered, and handled improperly. Used and dirty oxygen tanks were commingled with clean unused oxygen tanks. Dirty ADL carts were brought into the clean utility room from the shower room, containing used and dirty resident care items. Medication carts were unsanitary, and dirty. Clean items were stored together in the room, with dirty items, and commingled. Staff did not practice accepted infection control standards. The findings included:	F 880	F880 It is the intended practice of this facility to ensure the facility follows the infection prevention and control program in accordance with the regulation. Criterion 1 Upon notification from surveyors regarding the linens, oxygen and ADL care supplies being allegedly improperly stored, staff members immediately stored and/ or cleaned items to prevent the spread of infection: The unit 2 clean utility room, medication carts and shower room on unit 2 were cleaned, dust and mildew were removed from ventilation areas, clean linens were stored properly, O2 tanks were stored properly and not mixed, ADL carts were cleaned, clean and dirty items were stored separately. Mattresses stored in poor condition were discarded.	

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F 880	Continued From page 134 The observations of 3-12-19 through 3-14-19 included the following (8) areas: 1. During initial tour of the facility, in the units 1, and 2 hallways, the ceiling vents were thickly coated in a spotty black substance which appeared like mildew, and covered in dust. Mattresses were found propped against the walls in numerous rooms, and found to have holes, and rips (appeared shredded) in various areas of the plastic/nylon fabric coverings, revealing the sponge like foam core which could not be disinfected. Staff stated these were used for fall mats, after they could no longer be used on beds because of "the torn up covers". 2. During observations of unit 3, laundry staff on unit 3 at 10:58 a.m., were pushing dirty laundry through the unit in an uncovered cart. 3. In a unit 2 shower stall which was dirty, a black spotted substance which appeared to be mildew was circumferentially around the base of the shower. There was a soap residue clumped and white on the shower floor, a staff member (CNA D) was seen from the hallway exiting the shower room with a large 2 shelf cart, and pushed the cart into the clean utility room. 4. In the dirty utility room the cabinet under the sink had a broken door which had fallen with one corner touching on the floor. 5. The unit 2 clean utility room observation was	F 880	Criterion 2 All residents have the potential to be affected by the cleanliness. Criterion 3 All staff, re-educated on proper infection control measures. The facility Maintenance Director will review the water management plan for Legionella, and ensure that it includes. Staff be re-educated regarding the storage and cleanliness of items in regards to infection control. Maintenance director will be re-educated to ensure the facility has a water management plan for legionella that includes a description of the facility water system. The facility QA nurse has attended Infection Preventionist training since the survey and will be reviewing facility policies and procedures to ensure that the standard or source of each practice is identified. Facility specific policies and procedures, including those for antibiotic stewardship, will be clearly identified within the infection control manuals. Criterion 4 Administrator or designee will complete five (5) random audits of resident care areas to ensure facility is following proper infection control procedures. Maintenance director or designee will ensure the facility implements a water management plan for	

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F 880	Continued From page 135 conducted with the unit 2 nurse manager. No Isolation supplies (gowns, and masks) were in the clean utility room, and were not readily available to staff. The unit 2 clean utility room contained 2 oxygen racks side by side as if they were connected, with 9 slots each, for oxygen tanks. In the first rack there were 6 oxygen tanks, 3 of the tanks were open, and 3 were closed. In the second rack there were 6 closed tanks. There was one more tank sitting in a rolling cart, with a regulator attached to it, that administers the oxygen for use. The oxygen had been recently used, as the oxygen regulator had been tapped into the tank, and the Christmas tree green oxygen tubing connector was still attached to the tank which allows tubing to be immediately connected. The tank was half full. The key to tap and access the oxygen, was laying on the floor connected to the rack by a lanyard. The Registered Nurse unit manager (RN B) was asked why clean and dirty oxygen was stored together in the clean utility room, when the clean and dirty utility rooms were directly beside one another. She responded "I would consider these open, and used, and I see what you are saying, it is questionable, I absolutely get it." She stated they had an oxygen delivery gentleman that brings the oxygen in and takes away the empty bottles, and that is where he put them. Oxygen policies were requested and supplied. The facility policy on oxygen storage stated under item #7, "Full and empty cylinders are segregated (separated) in facility storage. If a cylinder is partially full, it is stored with the empty cylinders or stored completely separately from full and empty cylinders."	F 880	legionella. audits will be done weekly x four (4) and monthly x two (2). These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criterion 5 Date of compliance is April 28, 2019.	

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6. The unit 2 clean utility room also contained 2 soiled PVC plastic rolling carts. The carts were approximately 3 feet tall by 2 feet wide by 4 feet long with an upper and lower shelf. The carts were heavily soiled on both shelves. The shelves were covered in a red speckled greasy substance, tan crusty crumbs which looked like cracker crumbs, human hair, a brown caked substance, and the wheels were wet with hair wrapped in them. On one cart was a clear bag open and the contents spilling onto the cart. The bag held clean, and dirty gloves and an open tube of lotion with a black banded watch wrapped around the lotion. The unit 2 nurse manager stated she believed the watch belonged to a male resident, and would find out. The carts also contained clean linens (towels and wash cloths) commingled with soiled gloves, soiled soap, soiled lotion, 2 used small rat tail combs, for hair, heavily soiled with grease, dandruff, and hair, a used drinking cup with a lid had fallen onto the floor. Another bag open and spilling onto the second cart contained open "butt paste" incontinence barrier cream, drinking cups open and spilling uncovered onto the dirty cart. This room contained the uncovered clean linen on shelves for the residents on the unit, nutritional supplements such as ensure and glucerna and lab supplies for drawing blood, and nebulizer and suction machines. A third cart was in the room, and the unit manager stated it was a treatment cart. The trash can on the treatment cart had used gloves and bandages in the open trash can on the cart.

Interview with CNA D immediately after the observation (certified nursing assistant) revealed "After we use a linen cart, we are to remove the

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items on it, and return the cart to the clean utility room." CNA D was asked if the 2 carts in the clean utility room were clean linen carts used to deliver linen to Resident rooms, and she stated "yes, everybody uses them".

RN B was asked if this was acceptable in the clean utility room to commingle obviously soiled items with clean items that would be distributed to residents all over the unit. RN B stated "no, these carts look well used", and "this one, it's filthy dirty."

7. On 3-14-19 during medication pour and pass observations, and medication storage observations, the medication carts on units 1 and 2 were examined. The carts were found to have cracker crumbs, red sticky liquid, hair, what appeared to be insect wings, all inside the medication drawers where the bulk dose and unit dose medications were stored and administered from. A red, white, and brown commingled bumpy substance stuck to the outside of the medication cart above the trash can. The accumulated different substances had been adhered to the cart for long enough for each layer to dry hard, and could not be removed by a gloved hand wiping it briskly.

8. On 3-14-19 during environmental rounds observations, the laundry was observed at 2:30 p.m. The dining services director opened the laundry and went in with surveyors. The room was found to have dirty linen carts immediately in the first door, and the carts were covered. Mattresses were found propped against the wall, and found to have holes, and rips (appeared

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F 880	Continued From page 138	F 880		

shredded) in various areas of the plastic/nylon fabric coverings, revealing the sponge like foam core, and could not be disinfected. The clean laundry was around a corner by the dryers, folded and uncovered under a vent which was covered in dust. In the clean laundry area, the 3 dryers were full of damp clothes, and condensation from moisture was visible on the clear glass dryer doors. The laundry was still wet, and would remain that way until the following day.

The Dining services director stated the laundry staff had gone home for the day, as they only worked until 2:30 p.m. As the area was being examined a nursing staff member entered with what she described as "Dirty laundry", in a thin large clear plastic bag. She carried the bag with both arms next to her uniform, while wearing gloves through the facility, without it being in a covered cart. She was asked if anything in the bag posed an infection control hazard. She stated "I don't know." She was asked what she would do if the bag broke in a hallway while she carried it, and she stated "I don't know." She removed her gloves grabbed an uncovered full clean linen cart and exited to carry the cart to the unit. No handwashing was performed.

The facility infection control linen transport operational policy stated Separate carts must be used for transporting clean and soiled linens.

The interim Director of Nursing (DON), was interviewed on 3-14-19 at 3:00 p.m. in regard to the facility infection control program. The DON was asked what the facility infection control policy reference was, and she stated "We use med pass policies and procedures". She was asked if any other sources were used, and she stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 139 "No.", She was asked if any governmental reference was used or researched, and she stated "No.". She was then asked directly if the CDC (Centers for Disease Control) was referenced at any time. She stated "We use CDC for handwashing times, and TB (tuberculosis) screening. I believe the medical director uses CDC guidelines. A copy of the facility infection control policies was requested, and supplied. The facility infection control policy manual which was devised in 2001, and purchased from "Med Pass, Inc." was not facility specific, nor devised by the facility. The document was reviewed. The facility Administrator and DON were notified on 3-13-19, and 3-14-19, at the end of day debriefs, of the failure of staff to adequately implement an infection control program, and to practice accepted infection control standards. No further information was presented by the facility. Complaint deficiency. 9. The facility failed to develop and implement a water management plan for Legionella. During review of the facility water management program the facility had blank forms for the facility risk assessment, used to identify where Legionella and other waterborne bacteria could grow and spread in the facility water system. Review of the facility policy, "Water Management Program" the purpose of the policy and procedure reads, "The purpose of this policy is to provide a	F 880		

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F 880	Continued From page 140	F 880		

method to identify areas in the water system where Legionella bacteria can grow and spread, to monitor these areas and to reduce the risk of Legionnaire's disease." Procedures include but are not limited to: "1. The facility's water management program includes a description of the water system in the facility, and methods to monitor temperature and bacterial risk. 2. A risk management assessment is done annually and at any time there is a disturbance or change in the facility's water supply. 3. In addition to the annual assessment will be done annually, a risk assessment will be done any time there has been: a. A change in the pipework or system b. A change in the use of the system c. Any time there is reason to suspect contamination of the system." [sic]

Interview with the facility maintenance director on 3/14/19 was conducted. When asked about the description of the water system in the facility he stated, "I don't have that." When asked about the facility risk assessment to identify where Legionella and other waterborne bacteria could grow, employee D responded, "It should be in this book." When asked if it could be anywhere else he said "no."

The facility reported to the State Agency on 2/8/18 that they were "undergoing a major plumbing repair in the main kitchen, which will put the kitchen out of service for the next 24 to 48 hours." The facility again communicated on 2/9/18 to "let the office know of the completion of the kitchen plumbing repair." When employee D was asked about water testing after this incident he indicated it had not prompted any additional water testing.

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F 880	Continued From page 141 The facility Legionella policy was reviewed and revealed that "any time there is a disturbance or change in the facility's water supply" a "risk management assessment is completed." The Maintenance Director, Employee D stated the assessment was not reviewed or updated after the repairs were made, as per their policy. Administrator was made aware of the lack of a water management program on 3/14/19. No further information was provided.	F 880		