STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495404	A. BUILDING _____ B. WING _____	03/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GLEBE	250 GLEBE ROAD DALEVILLE, VA 24083

(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 03/27/2019 through 03/29/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/27/19 through 3/29/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 32 certified bed facility was 29 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews.	F 000		
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	F 622		5/1/19

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

Electronically Signed | 04/24/2019

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F 622	Continued From page 1	F 622		

otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the 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.

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F 622	Continued From page 2 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide the comprehensive care plan goals to the receiving provider for 2 of 15 residents (Resident #15 and Resident #23). The findings included: 1. The facility staff failed to provide the receiving	F 622	This Plan of Correction is our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 622	Continued From page 3 provider the comprehensive care plan goals for Resident #15 when the resident was admitted to the hospital 3/5/19. The clinical record of Resident #15 was reviewed 3/27/19 through 3/29/19. Resident #15 was admitted to the facility 2/21/19 with diagnoses that included but not limited to gastroesophageal reflux disease, convulsions, pain, Vitamin D deficiency, implantation of dual chambered pacemaker, non-ischemic cardiomyopathy, stage 4 CKD (chronic kidney disease), IDDM2 (insulin dependent diabetes mellitus type 2), multiple sclerosis, right bundle branch block, and hypothyroidism. Resident #15's 14 day MDS (minimum data set) assessment with an assessment reference date (ARD) of 3/21/19 assessed the resident with a BIMS (brief interview for mental status) summary score as 15/15. The interdisciplinary note dated 3/5/19 at 4:09:39 read, "Left unit for cardiac procedure." The clinical record had no documentation of what information was sent with Resident #15 when the resident was admitted to the hospital 3/5/19. The surveyor interviewed the director of nursing on 3/28/19 at 4:02 p.m. The DON was asked what information was sent with residents when they are transferred to the hospital. The DON stated the facility provided the bed hold policy, transfer/discharge form, a copy of the medication list, notification to ombudsman, advanced directive, and face sheet. The DON was asked if the comprehensive care plan goals were sent with the resident to the receiving provider. The DON stated care plans were not sent.	F 622	Tag 622 A. During review, the alleged deficient practice is the facility failed to send comprehensive care plan goals to the receiving provider for 2 of 15 residents. No residents were affected by the alleged deficient practice. In response, Transfer/Discharge envelopes were developed outlining required document/items to be sent to receiving facilities to ensure compliance with the comprehensive care plan goals. B. Residents residing on the healthcare unit have the potential to be affected by the alleged deficient practice. C. The facility will ensure that the alleged deficient practice will not occur by providing re-education to healthcare nursing staff on F Tag 622 Transfer and Discharge Requirements and education on the Transfer/Discharge envelopes. D. Director of Nursing and/or designee will audit Transfer and Discharge records to	

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F 622	Continued From page 4 The surveyor informed the administrator, the director of nursing, the infection preventionist, and the executive director of the above concern on 3/28/19 at 5:00 p.m. and again on 3/29/19 at 11:41 a.m. No further information was provided prior to the exit conference on 3/29/19. 2. The facility staff failed to send the CCP (Comprehensive Care Plan) goals when Resident #23 had to be transferred to the emergency room on 2/1/19. Resident #23 was admitted to the facility on 3/18/17 with the following diagnoses of, but not limited to Alzheimer's disease, stroke, anxiety and depression. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/1/19, the resident was coded as having short term and long-term memory problems and was severely impaired daily decision making. Resident #23 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene. The resident was totally dependent on 1 staff member for bathing. During the clinical record review conducted on 3/28/19 for this resident, the surveyor noted the resident had sustained facial injuries that occurred with a fall on 2/1/19. The surveyor could not find documentation of the CCP goals being sent to the emergency room on 2/1/19. At 4:02 pm, the surveyor asked the DON (director of nursing) what information is sent with a resident when they go to the emergency room. The DON stated, "transfer/discharge form, copy of the med (medication) list. We also notify the	F 622	ensure compliance in sending Comprehensive Care Plan Goals weekly x4 weeks then monthly x2 months randomly thereafter reporting compliance to Quality Assurance Committee.	

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F 622	Continued From page 5 RP (Responsible Party) of the bed hold policy and notify the Ombudsman if the resident is admitted to the hospital." The surveyor asked the DON if the CCP goals are sent with the resident when they are transferred to the emergency. The DON stated that she would get back with the surveyor on this. At 4:29 pm, the Don returned and stated, "The care plan goals are not sent." On 3/29/19 at 11:48 am, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 3/29/19.	F 622		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to administer the correct amount of eye drops to 1 of 15 residents (Resident #21). The findings included:	F 684	F684 1. Physician was notified of the incorrect number of eye drops administered to resident #21. Resident #21 is currently receiving Combigan as ordered by the physician. 2. Current residents were reviewed to	5/1/19

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F 684	Continued From page 6 The facility staff failed to administer the correct amount of eye drops to Resident #21 during a medication pass and pour observation. Licensed practical nurse #1 administered two (2)-eye drops of Combigan in Resident #21's right eye-not one drop as ordered. The surveyor observed a medication pass on 3/28/19 with licensed practical nurse #1 beginning at 7:51 a.m. L.P.N. #1 prepared medications for Resident #21 at the medication cart, entered the resident's room and administered the oral medications without any issues. L.P.N. #1 donned gloves. L.P.N. #1 attempted to administer Combigan 0.2-0.5% eye drops one (1) drop in the left eye but missed the eye. L.P.N. #1 then administered one drop in the left eye. L.P.N. #1 then administered two (2) drops of Combigan in the resident's right eye. L.P.N. #1 removed gloves and hands were washed. The surveyor reconciled the medications administered with the current March 2019 physician's orders. The order for the eye drops read, "Combigan 0.2%-0.5% eye drops Instill 1 drop by ophthalmic (eye) route every 12 hours-unspecified glaucoma." The surveyor informed L.P.N. #1 of the observation on 03/28/19 10:00 AM L.P.N. #1 stated she thought she had only given the resident 1 drop in each eye. The surveyor informed the director of nursing of the medication observation on 3/28/19 at 10:29 a.m. and requested the facility policy on medication administration.	F 684	identify correct administration of eye drops in the last 30 days. Corrections will be made as indicated. 3. Current licensed nursing staff were educated regarding administration of eye drops. Licensed nursing staff will administer eye drops per physician orders. Nursing leadership will review residents receiving eye drops weekly X 4 to ensure compliance in eye drop administration. 4. Process will be reviewed in QA committee for one quarter. 5. 5-1-2019	

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F 684	Continued From page 7	F 684		

The facility policy titled "Medication Administration and Documentation" read in part "C. Administer the medication verifying the "6 Rights"
1. Right resident
2. Right medication
3. Right dosage
4. Right route
5. Right time
6. Right documentation"

Resident #21 was admitted to the facility 3/11/19 with diagnoses, that included but not limited to, poisoning by other opioids, accidental, hyponatremia, hypertension, pain, allergic rhinitis, Vitamin D deficiency, glaucoma, hypothyroidism, insomnia, constipation, and urinary tract infection.

Resident #21's admission MDS (minimum data set) assessment with an assessment reference date (ARD) of 3/18/19 assessed the resident with a BIMS (brief interview for mental status) summary score as 15/15. The resident was interviewable.

The surveyor interviewed the resident after informing the director of nursing of the medication pass observation on 3/28/19 at 10:29 a.m. Resident #21 stated the nurse gave her one drop of her eye drops in each eye. Resident #21 did not acknowledge the missed attempt of medication in the left eye.

The surveyor informed the administrator, the director of nursing, the infection preventionist, and the executive director of the above concern during the end of the day meeting on 3/28/19 at 5:00 p.m.

No further information was provided prior to the

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F 684	Continued From page 8 exit conference on 3/29/19.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess for pain prior to wound care for 1 of 15 residents in the survey sample (Resident #29). The findings included: The facility staff failed to assess for pain prior to providing the wound care to Resident #29 on 3/28/19. Resident #29 was admitted to the facility on 2/5/19 with the following diagnoses of, but not limited to heart failure, high blood pressure, pneumonia, dementia, anxiety disorder, depression, respiratory failure and Stage 3 pressure ulcer. On the admission MDS	F 686	F686 1. Resident #29 was immediately assessed for pain. Resident #29'□s pain is monitored using the universal pain assessment tool. 2. Current residents receiving treatment for wounds were assessed for pain to ensure their pain is monitored using the universal pain assessment tool. Corrections will be made as indicated. 3. Current licensed nursing staff were educated regarding pain monitoring, assessing for pain prior to wound care and using the universal pain assessment tool. Nursing leadership will review residents receiving wound care weekly X 4 to ensure compliance in assessing for pain	5/1/19

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F 686	Continued From page 9 (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/19/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #29 was also coded as requiring limited assistance with dressing, personal hygiene and bathing. During the wound care observation made by the surveyor on 3/28/19 at 10 am, the nurse did not assess for pain prior to the performing wound care on Resident #29. The surveyor reviewed the MAR (medication administration record) for March 2019 and noted the following: " " ...Monitor Pain using Universal Pain Assessment Tool ... This pain monitoring was signed off as being carried out for the shifts of 7:00am-3:00pm, 3:00pm - 11 pm and 11pm-7:00 am. However, this pain monitoring was not specific to the time that RN (registered nurse) #1 had assessed for pain prior to the wound care that was observed by the surveyor. At 10:46 am, the surveyor notified the Infection Preventionist of the above documented findings. On 5:00 pm, the surveyor notified the administrative team of the above documented findings. The surveyor asked if the expectation by this team was for the nurses to assess for pain prior to performing wound care. The Infection Preventionist stated, "Yes, I would expect them to do this before performing any procedure." No further information was provided to the surveyor prior to the exit conference on 3/29/19.	F 686	4. Process will be reviewed in QA committee for one quarter. 5. 5-1-2019	

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to have scheduled medications available for administration to 2 of 15 residents (Resident #23 and Resident #28).	F 755	F755 1. The physician was notified of the omitted medication for Resident # 23 and # 28. Resident # 23 is currently receiving	5/1/19

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F 755	Continued From page 11 The findings included: 1. The facility staff failed to have a scheduled medication, Donapezil, available for Resident #23. Resident #23 was admitted to the facility on 3/18/17 with the following diagnoses of, but not limited to Alzheimer's disease, stroke, anxiety and depression. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/1/19, the resident was coded as having short term and long-term memory problems and was severely impaired daily decision making. Resident #23 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene. The resident was totally dependent on 1 staff member for bathing. During the clinical record review on 3/28/19, the surveyor noted on the February 2019 MAR (medication administrative record) the following: " " ... 2/16/19 9 pm ...Donepezil 10 mg (milligram) tab (tablet) none available-awaiting from Rx (pharmacy) ..." The surveyor notified the DON (director of nursing) of the above documented findings on 3/28/19 at 5 pm in the conference room. The DON stated, "I didn't realize this was not available." The surveyor notified the administrative team of the above documented findings on 3/29/19 at 11:48 am. No further information was provided to the surveyor prior to the exit conference on 3/29/19.	F 755	Donapezil as ordered by the physician. Resident # 28 is currently receiving Ativan as ordered by the physician. 2. Current residents were reviewed to identify any medications that have not been administered in the last 30 days. Corrections made as indicated. 3. Current licensed nursing staff were educated regarding procedures when a medication is not available at the time of administration. Licensed nursing staff will administer medications daily per physician orders. Nursing leadership will review medications not administered daily X 4 weeks to ensure availability of medications. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for one quarter. 5. 5-1-2019	

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F 755	Continued From page 12	F 755		

2. The facility failed to have a scheduled medication, Ativan, available for administration to Resident #28.

Resident #28 was originally admitted to the facility on 10/9/16 but was redmitted to the facility on 4/11/18 with the following diagnoses of, but not limited to heart failure, high blood pressure, dementia and anxiety disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/4/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 2 out of a possible score of 15. Resident #28 was also coded as requiring limited assistance for dressing, personal hygiene and bathing.

During the clinical record review on 3/27/19, the surveyor noted the following on the February 2019 MAR (Medication Administrative Record): " " ...2/11/19 9 pm ...Lorazepam 0.5mg (milligram) 1 po (by mouth) unavailable to give qhs (every night at bedtime). Meds (medicine) is reordered. Pharmacy is aware ..."

On 3/28/19 at 5 pm, the surveyor notified the administrative team of the above documented findings. The DON (director of nursing) stated, "Since this medication was a controlled medicine, the pharmacy would not do an emergency run because we were out. In addition, we couldn't use the backup pharmacy because the doctor would have to give us a hard script and then call and arrange this with the backup pharmacy. The physician had ordered this medication to be administrated daily at 9 pm.

The surveyor notified the administrative team of

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F 755	Continued From page 13 the above documented findings on 3/29/19 at 11:48 am. No further information was provided to the surveyor prior to the exit conference on 3/29/19.	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		5/1/19

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F 758	Continued From page 14 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 6 of 15 residents were free of unnecessary psychotropic medications that affected Resident #3, Resident #19, Resident #20, Resident #22, Resident #23, and Resident #31. The findings included: 1. The facility staff failed to monitor behaviors associated with the use of Sertraline for Resident #3. The clinical record of Resident #3 was reviewed 3/27/19 through 3/29/19. Resident #3 was admitted to the facility 3/6/17 with diagnosis that included but not limited to benign intracranial hypertension, encephalopathy, dysphagia, dysarthria and anarthria, non-traumatic intracranial hemorrhage, cognitive deficits	F 758	F758 1. The targeted behaviors of resident #3, #19, #20, #22, #23 and #31 are monitored as part of their comprehensive care plan to ensure they are free of unnecessary psychotropic medications. 2. Current residents receiving psychotropic were reviewed to determine that residents are free from unnecessary psychotropic medications. Corrections will be made as indicated. 3. Current licensed nursing staff were educated regarding psychotropic medication use to include targeted behavior monitoring. Licensed nursing staff will use behavioral monitoring sheets. Nursing leadership will review psychotropic medication use daily X 4 weeks to ensure compliance with behavioral monitoring. Any issues will be addressed immediately at the time of	

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F 758	Continued From page 15 following cerebrovascular disease, hypertension, major depressive disorder, hypothyroidism, pain, and neuromuscular dysfunction of the bladder. Resident #3's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 12/27/18 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #3 was not assessed with any signs or symptoms of delirium, no behaviors that affected others, and no indicators of psychosis. Resident #3's March 2019 physician's orders read in part "Sertraline 50 mg (milligrams) tablet give 1 tablet (50 mg) by oral route once daily." The current comprehensive care plan dated 4/8/18 identified "Psychotropic Drugs" as a concern. The care plan read in part "Resident #3 is on psychotropic medication related to anxiety and depression. (G) Resident #3 will be free of depressive behaviors and adverse effects of med through the review date. (A) Monitor and document all behaviors related to depression such as episodes of tearfulness, withdrawal from friends/family. (A) Monitor and document side effects of antidepressant such as lethargy, irritability, excitability, constipation, dry mouth. Monitor for least effective dose." The surveyor was unable to locate any evidence of monitoring of the targeted behaviors associated with the use of Sertraline. The surveyor informed the director of nursing (DON) of the above concern on 3/29/19 at 9:33 a.m. and requested the monitoring sheets for Sertraline. The DON stated, "We don't monitor antidepressants, hypnotics or antianxiety	F 758	identification. 4. Process will be reviewed in QA committee for one quarter. 5. 5-1-2019	

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medications-only antipsychotics."

The surveyor requested the facility policy on psychotropic medications on 3/29/19.

The facility policy titled "Psychotropic Drugs" read in part: "Individuals who are prescribed psychotropic drugs shall be regularly and systematically assessed and evaluated for tardive dyskinesia." The policy did not contain any other information about psychotropic medications other than tardive dyskinesia.

The surveyor informed the administrator, the director of nursing, the infection preventionist, and the executive director of the above concern in the end of the survey meeting on 3/29/19 at 11:41 a.m.

No further information was provided prior to the exit conference on 3/29/19.

2. The facility staff failed to monitor resident specific targeted behaviors, offer/implement non-pharmacological interventions prior to the use of Flurazepam, and monitor for side effectsassociated with the use of the hypnotic Flurazepam
for Resident # 19.

The clinical record of Resident #19 was reviewed 3/27/19 through 3/29/19. Resident #19 was admitted to the facility 3/6/19 with diagnoses that included but not limited to insomnia, dementia with behavioral disturbances, chronic diastolic heart failure, atherosclerotic heart disease, chronic kidney disease, stage 3, fall, contusion of right eyelid and periocular area, hypertension, paroxysmal atrial fibrillation, type 2 diabetes

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mellitus, mitral stenosis, gastroesophageal reflux disease, acute pain due to trauma, and hyperlipidemia.

Resident #19's fourteen (14) day MDS (minimum data set) assessment with an assessment reference date (ARD) of 3/20/19 assessed the resident with a BIMS (brief interview for mental status) summary score as 15/15. There were no assessed signs or symptoms of delirium, psychosis, or behaviors affecting others.

The current comprehensive care plan dated 3/19/19 identified an area that read: "Psychotropic Drugs-Resident requires us of Psychotropic Medication to manage insomnia-see insomnia CP (care plan). Alteration in sleep pattern related to insomnia. The care plan identified attempts to manage environment as able-minimize noise and light, allow soft music, use scent cammomille (sic), lavender for relaxation, soft soothing music. Manage comfort level-warm milk, position with pillows, back rub, pain control. Administer hypnotic, antianxiety or antidepressant as ordered-see POS (physicians order sheet) for med (medication), dose, and schedule. Assess effectiveness of med on sleep patterns.

Resident #19's March 2019 physician's orders included the order for Flurazepam 15 mg (milligrams) give 1 capsule by oral route once daily at bedtime for 14 days as needed for insomnia-order date 3/6/19. A second order dated 3/18/19 read "Flurazepam 15 mg capsule give 1 capsule (15 mg) by oral route once daily at bedtime for insomnia."

A review of the March 2019 medication

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administration record (MAR) revealed Resident #19 received prn Flurazepam every night from 3/6/19 through 3/17/19. The surveyor found no non-pharmacological interventions prior to the use of the medication documented on the reverse side of the March 2019 MAR. A review of the interdisciplinary notes indicated there were no non-pharmacological interventions prior to the use of the medication.

3/7/19 2:49:21 interdisciplinary note read "Flurazepam given for insomnia at 2330 (11:30 p.m.)." No non-pharmacological interventions offered or documented prior to use on the March MAR or in the interdisciplinary notes.

3/8/19 March MAR read "Flurazepam 15 mg insomnia (reason) 9P." No non-pharmacological interventions offered or documented prior to use on the March MAR or in the interdisciplinary notes.

3/9/19 21:30:46 (9:30:46 p.m.) interdisciplinary note read "Medicated for pain and insomnia." No non-pharmacological interventions offered or documented prior to use on the March MAR or in the interdisciplinary notes.

3/10/19 March MAR read "Flurazepam 15 mg insomnia (reason) 9P. Rsd request for sleep." No non-pharmacological interventions offered or documented prior to use on the March MAR or in the interdisciplinary notes.

3/11/19 March MAR read "Flurazepam 15 mg insomnia (reason) 9P. Rsd request for sleep." No non-pharmacological interventions offered or documented prior to use on the March MAR or in the interdisciplinary notes.

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3/12/19 March MAR read "Flurazepam 15 mg insomnia (reason) 9P. Requested for sleep." No non-pharmacological interventions offered or documented prior to use on the March MAR or in the interdisciplinary notes.

3/13/19 01:43:11 note read in part "Rsd (resident) requested pain medication and sleep medication @ (at) 9pm d/t (due to) facial pain and chronic insomnia. Rsd (resident) given prn Flurazepam 15 mg to help with noted pain to face and insomnia." No non-pharmacological interventions offered or documented prior to use.

3/13/19 22:43:30 (10:22:30 p.m.) read in part "PRN pain medication and PRN insomnia medication requested by resident; both administered at HS (bedtime)." No non-pharmacological interventions offered or documented prior to use.

3/15/19 March MAR read "Flurazepam 15 mg insomnia (reason) 9P. Rsd request-sleep." No non-pharmacological interventions offered or documented prior to use.

3/16/19 March MAR read "Flurazepam 15 mg insomnia (reason) 9P. Insomnia qhs." No non-pharmacological interventions offered or documented prior to use.

3/17/19 02:24:10 a.m. interdisciplinary note read in part "Rsd requested PRN Percocet 5/325 mg + Flurazepam 15 mg @ 9pm (QHS-every bedtime) for facial pain and insomnia. Rsd requests these each evening QHS. Noted in MD (medical doctor) communication book about considering scheduling medications at bedtime d/t (due to)

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use." No non-pharmacological interventions offered or documented prior to use.

The medication was ordered for nightly administration on 3/18/19 and the staff monitored the medication Flurazepam nightly from 3/18/19 through 3/25/19 to include targeted behaviors. The monitoring of the hypnotic was done for 1 week and then stopped.

The director of nursing was notified of the above concern on 3/29/19 at 10:47 a.m. The DON stated the staff monitor for 7 days and then stop. The DON stated the staff do not monitor antidepressants, antianxiety medications or hypnotics. The DON stated the staff do monitor antipsychotic medications.

The surveyor informed the administrator, the director or nursing, the infection preventionist and the executive director of the above concern on 3/29/19 at 11:41 a.m.

No further information was provided prior to the exit conference on 3/29/19.

3. The facility staff failed to monitor targeted behaviors while Resident #20 was receiving Ativan and Restoril.

Resident #20 was admitted to the facility on 3/1/19 with the following diagnoses, but not limited to cancer, heart failure, high blood pressure, thyroid disorder, anxiety and depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/13/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15.

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Resident #20 was also coded as requiring extensive assistance of 1 staff member for dressing and limited assist of 1 staff member for personal hygiene. The resident was coded as being totally dependent on 1 staff member for bathing.

During the clinical record review, the surveyor noted physician's orders for Ativan 0.25 milliliter by mouth three times a day as needed for 14 days for anxiety and Restoril 15 mg (milligrams) by mouth once daily as needed at bedtime for 14 days for sleep. The Ativan had a start date of 3/8/19 and the Restoril had a start date of 3/1/19. The surveyor reviewed the clinical record and could not find any behavior monitoring for the targeted behaviors that the staff was to monitor while a resident was on Restoril and Ativan.

On 3/29/19 at approximately 10 am, the surveyor notified the DON (Director of Nursing) that the surveyor could not find any behavior monitoring for the Restoril and Ativan that Resident #20 had been ordered and given. The DON stated, "We monitor the behaviors for the first 7 days then it is stopped. We don't continue the monitoring after that."

On 3/29/19 at 11:48, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 3/29/19.

4. The facility staff failed to monitor targeted behaviors while Resident #22 was receiving Cymbalta and Temazepam.

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Resident #22 was admitted to the facility on 8/1/18 with the following diagnoses of, but not limited to heart failure, anxiety, depression and insomnia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/27/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. Resident #22 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and was totally dependent on 1 staff member for bathing.

During the clinical record review on 3/29/19, the surveyor noted that the physician had ordered "Cymbalta 60 mg (milligram) by oral (mouth) route once daily" for anxiety disorders and "Temazepam 15 mg give 1 capsule by oral route daily at bedtime". These medications were originally ordered by the physician on 8/1/18 and was renewed by the physician on 3/7/19.

The surveyor reviewed the clinical record for behavior monitoring of the targeted behaviors for these medications. On 3/29/19 at approximately 11 am, the surveyor notified the DON (director of nursing) of the above documented findings. The DON stated, "We monitor the behaviors for the first 7 days then it is stopped. We don't continue the monitoring after that."

The administrative team was notified of the above documented findings at 11:48 in the conference room.

No further information was provided to the surveyor prior to the exit conference on 3/29/19.

5. The facility staff failed to monitor targeted

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behaviors while Resident #23 was receiving Celexa and Clonazepam.

Resident #23 was admitted to the facility on 3/18/17 with the following diagnoses of, but not limited to Alzheimer's disease, stroke, anxiety and depression. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/1/19, the resident was coded as having short term and long-term memory problems and was severely impaired daily decision making. Resident #23 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene. The resident was totally dependent on 1 staff member for bathing.

During the clinical record review on 3/29/19, the surveyor noted the that the physician had ordered Celexa 20 mg (milligram) 1 tablet by mouth daily for "depressive episodes" and Celexa 0.5 mg 1 tablet by mouth daily for "anxiety disorder". There were no monitoring of targeted behaviors while the resident was receiving these medications.

The surveyor notified the DON (director of nursing) was notified of the above documented findings at approximately 11 am. The DON stated, "We monitor the behaviors for the first 7 days then it is stopped. We don't continue the monitoring after that."

The surveyor notified the administrative team of the above documented findings at 11:48 am in the conference room.

No further information was provided to the surveyor prior to the exit conference on 3/29/19.

6. The facility staff failed to monitor targeted

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behaviors while Resident #31 was receiving Remeron, Zoloft and Abilify.

Resident #31 admitted to the facility on 12/18/17 with the following diagnoses of, but not limited to dementia, depression and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/8/19, coded the resident as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. Resident #31 was also coded as having short term and long term memory problems with being severely impaired in making daily decisions.

During the clinical record review on 4/4/19, the surveyor notes that the physician had ordered Remeron 15 mg (milligram) 1 tablet by mouth daily before bedtime, Zoloft 125 mg by mouth daily in the mornings and Abilify 2 mg by mouth daily for mood disorder. The surveyor reviewed the MAR (medication administration record) for February and March 2019 and noted the following:
" " ...Monitor for targeted behaviors and/or side effects utilizing the facility's Behavioral and Side Effect Monitoring flow sheet for psycho-tropic medication use ..."
There were nurses' initial in the boxes on the MAR as being monitored for the shifts of 7am -3 pm, 3pm -11pm and 11pm -7 am. There were no specific targeted behaviors for the nurse to monitor for Resident #31 while receiving the above documented medications.

The surveyor notified the DON (director of nursing) of the above documented findings at 11:07. The DON stated, "We monitor the behaviors for the first 7 days then it is stopped.

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F 758	Continued From page 25 We don't continue the monitoring after that." The surveyor notified the administrative team of the above documented findings at 11:48 am in the conference room. No further information was provided to the surveyor prior to the exit conference on 3/29/19.	F 758		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow the physician orders for 1 of 15 residents (Resident #1). The findings included: The facility staff failed to follow the physician orders for an x-ray of the left hand for Resident #1. The x-ray was obtained on the right hand-not the left hand as ordered. The clinical record of Resident #1 was reviewed	F 777	F777 1. Physician was notified of x-ray results. Physician evaluated the left hand and discontinued order for x-ray. 2. Current residents were reviewed to identify x-ray results per physician orders in the last 30 days. Corrections made as indicated. 3. Current licensed nursing staff were educated regarding review of diagnostic tests ensuring physician orders are followed. Nursing leadership will review diagnostic results daily X 4 weeks to	5/1/19

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	495404	A. BUILDING _____ B. WING _____	03/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GLEBE	250 GLEBE ROAD DALEVILLE, VA 24083

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F 777	Continued From page 26 3/27/19 through 3/29/19. Resident #1 was admitted to the facility 9/19/18 with diagnoses that included but not limited to arthritis of left hand, macular degeneration of both eyes, skin hemangioma, hypothyroidism, ovarian failure, hyperlipidemia, Alzheimer's disease, anxiety, depressive disorder, osteopenia, hiatal hernia, and Parkinson's. Resident #1's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/26/18 assessed the resident with a BIMS (brief interview for mental status) as 8/15. An order dated 11/5/18 read in part "X-ray of L (left in a circle) hand pain/swelling 3rd digit." A review of the laboratory section/radiologic section revealed the results of a right hand x-ray completed 11/5/18. The surveyor was unable to locate the x-ray results for the left hand. The surveyor informed the director of nursing of the above concern on 3/28/19 at 3:57 p.m. The surveyor informed the administrator, the director of nursing, the infection preventionist, and the executive director of the above concern during the end of the day meeting on 3/28/19 at 5:00 p.m. and again 3/29/19 at 11:41 a.m. and in addition, requested the facility contract with the x-ray company. The contract with the x-ray company read in part "2.2.4 only perform tests as requested in writing by a physician on a test requisition form." The DON stated the x-ray technician did the x-ray	F 777	ensure compliance with physician orders. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for one quarter. 5. 5-1-2019	

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F 777	Continued From page 27 on the wrong hand. No further information was provided prior to the exit conference on 3/29/19.	F 777		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and 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	F 880		5/1/19

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F 880	Continued From page 28 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview facility document review, and clinical record review, the facility staff failed to follow infection control guidelines for wound care for 1 of 15 residents (Resident #29).	F 880	F880 1. Wound care was performed on resident # 29 following infection control guidelines. 2. Current residents receiving treatment	

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F 880	Continued From page 29 The findings included: Resident #29 was admitted to the facility on 2/5/19 with the following diagnoses of, but not limited to heart failure, high blood pressure, pneumonia, dementia, anxiety disorder, depression, respiratory failure and Stage 3 pressure ulcer. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/19/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #29 was also coded as requiring limited assistance with dressing, personal hygiene and bathing. During the wound care observation made by the surveyor on 3/28/19 at 10 am, the surveyor observed RN (registered nurse) #1perform a dressing change to the coccyx area of Resident #29. RN #1 placed a paper towel on the counter beside the sink. This surveyor did not observe RN #1 cleaning this area prior to putting paper towels down as a barrier. RN #1 washed her hands and applied clean gloves. The old dressing was removed from the area on the coccyx and a clean 4x4 that was folded by the RN was moistened with sterile water. RN #1 cleaned the wound by using a patting method up and down the wound from the top to the bottom. The nurse did not change gloves nor wash her hands prior to applying the clean dressing. RN #1 cut the clean Xerofoam with scissors that she took out of her pocket. RN #1 continued to wear the gloves that she wore when removing the old dressing from the resident's wound. At 1:30 pm, the infection control nurse was	F 880	for wounds were assesses for wound care in accordance with infection control guidelines. Corrections will be made as indicated. 3. Current licensed nursing staff were educated regarding facility policy dressings dry/clean and infection control standards. Nursing leadership will review wound care standards daily X 4 weeks to ensure compliance with infection control standards. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for one quarter. 5. 5-1-2019	

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F 880	Continued From page 30	F 880		

notified of the above documented findings that the surveyor observed during the dressing change to Resident #29. The infection control nurse stated, "She should had taken her gloves off after she removed the old dressing and washed her hands."

The surveyor notified the administrative team of the above documented findings on 3/28/19 at 5 pm in the conference room. The surveyor requested copies of the facility's policies on infection control while performing a dressing change.

On 3/29/19, the surveyor received a copy of the facility's policy titled "Dressings, Dry/Clean" which read in part:
" " ...Establish a clean field ...
" Loosen tape and remove old dressing.
" Pull glove over dressing and discard into a plastic or biohazard bag.
" Wash and dry your hands thoroughly.
" Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface ...
" If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward) ..."

No further information was provided to the surveyor prior to the exit conference on 3/29/19.