STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING _____ B. WING _____	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD REVISED NORFOLK, VA 23502

(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 06/19/18 through 06/28/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Ten complaints were investigated during the survey.	E 000	Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or of any conclusion set forth in this statement of deficiencies. This plan of correction is prepared and or executed solely because it is required by the provision of federal and state laws.	
E 036 SS=C	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	E 036	1. A written training and testing program on the emergency operations plan (EOP) was developed. Staff in all departments will be educated on the Emergency Operations Plan using a written training and testing program that included staff responsibilities and duties providing care during emergency. 2. In the absence of staff training on EOP all residents are at risk. 3. Director of Maintenance or designee will educate facility staff on the EOP and perform testing to validate knowledge upon hire on an as needed basis to reflect any change or revisions in the facility EOP 4. Staff Development or designee will audit employee education records monthly x 3 months to ensure current staff and new staff participatoin in a written facility training and testing program. Results of audit wil be shared with the QAPI team for review and recommendation. 5. Date Compliance: August 12, 2018	

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

Robert Keeton, ADMINISTRATOR | 7-30-2018

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

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E 036	Continued From page 1 preparedness training, testing and patient orientation 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, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have a written training and testing program. The findings included: During an interview on 6/27/18 at 11:05 A.M. with the Administrator, and the Maintenance Director, they were asked for documentation that the facility staff had been trained and tested on the facilities emergency preparedness plan. The administrator stated, the facility had not developed a training and testing program for all staff based on the emergency preparedness program. The facility staff failed to have a written training and testing program.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 2 policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the	E 037	1. An initial emergency training program was developed and facility staff will receive initial training on the facility Emergency Operations Plan (EOP) 2. In the absence of staff training on the EOP all residents are at risk. 3. Maintenance Director or designee will educate facility staff on EOP and perform testing to validate knowledge upon hire on and on an as needed basis to reflect any changes or revisions in the facility EOP 4. Staff Development or designee will audit all new employee records for 60 days to ensure staff are receiving initial training on the emergency preparedness as part of the orientation process. Findings of audits will be presented to QAPI for review and recommendation. 5. Date of Compliance: August 12, 2018	

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E 037	Continued From page 3 procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent	E 037		

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E 037	Continued From page 4 with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must	E 037		

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E 037	Continued From page 5 demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have an initial Emergency Preparedness training program. The findings included: During an interview on 6/27/18 at 11:20 A.M. with the Administrator, and the Maintenance Director, they were asked for documentation that the facility staff had initial Emergency Preparedness training on the facility's emergency preparedness plan. The administrator stated, the facility had not developed an initial Emergency Preparedness training program. The facility staff failed to have an initial Emergency Preparedness training program.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/19/18 through 06/28/18. An extended survey was conducted 06/22/18 through 06/28/18. Substandard Quality of Care was identified in Quality of Care at a Scope and Severity Level 3 on 6/22/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Ten complaints were investigated during the survey.	F 000		

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F 000	Continued From page 6 The census in this 197 certified bed facility was 125 at the time of the survey. The survey sample consisted of 56 current resident reviews (Resident #'s 38, 71, 107, 11, 5, 21, 20, 56, 63, 476, 477, 103, 91, 18, 89, 64, 72, 95, 125, 62, 578, 176, 42, 61, 110, 55, 48, 35, 98, 49, 100, 22, 79, 124, 118, 66, 97, 12, 88, 86, 73, 53, 7, 1, 68, 28, 2, 276, 14, 52, 6, 23, 108, 117, 277, & 112) and 5 closed record reviews (Resident #'s 54, 127, 128, 326, & 479).	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 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.	F 550	1. Resident # 124 and Resident # 23 received incontinence care and personal hygiene care by nursing as soon as the issues were identified. Patient advocates have visited with resident #124 on 7/20/18 & 7/23/18 and Resident # 23 7/10/18 & 7/23/18 to discuss services provided. License nursings caring for residents # 124 and #23 received 1:1 education on residents rights and diginity (7/7/18 and 7/11/18) 2. Any resident requiring incontinence care and personal care have the potential to be affected by this deficient practice. 3. LTC Consultant, Staff Development or designee will educate facility staff on the standards of practice for providing residents with a dignified living experience to include personal care. The Ombudsman met with the facility staff to discuss resident rights and abuse/ neglect on 7/19/18 and 7/24/18. Personal care schedules for the residents identified have been reviewed to ensure appropriate care is provided.	

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F 550	Continued From page 7 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 observations, clinical record review, staff and resident interview and facility documentation review, the facility staff failed to ensure 2 of 61 residents (Resident #124 and #23) in the survey sample were treated in a respectful dignified manner in an environment that enhances their quality of life. 1. Resident #124 felt ashamed to be sitting in urine for 5.5 hours which did not dignify the resident or enhance her quality of life. 2. Resident #23 was left wet in urine, uncovered and cold for 2.5 hours waiting for the CNA (Certified Nursing Assistant) to return to assist with care which did not dignify the resident or enhance her quality of life. The findings include: 1. Resident #124 was admitted to the nursing facility on 10/20/14 with diagnoses that included	F 550	4. Clinical Manager (CM) or designee will round on 25% of residents 3 times weekly x 4 weeks, then weekly x 4 weeks to ensure incontinence care and personal hygiene needs are met. CM or designee will review call bell report weekly x 4 weeks to ensure that call lights are answered timely and any variances identified will be corrected and staff re-educated as necessary. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI monthly for 3 months. 5. Date of Compliance: August 12, 2018	

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F 550	Continued From page 8 high blood pressure, diabetes mellitus, paralytic syndrome and history of falling. Resident #124's most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/1/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the skills need for daily decision making. The resident was not assessed to have any mood or behavioral problems. Resident #124 was coded totally dependent on two staff for transfers, bed mobility and personal hygiene. She was assessed totally dependent on one staff for toilet use and bathing. The resident was impaired on both sides of lower extremities and one side upper extremity. She required stabilization from staff for all surface to surface transfers. The resident was coded as non-ambulatory and used a wheelchair as her primary mobility device. She was able to fully understand staff and was fully understood. The resident was assessed as frequently incontinent of bladder and had a colostomy. The resident was not coded to resist care to include ADL assistance. The care plan dated 6/12/18 indicated Resident #124 was identified with ADL care needs to be provided by staff and some ADLs with supervision, was at risk for falls and would receive the necessary assistance for bladder incontinence. The goals set for the resident by the staff was that the resident would maintain the highest level of psychosocial well-being, transfer with assist without falls and was dependent on staff with assistance for in and out of bed transfers via mechanical lift. Some of the interventions to implement these goals included	F 550		

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F 550	Continued From page 9 anticipate her needs, always use mechanical lift with two staff for all transfers and monitor for incontinence, provide hygiene after voiding with mild soap and water, change pads and briefs as needed, as well as check for areas of redness related to urinary incontinence. On 6/26/18 at 10:10 a.m., Resident #124 stated she sat in urine over 5.5 hours waiting to be cleaned up and put to bed on the evening shift (3-11) 6/25/18. She stated she told the Certified Nursing Assistant (CNA) staff around 7:00 p.m., and was told there was not enough staff to put her to bed and clean her up. She said she was not placed back to bed and provided incontinence care until 12:20 a.m. of the next shift (6/26/18). The resident added, " I was so hurt because I wearing a designer dress my son gave me and it was ruined sitting in urine. I took it to the activities department to use their washer because I was afraid of the the industrial machines for general wash. I told them to throw away the Hoyer (brand name for mechanical lift pad) pad in the incinerator because it was saturated with urine." When asked how she felt about the aforementioned incident she stated, "I am a proud women and love to be clean and neat. I felt inadequate and ashamed. I knew I smelled around others too." On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit. 2. Resident #23 was admitted to the nursing facility on 8/21/13 with diagnoses that included	F 550		

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F 550	Continued From page 10 diabetes mellitus, high blood pressure and major depressive disorder. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/15/18 and coded the resident with a score of 15 out of a possible score of 15 which indicated Resident #23 had intact cognitive skills for daily decision making. The resident was not assessed to refuse care to include ADL assistance. The resident was assessed to require extensive assistance from one staff for dressing and was totally dependent on one staff for toilet use and bathing. The care plan dated 6/20/18 indicated Resident #23 had a left ankle fracture with boot in place, was at risk for falls, and that she required assistance from staff for activities of daily living (ADL) needs to include dressing, personal hygiene, bathing and toileting. The goal set for the resident by the staff was that she would be free from further injuries, she would receive assistance from staff to meet all ADL needs. Some of the interventions the staff would use to accomplish these goals included assist as needed for transfers, monitor for incontinence and change briefs and pads as needed, as well as provide hygiene after voiding and bowel movements to prevent skin breakdown and clean and dry skin if wet or soiled. On 6/26/18 at 10:40 a.m., Resident #23 stated on 6/25/18 on the 3-11 shift at 9:00 p.m. she was set up to have the routine personal care and the Certified Nursing Assistant (CNA) and told by the CNA that she would return at 9:30 p.m. The resident stated she was in bed and had completed some of her peri-care and as per her routine the CNA would return 30 minutes later to	F 550		

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F 550	Continued From page 11 wash her buttocks and apply a new brief and bed pad. She stated she called around 9:30 p.m. when the CNA did not return and again at 10:30 p.m. She said she was re-soiled herself, was cold and had stuffed the clean towel between her legs to absorb the urine. The Call Bell Response log verified the call times as stated by the resident. According to the resident, the CNA returned around 11:15 p.m. and finished the ADL care. The resident stated this was not an isolated event and it happens frequently. She said she reports these occurrences to the Director of Nursing (DON), Unit Manager and or the Administrator. When asked how she felt about the aforementioned incident on 6/25/18, stated, "I felt they did not care about my feelings and that their feelings and priories meant more than mine. She did not even say she was sorry she came back 2.5 later and I was left cold and wet. I can't get up out of bed or reach certain areas to clean myself; I felt helpless." On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		

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SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD REVISED NORFOLK, VA 23502

(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 580	Continued From page 12 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580	1. Resident #176 was discharged from facility on 3/9/18. Facility notified Resident #118 physician of resident refusing therapy on 6/28/18 as indicated in the medical record. 2. All residents who have a fall, change in condition, or have missed an outside therapy appointment are identified to be at risk by this deficient practice. 3. An audit of residents who had a change in condition or missed outside therapy appointment since June 1, 2018 were reviewed to ensure Responsible Party and physicians were notified. Facility staff will be educated on procedure to notify resident's responsible party and physician for changes Educated unit secretaries on outpatient appointment scheduling tool on 7/27/18. 4. The DON or designee will review 10% resident with falls, changes in condition and/or outside therapy appointments weekly x 4 weeks, and then 5% monthly x 4 weeks to ensure Responsible Party and physician notification were complete. Results of audits will be reviewed for patterns and/or trends and reported to QAPI monthly for 3 months 5. Date of Compliance: August 12, 2018	

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F 580	Continued From page 13 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, resident interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed for 2 (Resident #176 and #118) of 61 residents in the survey sample to notify the physician and/or resident's family of a change of conditions 1. For Resident #176, the facility staff failed to notify the resident's family of a fall. 2. For Resident #118, the facility staff failed to notify the physician and/or designee of missed Physical Therapy (PT) appointments. The findings included: Resident # 176 was admitted to the facility on 2/19/18 with diagnoses of depression, insomnia, and bradycardia. Resident #176 had an unwitnessed fall on 2/27/18. An Initial Minimum Data Set (MDS) dated 2/24/28 assessed this resident in the area of Hearing, Speech, and Vision as having minimal hearing difficulty. In the area of Cognitive Patterns this resident was assessed as having a Brief Interview for Mental Status (BIMS) score of 9. Resident #176 was assessed in the area of Activates of Daily Living (ADL) for transfer as requiring limited assistance of one staff person. Resident #176 was not assessed in the area of locomotion or walking. This resident was assessed in the area of Mobility Devices as using a walker and wheelchair for mobility.	F 580		

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F 580	Continued From page 14 A Care Plan dated 2/27/18 assessed Resident #176 in the areas of bed mobility as being at risk for falls. This resident was care planned for short term memory impairment - unable to recall after 5 minutes. Interventions- Re-orient to time, location, events and activities. Problem- Transfer (to/from bed, chair, wheelchair, standing position. Intervention- remind resident to call for assistance before moving from bed to chair and from chair to bed. A review of the clinical records dated 2/27/18 at 7:46 A.M. indicated: "Patient had unwitnessed fall this am. Pt attempted to return to bed from wheelchair. Pt reports that "He forgot to lock the wheelchair and landed on his butt." Pt denies pain. The review of the clinical records and staff interview indicated the family was not notified. A physician's progress note dated 2/28/18 at 9:21 A.M. indicated: " Patient's wife requests consultation with the provider today to discuss her husband's recent fall, which occurred this morning around 0645 (6:45 A.M.). He was trying to transition to his bed from W/C, and forgot to lock the wheels. As he attempted to stand, the wheelchair rolled and he fell to the floor on his buttocks. The fall was unwitnessed. He is unsure how long he laid on the floor before help arrived, but does not believe it was more than a few minutes. He denies injury or worsening of pain since the fall. He is a high risk patient and fall prevention protocols are in place. During an interview on 6/ 27/18 at 10:00 A.M. with the Director of Nursing (DON) she stated, the family was not notified of the fall. A request was made for a notification policy	F 580		

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F 580	Continued From page 15 during the survey and no-policy was provided. The facility staff failed to notify Resident #176 family of a fall. Complaint Deficiency Based on a information obtained during a complaint investigation, resident, staff and family interviews, review of the clinical record and review of the facility's policy; the facility staff failed to keep the physician and/or designee informed of events which may require an intervention for 1 of 58 residents (Resident #118), in the survey sample. The facility staff failed to notify Resident #118's physician and/or designee of missed Physical Therapy (PT) appointments. The findings included: Resident #118 was originally admitted to the facility 8/10/16. The admission diagnoses included Parkinson's disease, Major Depressive disorder, Unspecified Psychosis, an anxiety disorder, and an Adjustment disorder with mixed Disturbance of emotions and conduct. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This	F 580		

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F 580	Continued From page 16 indicated Resident #118's cognitive abilities for daily decision making were intact. In section "D" (Mood), the resident was coded for feeling downed, depressed and hopeless and in section "E" (Behaviors), the resident was coded for exhibiting physical and verbal behaviors directed towards others 1-3 days each week. The resident was also coded indicating the behaviors didn't put the resident at risk for illness/injury, not significantly interfering with resident care, activities or social interactions, and the resident was coded to indicate the behaviors didn't put others at significant risk for physical injury or as causing disruption to the living environment. The resident was also coded for rejection of care 1-3 days each week. In section "G" (Physical functioning), the resident was coded as requiring supervision of 1 person with wheelchair locomotion, limited assistance with transfers, extensive assistance of 1 person with bed mobility, personal hygiene, dressing and toileting and total care with bathing. The clinical record revealed Resident #118 had a physician's order dated 4/3/18, for physical therapy (PT) services; heat therapy to the left posterior shoulder, for muscle pain; limiting range of motion. Resident #118 stated during an interview on 6/20/18, at approximately 10:30 a.m., that she was told by the facility physical therapist they saw no improvement in her and they couldn't help her therefore; the Neurologist recommended she see a community based physical therapist. The resident further stated, during the initial visit approximately 4/26/18, her needs were assessed	F 580		

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F 580	Continued From page 17 and the therapist developed a treatment plan and a schedule of future appointments. The appointments were later changed to Tuesdays and Thursdays at 10:00 a.m. A copy of the scheduled appointments were sent to the nursing facility and the Unit Secretary arranged transportation for travel to and from the community based PT office. Resident #118 stated facility staff accompanied her to the initial appointment and no one informed her that was not the plan for future PT appointments. The resident also stated she frequently reminded staff she preferred and required 2 staff during care and 1-2 staff for non activities of daily living. Resident #118 stated the facility staff was aware she has only 3 relatives locally and they are unable to accompany her to appointments because her daughter is visually impaired and requires assistance and her 2 granddaughters have commitments to their jobs and families. She stated on one occasion her sister traveled from South Carolina to accompany her on an appointment. The resident further stated because of her family's obligations and inability to aide her with needed services she elected to remain in the nursing facility. During the 6/20/18 interview at approximately 10:30 a.m., Resident #118 stated, the first official day of therapy was 6/5/18. The resident stated she got ready for the appointment, went to the nurse's station and was told by the Unit secretary and the information was confirmed by the Unit Manager that the Administrator and Director of Nursing stated said she was to go alone to the appointment because she had no cognitive deficits or other limitations preventing her from going unaccompanied. The resident then, stated	F 580		

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F 580	Continued From page 18 the Assistant Administrator told her "go ahead and try going by yourself". The resident stated, she was reluctant but left the facility without facility staff accompanying her, she arrived to the PT office, the driver assisted her inside, she had therapy, the office staff called the transport company to pick her up and she asked the office staff to sit her outside the office so the transport driver could see her upon arrival. Resident #118 stated she waited approximately 20-30 minutes outside the PT office but; the transport company didn't arrive therefore; she used her cell phone to call the nursing facility and alerted them that the transport company hadn't returned to transport her back to the nursing facility. Resident #118 stated the nursing facility staff told her to calm down because she couldn't understand what she was saying, then the nurse stated (name of resident), the transport company says you have already been picked up". Resident #118 stated she asked the Unit Secretary each Monday and Wednesday after the 6/5/18 event, "who would be accompanying me" to the community PT office on Tuesday and Thursday; if the Unit Secretary stated no one, she stated she told her to cancel the appointment because she felt unsafe going unaccompanied. An interview was conducted with the Unit Secretary 6/20/18 at approximately 11:15 a.m. The Unit Secretary stated prior to 6/5/18 she accompanied Resident #118 to appointments in the community if family was unable to attend. The Unit Secretary stated she didn't work 6/5/18 and there was no one to accompany the resident to the appointment therefore she was sent alone. The Unit Secretary stated she was told the	F 580		

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F 580	Continued From page 19 resident returned to the facility 6/5/18 crying and upset. A nurses's note dated 6/14/18 read; Resident scheduled to go out for therapy today. She refused to go because a staff member is unable to accompany her. She is alert and oriented with a BIMS score of 15. This resident makes all her needs known. She is her own responsible party. (name of resident) is able to self maneuver herself in her wheelchair. Staff offered to get her ready for this appointment but she still refused to go". An interview was conducted with Licensed Practical Nurse (LPN) #5 on 6/22/18 at approximately 1:10 p.m. LPN #5 stated she was aware it was Resident #118's preference for a staff member to accompany her on appointments in the community and she was aware on 6/5/18, Resident #118 returned to the facility upset because the transportation driver didn't pick the resident up until approximately 2 hours after transport was called to return the resident back to the facility. LPN #5 stated she informed the resident that hand to hand transport; (transportation driver takes the resident inside the office and picks the resident up inside the office) was requested on her behalf therefore what occurred on 6/5/18, should not happen again, but the resident stated she would not go again unless she was accompanied because she didn't feel safe. LPN #5 stated she kept the Administrator and Director of Nursing informed of the resident's preference to be accompanied by a staff member and of each episode of refusal to attend appointments when there wasn't a staff member to accompany her. LPN #5 stated the Administrator and Director of Nursing stated each	F 580		

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F 580	Continued From page 20 time Resident #118 was alert, oriented, had a BIMS score of 15 and a cell phone therefore; capable of going unaccompanied. During the interview with LPN #5 on 6/22/18 at approximately 1:10 p.m., she stated the physician hadn't been notified of the missed PT appointments. On 6/25/18 at approximately 11:30 a.m., the Unit secretary provided the surveyor with the appointment scheduling forms for Resident #118's past community PT appointment; some of the forms had a note written across the top that stated, "canceled appointment due to resident's request". The Unit Secretary stated the resident canceled the appointments because staff was not available to accompany her and it was the resident's preference to have an escort. On 6/28/18 at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing, Director of Operations, 2 visiting Administrators and the Dietitian. An opportunity was given to the facility staff to provide additional information but; none was presented. The facility policy titled "Life Care - Notification of Changes of Condition" with an original date of 10/7/1995 and revision date of 6/23/16 read, in part, as follows, "...2. The nurse on duty will notify the Practitioner and Resident/Legal Representative/Family Member when a significant change in the resident's physical, mental or psychosocial status (i.e., deterioration in health, mental or psychosocial status is either life threatening conditions or clinical complications)."	F 580		

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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 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, resident interview, staff interview, facility documentation review, the	F 583	1. The License Nurse #1 responsible for leaving the Resident Assignment sheet face up on medication cart removed the sheet off med cart. The License nurse also received 1:1 HIPPA education and safe guarding of residents privacy and confidentiality of records on 7/20/18. 2. All residents living in facility are at risk for HIPPA violations. 3. Facility staff will complete Compliance and Privacy Computer Based Training (CBT) that includes patient rights to privacy, breeches of privacy, and standards of practice related to HIPPA. 4. Clinical Managers or designee will round 3 times weekly x 4 weeks, then weekly for 1 month to ensure resident information is not visible to public and any variances identified will be corrected and staff re-educated. Results of these audits will be reviewed for patterns and/or trends and reported to QAPI monthly or 3 months. 5. Date of Compliance: August 12, 2018	

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F 583	Continued From page 22 facility staff failed to ensure the Privacy of Residents related to leaving a team assignment face up on 1 medication cart of 10 med carts (Cart 2 Unit 2) The findings included: During a medication administration observation on 6/20/18 at approximately 11:11 AM, Registered Nurse #1 left her medication cart to retrieve a supply of insulin syringes and left her Patient Assignment face up on her medication cart. The Patient Assignment included medical information (diagnoses) on the Residents that anyone passing the medication cart may have seen. RN #1 on 6/20/18 at approximately 11:12 AM, when asked about the Resident Assignment being left face up, she stated, "Oh that is a HIPPA (Health Insurance Portability and Accountability Act) issue." Other than the Surveyor remaining at the medication cart, no one saw the information. In addition, during medication pass, RN #1 was heard giving a medical update to a family member in the hall way where any resident or visitors in the Resident rooms could have heard the medical information shared. The information included a resident had become lethargic and was sent to the hospital. The Facility Policy titled, "HIPAA - Notice of Privacy Practices" with a revision date of 2/2015, documented the following: (Facility) will maintain a Notice of Privacy Practices (NPP) statement. The statement will provide individual's information as to how	F 583		

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F 583	Continued From page 23 (Facility) will may use and disclose protected health information about the individual, as well the individual's rights and the covered entity's obligations with respect to that information. (Facility) will provide its patients/members and anyone who requests the (Facility) NPP. The Administrator was notified of the findings during a meeting on 6/20/18 at approximately 5:45 PM. No further information was provided.	F 583		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interview and facility documentation review, the facility staff failed to ensure 2 of 61 residents (Resident #124 and #23) in the survey sample were free from neglect. 1. The facility staff neglected the ADL needs of	F 600	1. Residents #124 and #23 received incontinence care when the issue was identified. The two CNA staff assigned to care for residents #124 and #23 received 1:1 abuse/neglect and dignity training on 7/6/18 and 7/11/18. 2. All residents living in facility are at risk for the potential neglect. 3. Long Term Care Consultant, Staff Development or designee will educate facility staff on preventing, identifying, reporting abuse and neglect. The Ombudsman will meet with facility staff to discuss residents rights and abuse/neglect on 7/19/18 and 7/24/18. Facility Risk Reporting System "STARS" report and grievance logs will be reviewed daily. Allegations of neglect will be investigated reported and resolved as appropriate by the administrator or DON. 4. Corporate QA/Regulatory staff or designee will audit 10% of STARS report and grievance log for 4 weeks and 5% weekly x 4 to assure compliance and appropriate follow-up	

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F 600	Continued From page 24 Resident #124 and left the resident in her chair for 5.5 hours heavily soiled before placing her to bed on the next shift at 12:20 a.m. 2. The facility staff promised to return 30 minutes later to finish evening peri-care for Resident #23. The Certified Nursing Assistant (CNA) neglected to return to complete the necessary ADL needs as promised, and returned 2.5 hours later, at which time the resident had re-soiled herself and was cold due to urinary incontinence. The findings include: 1. Resident #124 was admitted to the nursing facility on 10/20/14 with diagnoses that included high blood pressure, diabetes mellitus, paralytic syndrome and history of falling. Resident #124's most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/1/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the skills need for daily decision making. The resident was not assessed to have any mood or behavioral problems. Resident #124 was coded totally dependent on two staff for transfers, bed mobility and personal hygiene. She was assessed totally dependent on one staff for toilet use and bathing. The resident was impaired on both sides of lower extremities and one side upper extremity. She required stabilization from staff for all surface to surface transfers. The resident was coded as non-ambulatory and used a wheelchair as her primary mobility device. She was able to fully understand staff and was fully understood. The resident was assessed as frequently incontinent	F 600	for allegations of neglect. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI monthly x 3 months and quarterly after. 5. Date of Compliance: August 12, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING _____ B. WING _____	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 25 of bladder and had a colostomy. The resident was not coded to resist care to include ADL assistance. The care plan dated 6/12/18 indicated Resident #124 was identified with ADL care needs to be provided by staff and some ADLs with supervision, was at risk for falls and would receive the necessary assistance for bladder incontinence. The goals set for the resident by the staff was that the resident would maintain the highest level of psychosocial well-being, transfer with assist without falls and was dependent on staff with assistance for in and out of bed transfers via mechanical lift. Some of the interventions to implement these goals included anticipate her needs, always use mechanical lift with two staff for all transfers and monitor for incontinence, provide hygiene after voiding with mild soap and water, change pads and briefs as needed, as well as check for areas of redness related to urinary incontinence. On 6/26/18 at 10:10 a.m., Resident #124 stated she sat in urine over 5.5 hours waiting to be cleaned up and put to bed on the evening shift (3/11) 6/25/18. She stated she told the Certified Nursing Assistant (CNA) staff around 7:00 p.m., and was told there was not enough staff to put her to bed and clean her up. She said she was not placed back to bed and provided incontinence care until 12:20 a.m. of the next shift (6/26/18). The resident added, " I was so hurt because I wearing a designer dress my son gave me and it was ruined sitting in urine. I took it to the activities department to use their washer because I was afraid of the the industrial machines for general wash. I told them to throw away the Hoyer (brand name for mechanical lift pad) pad in	F 600		

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F 600	Continued From page 26 the incinerator because it was saturated with urine." On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). This allegation of neglect was reported to Administrative staff on 6/26/18 and an investigation was initiated. The facility's policy titled Abuse-Freedom From dated 11/23/16 indicated that all residents had the right to be free from neglect. Neglect is defined as failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 2. Resident #23 was admitted to the nursing facility on 8/21/13 with diagnoses that included diabetes mellitus, high blood pressure and major depressive disorder. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/15/18 and coded the resident with a score of 15 out of a possible score of 15 which indicated Resident #23 had intact cognitive skills for daily decision making. The resident was not assessed to refuse care to include ADL assistance. The resident was assessed to require extensive assistance from one staff for dressing and was totally dependent on one staff for toilet use and bathing. The care plan dated 6/20/18 indicated Resident #23 had a left ankle fracture with boot in place, was at risk for falls, and that she required	F 600		

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F 600	Continued From page 27 assistance from staff for activities of daily living (ADL) needs to include dressing, personal hygiene, bathing and toileting. The goal set for the resident by the staff was that she would be free from further injuries, she would receive assistance from staff to meet all ADL needs. Some of the interventions the staff would use to accomplish these goals included assist as needed for transfers, monitor for incontinence and change briefs and pads as needed, as well as provide hygiene after voiding and bowel movements to prevent skin breakdown and clean and dry skin if wet or soiled. On 6/26/18 at 10:40 a.m., Resident #23 stated on the 3/11 shift at 9:00 p.m. she was set up to have the routine personal care and the Certified Nursing Assistant (CNA) and told by the CNA that she would return at 9:30 p.m. The resident stated she was in bed and had completed some of her peri-care and as per her routine the CNA would return 30 minutes later to wash her buttocks and apply a new brief and bed pad. She stated she called around 9:30 p.m. when the CNA did not return and again at 10:30 p.m. She said she was re-soiled herself, was cold and had stuffed the clean towel between her legs to absorb the urine. The Call Bell Response log verified the call times as stated by the resident. According to the resident, the CNA returned around 11:15 p.m. and finished the ADL care. The resident stated the CNA did not apologize, but instead told her, "It is just the way it is tonight". The resident stated this was not an isolated event and it happens frequently. She said she reports these occurrences to the Director of Nursing (DON), Unit Manager and or the Administrator. On 6/28/18 at 3:35 p.m., the aforementioned	F 600		

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F 600	Continued From page 28 issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). This allegation of neglect was reported to Administrative staff on 6/26/18 and an investigation was initiated.	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		

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F 623	Continued From page 29 this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and	F 623	1. A notice of discharge for Resident #42 and Resident # 91 were sent to the Office of the State Long Term Care Ombudsman on July 23, 2018 2. All residents who receive facility initiated discharge are required to have notification to the State Long Term Care Ombudsman. 3. Social Workers were educated by the Sentara Social Worker Peer Group leader on the requirement to notify the State Long Term Care Ombudsman's Office for facility initiated discharges on 6/12/18. Facility initiated discharges from November, 2017 until June, 2018 were faxed to Ombudsman's Office on July 3, 2018 4. The Director of Social Services or designee will audit facility initiated hospital discharges to assure the notice provided to the Ombudsman is complete and accurate. The Social Services Peer Group or designee will audit 25% weekly x 4 weeks and 10% weekly x 4 weeks for accuracy. Any variances identified will be corrected. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI monthly x 3 months. 5. Date of Compliance: August 12, 2018	

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F 623	Continued From page 30 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 2 of 61 residents in the survey sample, Resident #42 and 91. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #42's transferred and admitted to the hospital on 5/19/18. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of	F 623		

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F 623	Continued From page 31 Resident #91 transferred and admitted to the hospital on 04/25/18. The finding include: 1. Resident #42 was originally admitted to the facility on 1/17/15. Diagnosis for Resident #42 included but not limited to *Chronic Respiratory Failure with *hypoxia -dependent on respiratory (*Ventilator). *Respiratory Failure is the inability of the cardiovascular and pulmonary systems to maintain adequate exchange of oxygen and carbon dioxide in the lungs (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition). *Hypoxia is diminished availability of oxygen to the body tissues (Reference: http://medical-dictionary.thefreedictionary.com/hypoxia) *Ventilator is a machine that supports breathing (Source: http://www.nhlbi.nih.gov/health/health-topics/topics/vent). The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 04/06/18 coded the resident with as comatose - persistent vegative state/no discernible consciousness. The Discharge MDS assessments was dated for 5/19/18 - discharged with return anticipated. The clinical note revealed the following: on	F 623		

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F 623	Continued From page 32 5/19/18, Resident #42 was noted with increased respiratory rate. The other vital signs were stable. The respiratory department recommended for resident to be sent out for evaluation; on call physician notified with new orders to send out for evaluation. The above findings were shared with the Administrator 6/20/18 at approximately 430 p.m. No additional information was provided. An interview was conducted with the Part-time Social Worker on 6/20/18 at approximately 5:30 p.m. She stated, "The Ombudsman was only being notified of the residents who where discharged home and not to the hospital." The facility's policy: Life Care - Bed Hold (Revision: 1/17/17). -Purpose: To define requirements regarding bed hold when a resident or patient is admitted to an acute care setting on therapeutic leave. -Performed by: Business Office / Social Services -Procedure: Before a facility transfers or discharges, a resident the facility must notify the resident and the resident's representative(s) and the reasons for the move in writing and in a language and manner, they understand. The facility must send a copy of the notice to the State Long-Term Ombudsman. Contents of the notice include but not limited too: -Notice must be at least 30 days -Specific reason for the transfer or discharge -Effective date of transfer or discharge -Location to which resident is to be transferred or discharged -A statement of the residents appeal right to State	F 623		

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F 623	Continued From page 33	F 623		

2. The facility staff failed to provide notice of discharge to Resident #91 and send a copy of the notice to a representative of the Office of the Long Term care Ombudsman.

Resident #91 was admitted to the facility on 2/10/14 with diagnoses which included atherosclerotic heart disease, dysphagia, legal blindness, depression type two diabetes, Parkinson's Disease and peripheral vascular disease.

A 5/2/18 re-entry Minimum Data Set (MDS) assessed this resident as having impaired vision. In the area of Cognitive Patterns this resident was assessed as being severely impaired cognitive skills for daily decision making. In the area of Activities of Daily Living (ADL) this resident was assessed as being unable to transfer, unable to walk. Resident #91 required extensive assistance with one person assist with dressing. This resident required total dependence in the areas of eating, toileting and personal hygiene.

A Care Plan dated 5/15/18 indicated: Resident #91 demonstrated impaired in cognitive skills for daily decision making due to Parkinson's Disease.

A review of the clinical records indicated Resident #91 was discharged to the hospital on 4/25/18.

An interview was conducted with the Part-time Social Worker on 6/20/18 at approximately 5:30 p.m. She stated, "The Ombudsman was only being notified of the residents who where discharged home and not to the hospital."

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F 623	Continued From page 34 The facility staff failed to send a copy the discharge notice to the Ombudsman.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff	F 625	1. The bed hold policy from February's discharge was provided to the family of Resident #42 on 7/10/18 2. Residents transferred to the hospital are required to receive a copy of the Bed Hold Policy. 3. Social Workers were educated by the Director of Regulatory on July 24, 2018 on Bed Hold Policy and system practice of providing a written copy to resident and/or respresentative of policy upon transfer to hospital. License nurses will be educated on Bed Hold Policy and system practice by Manager of Education or designee. 4. Administrator, Social Worker Peer Group or designee will audit the daily discharge report 3 x per week x 4 weeks, to ensure discharges / transfers have the required documentation that bed hold policy was provided to the resident or resident representative as required. Variances identified will be corrected. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI monthly x 3 months 5. Date of Compliance: 8/12/18	

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F 625	Continued From page 35 failed send or provide a copy of the Bed-Hold Policy for 1 resident (Resident #42) of 61 residents in the survey sample, after being transferred to the hospital on 5/19/18. The facility staff failed to provide the resident #42 or the resident's representative with a written copy of the bed hold policy. The finding include: Resident #42 was originally admitted to the facility on 1/17/15. Diagnosis for Resident #42 included but not limited to Chronic Respiratory Failure with *hypoxia dependent on a ventilator-a machine that supports breathing (Source: http://www.nhlbi.nih.gov/health/health-topics/topics/vent). *Hypoxia is diminished availability of oxygen to the body tissues (Reference: http://medical-dictionary.thefreedictionary.com/hypoxia) The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 04/06/18 coded the resident with as comatose - persistent vegative state/no discernible consciousness. The Discharge MDS assessments was dated for 5/19/18 - discharged with return anticipated. The clinical note revealed the following: on 5/19/18, Resident #42 was noted with increased respiratory rate. The other vital signs were stable. The respiratory department recommended for resident to be sent out for	F 625		

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F 625	Continued From page 36 evaluation; on call physician notified with new orders to send out for evaluation. An interview was conducted with the Part-time Social Worker on 6/20/18 at approximately 5:30 p.m. She stated, "I was unable to locate any written documentation in the resident's medical record to validate that the resident or their representative were made aware of the bed hold policy. The above findings were shared with the Administrator 6/20/18 at approximately 430 p.m. No additional information was provided. The facility's policy: Life Care - Bed Hold (Revision: 1/17/17). -Purpose: To define requirements regarding bed hold when a resident or patient is admitted to an acute care setting on therapeutic leave. -Performed by: Business Office / Social Services -Procedure: Before a facility transfers or discharges, a resident the facility must notify the resident and the resident's representative(s) and the reasons for the move in writing and in a language and manner, they understand.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637		

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SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD REVISED NORFOLK, VA 23502

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F 637	Continued From page 37 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to complete a significant change MDS (minimum data set) assessment (SCSA) within 14 days for one (Residents #95) resident in the survey sample of 61 Residents. For Resident #95, the facility staff failed to complete a SCSA after altered mental status, hospitalization, and significant weight loss in a 6 week period from 2-1-18 to 3-13-18. Findings included: Resident #95 was admitted to the facility on 6-30-16. Current diagnoses included; Altered mental status, nutrition deficiency, vitamin D deficiency, and urinary tract infection. The current MDS (Minimum Data Set) was a significant change assessment with an ARD (assessment reference date) of 5-11-18. Staff assessment of mental status coded the Resident with severely impaired cognition. The Resident was coded as having no behaviors, and needing extensive to total assistance of 1-2 staff members for all activities of daily living. he Resident was also coded as needing to be fed. The MDS coded the Resident as having no swallowing disorder, no weight loss, and on a mechanically altered diet, and edentulous (no teeth). The	F 637	1. A significant change MDS was completed for Resident #95 and submitted on 7/28/18. 2. Residents who have been hospitalized and returned to the facility since their last MDS will be reviewed to determine if a significant change MDS assessment is needed; if found to be needed, a significant change assessment will be scheduled for completion. 3. MDS Coordinators will review Chapter 2, page 22-27 of the RAI manual and then complete a post-test to verify their knowledge and understanding of when a significant change assessment may be needed. Residents who return to the facility from inpatient hospital stays will be reviewed weekly in Standards of Care (SOC) meetings by the interdisciplinary team to assist in determining if a significant change assessment is needed; MDS Coordinator or designee will participate in the weekly SOC meeting. The SOC meeting will also discuss residents with significant changes in weight and cognition and recommendations for significant change will be determined by the IDT 4. DON or designee will review 10% of residents discussed during the weekly SOC that had recommendations for significant change assessments to validate that the significant change assessment has been scheduled and completed per RAI guidelines. Any observed variances will be investigated, corrected and	

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F 637	Continued From page 38 quarterly assessment due for this assessment reference date was changed to a significant change assessment due to "Resident's weight and overall decline", as stated in nursing notes by MDS staff on 5-23-18. The previous quarterly assessment with an ARD of 2-22-18 coded no weight loss for the Resident and stated her weight as 120 lbs. On 6-19-18 at approximately 12:00 p.m. during initial tour of the facility Resident #95 was sitting in a reclined chair, in the dining area of the south unit with a meal tray in front of her and she was staring at the food, which was an untouched pureed diet. A staff member was asked if the Resident would feed herself, and she replied, "I don't know, but I will help her", and she began to feed the Resident. On 2-9-18 the Resident went out to the hospital after a fall and laceration to the head which was repaired in the emergency room, and the Resident was readmitted to the facility the same day. The Resident had a wet cough and refused to eat throughout the next 24 hours and was again sent to the emergency room. The Resident returned on 2-15-18 (5 days later) and was given a pureed diet and was being fed. On 2-15-18 The Resident had a "Pre-Albumin" blood test, and the result was low at 13 (malnutrition). Normal range is 15-36, and the Resident was diagnosed with "under weight, inadequate caloric intake, at risk of further weight loss, weight loss 6.8% in less than 30 days. No further nutrition assessment occurred until 3 months later on 5-14-18 and the Resident had lost 9.8% of her weight by 3-13-18.	F 637	feedback provided to the interdisciplinary team. The findings for the audits will be reviewed for patterns and/or trends and reported to QAPI for input and guidance. 5. Date of compliance: 8/12/18	

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F 637	Continued From page 39 On 2-18-18 a Speech therapy consult was ordered by the physician, and was begun on 2-20-18. The consult states "No recent weight loss." On 2-25-18 the Resident's weight had dropped 8 lbs (pounds) since the 2-1-18 weight, and on 2-26-18 the doctor ordered "Pro-stat AWC 17 grams- 100 kcal (calories) per 30 ml (milliliters) liquid for nutritional deficiency one time daily. On 2-27-18 The physician changed the pro-stat order to increase it to three times per day, as documented in the physician progress notes, instead of once per day. That order was never instituted, and the Resident remained on Pro-stat once per day through the time of survey. The diet order was also changed this day and was "Mechanical soft ground with thin liquids." By this time the staff were aware of the Resident's significant weight loss. The Resident's weights were documented in the facility for 2018 as follows; 1-2-18 120 lbs 2-1-18 120.20 lbs 2-22-18 MDS 120 lbs 2-25-18 112 lbs 3-1-18 110 3-13-18 108.2 3-20-18 108 3-29-18 108.2 4-2-18 108.2 5-4-18 109.4 6-7-18 108.5 The Resident's current care plan was reviewed, and even though many areas in the clinical record	F 637		

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F 637	Continued From page 40 including nursing notes, the MDS, and speech therapy notes indicated the Resident needed to be fed by staff, the care plan still documented an intervention that the resident would feed herself. The care plan also documented the intervention of supplements per doctor's orders would be administered, which also did not happen, as Pro-stat was only given once per day and not three times per day as had been ordered. The Resident was ordered to have a mechanical ground diet with honey thickened liquids, and was observed consuming a pureed diet at lunch on 6-19-18 during initial tour of the facility. No nutrition evaluation was completed from 2-26-18, until 5-14-18 (approx 3 months later) and the Resident had already experienced a 9.8% weight loss between 2-1-18 and 3-13-18. (approx 6 week period). The facility staff were aware of the significant weight loss and overall decline as the Resident's daughter was made aware and signed a Do Not Resuscitate Order (DNR) on 3-28-18 according to nursing notes. No SCSA assessment was completed after the quarterly assessment of 2-22-18, until the next quarterly assessment was due, and completed on 5-11-18. This was a SCSA, however, the SCSA should have been completed within 14 days of staff becoming aware of the significant change and sometime in March 2018. On 6-21-18 at the end of day debrief at 4:00 p.m. the Director of Nursing, and Administrator were made aware of the issues, and asked to bring any information available to explain the lack of services provided for this Resident. No further information was supplied by the time of exit on	F 637		

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F 637	Continued From page 41 6-28-18.	F 637		
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 and clinical record review the facility staff failed to assure one resident (Resident #1) of 61 residents in the survey sample, was assessed at least quarterly utilizing the Minimum Data Set (MDS). For Resident #1, the facility staff failed to complete a quarterly MDS assessment within the required 92 days. The findings included: Resident #1 was admitted to the nursing facility 7/27/07. The diagnoses for Resident #1 included but not limited to Type II Diabetes. Resident #1's last Minimum Data Set (MDS) was a Comprehensive Assessment with an Assessment Reference Date of 01/29/18 coded Resident #1 Brief Interview for Mental Status (BIMS) scoring a 11 out of a possible 15 indicating moderate cognitive impairment. In addition the MDS coded Resident requiring supervision with one assist with bed mobility, transfer, dressing, toilet use and personal hygiene.	F 638	1. Resident # 1 quarterly MDS was submitted on 6/29/18. 2. All residents are at risk to ensure that quarterly MDS assessments have been completed and/or scheduled 3. Missing OBRA Assessment Report are reviewed monthly to identify missing MDS assessments by the MDS Coordinator or designee and report action taken will be given to the DON. MDS coordinator or designee will schedule and open the next OBRA assessmet in the MDS software upon completion of current assessment. MDS Coordinators will be re-educated in the use of MDS scheduler witin Vision (MDS software) and the MDS at Risk for Non-Compliance exception analysis will be reviewed monthly to identify any potentially missed OBRA assessments. The Final Validation report will be printed and reviewed following the MDS transmission. 4. The DON or designee will review monthly x 3 months that Final Validation reports have been printed, reviewed, and appropriate action taken and that the Vision compliance exception report for potential missed OBRA assessments has been reviewed and appropriate action taken. A summary of the monthly analysis for compliance and appropriate actions taken for any identified missing assessments will be reported to QAPI. 5. Date of Compliance: 8/12/18	

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F 638	Continued From page 42 An interview was conducted with MDS Coordinator on 6/26/18 at approximately 11:00 a.m., who stated, "Resident #1 popped up on the Missing OBRA Assessment Report. She should have had a quarterly assessment completed before 4/30/18 - her quarterly assessment should have been signed and locked by day 92 which would have been 4/30/18. The Omnibus Budget Reconciliation Act (OBRA) of 1987 requires long-term care facilities to complete an ongoing OBRA assessments for each resident within 92 days of the ARD of the most recent MDS assessment. (RAI manual, MDS 3.0 chapter 2 pages 2-16). The above findings were shared with the Administrator 6/25/18 at approximately 8:30 a.m. No additional information was provided.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to accurately reflect, via the required Minimum Data Set (MDS) assessment, the resident's status for 1 of 61 residents (Resident #18) in the survey sample. The facility staff failed to accurately assess the resident's sacral pressure upon re-admission to the facility on 12/5/17.	F 641	1. Resident # 18 MDS was revised and re-submitted on 7/28/18 2. 100% of current residents with pressure injuries will have their MDS assessments reviewed to ensure accurate coding of Section M of the MDS within the respected ARD (Assessment Reference Date). Identified areas of variances will be scheduled for correction per RAI Manual. 3. LTC Consultant (RN), and Manager of Education (RN) or designee will educate MDS Coordinators on coding Section M according to the RAI guidelines. MDS Coordinators will review Section M instructions in the RAI Manual and will view CMS YouTube	

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F 641	Continued From page 43 The findings included: Resident #18 was originally admitted to the nursing facility on 11/9/17 with diagnoses that included right subdural hematoma, severe traumatic brain injury, closed facial fractures and mandible fracture, vegetative state, and enteral feedings via a gastrostomy tube (GT). The resident was seen in the Emergency Department (ED) on 11/10/17 and readmitted on 12/5/17 Resident #18 was readmitted to the nursing facility on 12/5/17 with an *unstageable sacral pressure ulcer. The facility staff failed to accurately assess and initiate an effective pressure ulcer treatment protocol, instead the ulcer was assessed as a *Stage I. In addition the facility staff failed to assess the wound every 7 days per facility protocol until 13 days later at which time the wound had progressively worsened and ultimately led to wound management by a specialized physician. Minimum Data Set (MDS) assessment analysis: The MDS assessment in effect at the time of Resident #18 initial, first entry dated 11/9/17 indicated no skin issues. In correlation with this MDS assessment, the hospital discharge summary dated 11/9/17 also indicated no skin issues. The discharge MDS assessment dated 11/10/17 with return anticipated, one day in the building, the resident was assessed to have one *Stage II pressure ulcer. The hospital wound care notes dated 11/23/17 indicated the resident's sacral ulcer progressed to a *Stage III and on 12/3/17 the hospital wound care notes indicated the pressure ulcer had further progressed to 4x3 centimeter unstageable, open with slough (soft	F 641	video on accurate completion of Section M; this will be followed by a post test and discussion to ensure understanding of the RAI guidance. MDS Coordinators independently reviewed and signed an Attestation Statement validating understanding of RAI guidelines when signing for completion of MDS. 4. DON or designee will audit 10% of MDS weekly x 4 weeks of residents with pressure injuries, then monthly x 1 month to ensure accuracy of MDS in Section M. Variances will be investigated, corrections made as appropriate and feedback provided to the person completing the MDS. Findings for audits will be reviewed for patterns and/or trends and reported to QAPI for input and guidance. 5. Date of Compliance: 8/12/18	

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F 641	Continued From page 44 adherent necrotic tissue). Resident #18 was coded with short and long term memory problems and severely impaired in the skills for daily decision making. The resident was non-verbal and not able to understand staff. The resident was totally dependent on one staff for all activities of daily living (ADL). The resident was re-admitted to the nursing facility on 12/5/17. The Admission MDS assessment with an assessment reference date of 12/12/17 indicated the resident had a one Stage I sacral pressure ulcer. The facility admission nursing note entered by Licensed Practical Nurse (LPN) #6 dated 12/5/17 indicated Resident #18 had one Stage I pressure ulcer 2 cm by 1 cm. The significant change in status MDS assessment dated 1/5/18 assessed the resident as having two pressure ulcers: one unstageable pressure ulcer with slough and/or eschar (hard black adherent necrotic tissue), as well as one unstageable deep tissue injury (*DTI). The quarterly MDS assessment dated 3/26/18 and the quarterly MDS assessment dated 6/18/18 assessed Resident #18 as having one Stage IV pressure ulcer. During an interview with the facility MDS coordinator and the Regional Corporate MDS coordinator on 6/26/18 at 3.00 p.m., they stated they get their information from the nurse's notes in order to complete the MDS and although they felt the most recent MDS' dated 3/26/18 and 6/18/18 were accurate representations of Resident #18 current sacral wound, the admission nurse's note assessment of the sacral	F 641		

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F 641	Continued From page 45 wound as a Stage I was not accurate, thus the 12/12/17 MDS assessment was not an accurate assessment of the sacral wound. They stated they follow through with care planning based on the MDS assessment. The re-admission nursing assessment dated 12/5/17 scored the resident with a 6 on the Braden Scale Pressure Sore Risk assessment which indicated the resident was at "very high risk" for the development of pressure ulcers. The care plan dated 12/14/17 indicated the resident had a Stage I pressure ulcer and the goal set by the staff for the resident was that it would decrease over the review period (3/12/18). Some of the interventions to accomplish this goal include assess and record the size of the ulcer, perform a complete assessment and record, perform nutritional screening and assessment and to implement the protocol for Stage I pressure ulcer and was at risk for having pressure ulcers. The nursing staff were to use pillows and or wedges to reduce pressure on heels and pressure points, and turn and position, as well as a pressure reducing mattress (standard mattress for all residents) and pad when sitting. The nursing staff would also check skin for redness, skin tears, swelling or additional breakdown. The resident was incorrectly care planned in the area of actual alteration in skin integrity and should have been care planned for an unstageable pressure ulcer to the sacrum. On 6/28/18 at 3:35 p.m., the aforementioned issues were shared during a debriefing with the Administrator, Director of Operations and Director of Nursing (DON). The DON stated the MDS coordinators use the RAI 3.0 manual to code	F 641		

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F 641	Continued From page 46 MDS assessments. No further information was provided prior to exit. RAI manual 3.0 SECTION M: SKIN CONDITIONS Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. *Category/ Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). *Category/ Stage I is Pressure Injury:	F 641		

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F 641	Continued From page 47 Non-blanchable erythema of intact skin (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). *Category/Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. Bruising indicates deep tissue injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/). *Category/Stage III: Full thickness skin loss: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/). *DTI (Deep Tissue Injury) - depth unknown Purple or maroon localized area of discolored	F 641		

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F 641	Continued From page 48 intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org).	F 641		
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	F 656	1. Comprehensive resident centered care plans were revised for resident # 95 to include risk for weight loss and resident #72 for constipation. 2. Residents with weight loss and/or constipation are at risk for inaccurate comprehensive care plan. 3. LTC Consultant, Staff Development, or designee will educate the interdisciplinary team on strategies and accuracy for completion of person-centered, comprehensive care planning. MDS Coordinators will review the care plans for residents with identified weight loss and/or constipation for person centered approaches and comprehensiveness. 4. Clinical Manager, DON or designee will audit care plans for residents identified with weight loss and/or constipation to assure comprehensiveness and person centered approaches are included in the care plan, 10% x 4 weeks, then 5% x 4 weeks.	

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F 656	Continued From page 49 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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, facility documentation review, and clinical record review, the facility staff failed to develop and implement a comprehensive person centered care plan for two Residents (Residents #95, & #72) of the 61 residents in the survey sample. 1. Resident #95's care plan did not include person centered interventions for weight loss. 2. For Resident #72 the facility staff failed to care plan the Resident for constipation. Findings included: 1. Resident #95 was admitted to the facility on 6-30-16. Current diagnoses included; Altered mental status, nutrition deficiency, vitamin D deficiency, and urinary tract infection.	F 656	Results of the audits will be reviewed for patterns and/or trends and reported to QAPI monthly for input and guidance. 5. Dates of Compliance: 8/12/18	

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F 656	Continued From page 50 The current MDS (Minimum Data Set) was a significant change assessment with an ARD (assessment reference date) of 5-11-18. Staff assessment of mental status coded the Resident with severely impaired cognition. The Resident was coded as having no behaviors, and needing extensive to total assistance of 1-2 staff members for all activities of daily living. he Resident was also coded as needing to be fed. The MDS coded the Resident as having no swallowing disorder, no weight loss, and on a mechanically altered diet, and edentulous (no teeth). The quarterly assessment due for this assessment reference date was changed to a significant change assessment due to "Resident's weight and overall decline", as stated in nursing notes by MDS staff on 5-23-18. On 6-19-18 at approximately 12:00 p.m. during initial tour of the facility Resident #95 was sitting in a reclined chair, in the dining area of the south unit with a meal tray in front of her and she was staring at the food, which was an untouched pureed diet. A staff member was asked if the Resident would feed herself, and she replied, "I don't know, but I will help her", and she began to feed the Resident. On 2-9-18 the Resident went out to the hospital after a fall and laceration to the head which was repaired in the emergency room, and the Resident was readmitted to the facility the same day. The Resident had a wet cough and refused to eat throughout the next 24 hours and was again sent to the emergency room. The Resident returned on 2-15-18 (5 days later) and was given a pureed diet and was being fed.	F 656		

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F 656	Continued From page 51 On 2-15-18 The Resident had a "Pre-Albumin" blood test, and the result was low at 13 (malnutrition). Normal range is 15-36, and the Resident was diagnosed with "under weight, inadequate caloric intake, at risk of further weight loss, weight loss 6.8% in less than 30 days. No further nutrition assessment occurred until 3 months later on 5-14-18 and the Resident had lost 9.8% of her weight by 3-13-18. On 2-18-18 a Speech therapy consult was ordered by the physician, and was begun on 2-20-18. The consult states "No recent weight loss." On 2-25-18 the Resident's weight had dropped 8 lbs (pounds) since the 2-1-18 weight, and on 2-26-18 the doctor ordered "Pro-stat AWC 17 grams- 100 kcal (calories) per 30 ml (milliliters) liquid for nutritional deficiency one time daily. On 2-27-18 The physician changed the pro-stat order to increase it to three times per day, as documented in the physician progress notes, instead of once per day. That order was never instituted, and the Resident remained on Pro-stat once per day through the time of survey. The diet order was also changed this day and was "Mechanical soft ground with thin liquids." The Resident's weights were documented in the facility for 2018 as follows; 1-2-18 120 lbs 2-1-18 120.20 lbs 2-25-18 112 lbs 3-1-18 110 3-13-18 108.2 3-20-18 108	F 656		

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F 656	Continued From page 52 3-29-18 108.2 4-2-18 108.2 5-4-18 109.4 6-7-18 108.5 The Resident's current care plan dated 5-16-18 with a quarterly revision goal date of 8-8-18 was reviewed. The document was compared to many areas in the clinical record including physician orders, the 2 nutrition assessments, nursing notes, both MDS assessments, and speech therapy notes, which all indicated the Resident needed to be fed by staff. The care plan still documented an intervention that the resident would feed herself. The care plan also documented the intervention of supplements per doctor's orders would be administered, which also did not happen, as Pro-stat was only given once per day and not three times per day as had been ordered. The Resident was ordered by a physician to have a mechanical ground diet with honey thickened liquids, and was observed consuming a pureed diet at lunch on 6-19-18 during initial tour of the facility, which was also an intervention on the care plan, and an error. The care plan was not measurable and was not implemented to show correct treatments, physician orders, and assessed needs. The interventions did not list the type or amount of supplements to be administered, What the Resident's food preferences were, whether to feed the Resident or not, or what swallowing strategies to use for this Resident. The care plan was not comprehensive, and did not assist in correcting the significant weight loss for Resident	F 656		

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F 656	Continued From page 53 #95, which is the purpose of a comprehensive care plan, to list needs and describe care interventions for those needs. On 6-21-18 at the end of day debrief at 4:00 p.m.The Director of Nursing, and Administrator were made aware of the issues, and asked to bring any information available to explain the lack of services provided for this Resident. No further information was supplied by the time of exit on 6-28-18. 2. Resident #72 was admitted to the facility on 7-17-15. Diagnoses for Resident #72 included but were not limited to; Traumatic Brain Injury, constipation, and quadriplegia. Resident #72's most recent Minimum Data Set (an assessment protocol) was a quarterly assessment, with an Assessment Reference Date of 5-3-18. The MDS coded Resident #72 as alert, oriented to person, place, time and situation, with no cognitive impairment. The Minimum Data Set further coded Resident #72 as being totally dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was coded as at risk for skin breakdown, and having currently, 2 acquired wounds, while in the facility. They were; (1) unstageable deep tissue injury on the right buttock, and (2) a stage 3 wound on the lower right leg shin. On initial tour of the facility on 6-19-18 at approximately 11:30 a.m. Resident #72 was interviewed and observed. The Resident was laying in a "Clinitron Bed" which is a specialty skin	F 656		

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F 656	Continued From page 54	F 656		

pressure removal bed used for individuals with skin breakdown from pressure. The Resident was asked if he was comfortable with his feet pushed against the foot board, and he responded that he slid down in the bed often, and had to wait for nurses to pull him up. He stated he loved the bed, however, needed to be pulled up to get his feet "right" "every couple hours". The Resident was asked if he had eaten his lunch, and he stated he had an upset stomach, and had no appetite. He was asked if this happened often, and he stated no, but for the last week he had not felt well because of constipation. He was asked if he was given medication for that problem, and he stated that staff had a hard time getting it for him, and he had to suffer and wait days sometimes to get the medicine.

A review of Resident #72's clinical record was conducted during the survey. The review revealed current physician orders for "Magnesium Citrate oral solution one bottle one time daily starting 6-14-18." The Medication Administration Record (MAR) was reviewed and revealed a medication note documented by a nurse stating "medication is unavailable, not administered, will be delivered 6-15-18."

Nursing progress notes were reviewed and revealed the medication was given 6-15-18.

The current care plan "starting 5-8-18" was reviewed and revealed no care plan for constipation.

The facility administration was informed of the findings during an end of day briefing on 6-21-18 at approximately 4:00 p.m. The facility did not present any further information about the findings

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F 656	Continued From page 55 up to the time of exit on 6-28-18.	F 656		
F 657 SS=E	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 medical record review, staff interviews and facility document review the facility staff failed to revise care plans for 5 of the 61 Resident's in the Survey Sample, Residents' #125, #28, #11, #5, and #72.	F 657	1. Resident Centered Care Plans were revised for the residents identified as follows: Resident #125 updated: 7/18/18 and 7/25/18 Resident #28 updated: 6/28/18 and 7/24/18 Resident #11 updated: 6/13/18 and 7/30/18 Resident #5 updated: 7/25/18 Resident #72 updated: 7/10/18 and 7/12/18 2. All residents are at risk for care plans not being revised or updated. 3. Residents centered care plans will be completed on all residents living in facility and revised to reflect changes in in care and services provided or requested by resident. LTC consultant (RN), Staff Development (RN) or designee will educate the interdisciplinary team on strategies for person-centered, comprehensive care planning. Care Plans for all residents living in facility will be reviewed by July 30, 2018 by MDS Coordinators, Clinical Managers or designee. 4. Clinical Manager, DON or designee will audit residents care plans to assure comprehensiveness and person centered approaches are included in the care plan, 10% for a month, then 5% for a month. Results of the audits will be reviewed for patterns and/or trends and reported to QAPI monthly x 3 months 5. Date of Compliance: 8/12/18	

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F 657	Continued From page 56 1. The facility staff failed to revise Resident #125's care plan on 5/21/18 to include the initial physician order for the antipsychotic medication Quetiapine 50 mg (milligram) tablet one time daily. 2. For Resident #28 care plan was not revised to include new wounds and pain from shingles. 3. For Resident #11 care plan has not been updated to accurately reflect Residents current communication abilities. 4. For Resident #5 care plan was not revised to include pain assessments or interventions. 5. For Resident #72 the facility staff failed to revise the care plan for wounds and treatments. The Findings Included: 1. Resident #125 was admitted to the facility on 4/26/18 with diagnoses to include . (1). Alcohol Abuse, (2). Anxiety Disorder and (3). Vascular Dementia. The most recent comprehensive Minimum Data Set (MDS) was a 5 Day with an Assessment Reference Date (ARD) of 5/28/18. The Brief Interview for Mental Status (BIMS) for Resident #125 was coded as a zero indicating the resident is rarely/never understood. Resident #125 was also coded as having short and long term memory recall and cognitive skills for daily decision making was moderately impaired. Under Section N Medications, N0410 Medications Received Resident #125 was coded as receiving an Antipsychotic for 6 days.	F 657		

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F 657	Continued From page 57 The following physician orders for Resident #125 were reviewed and are documented in part, as follows: Quetiapine 50 mg Tablet Oral One Time Daily Order Date: 5/21/2018 Discontinued: 5/21/2018 Quetiapine 50 mg Tablet Oral One Time Daily Order Date: 5/29/2018 Discontinued: 6/7/2018 Quetiapine 50 mg Tablet Oral One Time Daily Order Date: 6/7/2018 Discontinued: 6/12/2018 Quetiapine 25 mg Tablet Oral One Time Daily Order Date: 6/18/2018 Discontinued: 6/22/2018 Quetiapine 25 mg Tablet Oral One Time Daily Order Date: 6/22/2018 Discontinued: 6/22/2018 Resident #125's Medication Administration Records for May and June of 2018 were reviewed and the above orders for Quetiapine were noted and given as ordered. On 6/26/18 Resident #125's Comprehensive Care Plans dated 4/27/18 -5/8/18 and 5/8/18-Present were reviewed. The use of Quetiapine (an antipsychotic) initially ordered on 5/21/18 and still active was not identified on either Care Plan for Resident #125. On 6/27/10 at 10:06 A.M. an interview was conducted with the Director Of Nursing regarding	F 657		

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F 657	Continued From page 58 Resident #125's Care Plan not being revised for the medication Quetiapine initially ordered 5/21/18 and still active for the resident and what she would have expected to occur. The Director of Nursing stated, "In the morning we print all new orders and in the morning meeting all new orders are discussed. The Clinical Managers then go back and review the new orders and then the MDS nurses update the Care Plan. I would have expected for MDS to have updated the Care Plan and initiate the behavior monitoring sheets the same day the orders were reviewed in morning meeting." The facility policy "Comprehensive Care Plan" Revision Date: 1/22/2018 was reviewed and documented in part, as follows: Purpose: Establishment, periodic review of current patient-centered plan of care for each resident to assure a systemic, comprehensive approach to assessing, planning, and periodic review in meeting the resident's needs. IDT (Inter-disciplinary) Responsibilities (Activities, Nursing, Dietary, Therapy, MDS, and Social Services): 2. Care plans will be reviewed and updated as needed to reflect changes. A revised Comprehensive Care Plan for Resident #125 was presented to this surveyor on 6/27/18 upon arrival to the facility. The Comprehensive Care Plan dated 5/8/18-Present was reviewed and is documented in part, as follows: Problems: (Name) Resident #125 receives an Antipsychotic medication (started 5/21/18)	F 657		

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F 657	Continued From page 59 STATUS: Active (Current) EFFECTIVE: 6/26/2018-Present Goal: Minimize/avoid harmful side effects during the next 90 days. STATUS: Active (Current) GOAL DATE: 9/26/2018 EFFECTIVE: 6/26/2018-Present Interventions: Administer medications as ordered. STATUS: Active (Current) EFFECTIVE: 6/26/2018-Present Monitor for side effects (insomnia, agitation, nervousness, dizziness, rash, tardive dyskinesia, leg pain, upper respiratory infection, metabolic syndrome, weight gain, increased blood sugar, high cholesterol) STATUS: Active (Current) EFFECTIVE: 6/26/2018-Present Review by registered Pharmacist STATUS: Active (Current) EFFECTIVE: 6/26/2018-Present On 6/27/18 at 2:45 P.M. the above information was shared with the Administrator and prior to exit no further information was provided. (1). Alcohol Abuse: a dependency of alcohol. (2). Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to	F 657		

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F 657	Continued From page 60 aggressive acts, persistent helplessness, or withdrawal. (3). Vascular Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses. The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition. 2. Resident # 28 an 84 yr. old female was admitted to the facility on 05/05/2017 with diagnoses of, but not limited to, Hypertension, Gastroesophageal Reflux Disease, CVA (stroke), and has colostomy. Resident # 28's most recent MDS (Minimum Data Set) was coded as an annual an ARD (assessment reference date) of 3/30/18. She was coded as having a BIMS (Basic Interview of Mental Status) score of 14, indicating no cognitive impairment. She was coded as needing extensive assistance of 2 staff members for activities of daily living as being always incontinent of urine and as having a colostomy. She was coded as being at risk for pressure ulcers however she was also coded as having no open areas or pressure ulcers. On 6/19/18 a review of clinical record revealed that the resident was noted to have two open areas to the lateral side of abdomen 1.4 centimeters (cm) x 2.6 cm x 0.1 cm. and medial measuring 0.6 cm x 1.4 cm x 0.1 cm. On	F 657		

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SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD REVISED NORFOLK, VA 23502

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F 657	Continued From page 61 04/24/18 resident was noted to have these wounds on 4/24/18. On 6/6/18 a Note from Nurse Practitioner was reviewed and read: "ASP [asked to see patient] regarding painful area on her back. Pt states she has been having pain on her back for the last few weeks. She says she asked the staff to look at it while she was being bathed and was told there was nothing there. However, today when she was getting washed up the aide advised her she saw something and went to get a nurse. She asked if I would also take a look. She stated it's painful and has a burning quality and exacerbates when she lays on it. It can also itch. She has not tried anything to get relief'. Care plan for resident #28 was not revised to include pain, shingles, or the identified open areas on the abdomen. On 6/21/18 at 2:00 PM the DON (Director of Nursing) was interviewed . The DON stated she recognized the care plan had not been updated and no interventions were added for Shingles Pain and the pressure areas that were identified. Administration was notified of these issues on 6/20/18 and no new information was provided. 3. Resident #11 is a 71 yr. old female admitted to the facility on 10/20/17 with diagnoses of but not limited to Atrial Fibrillation, CAD (coronary artery disease), deep vein thrombosis, hypertension (high blood pressure), diabetes, aphasia (inability	F 657		

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F 657	Continued From page 62 to speak), CVA (stroke), seizure disorder, Hemiplegia (one sided weakness) and anxiety disorder. Resident # 11's most recent MDS dated 6/8/18 was coded as a quarterly. She was coded as having a BIMS score of 0, indicating severe cognitive impairment. She was coded as needing extensive assistance of 2+ staff members for all activities of daily living. She is transferred using a mechanical lift and 2 staff members. MDS also codes Resident in the section Makes self understood "Rarely/Never Understood" she is also coded under Ability to Understand Others as "Rarely/Never Understood" On 6/21/18 at 1:00 PM a review of clinical record revealed that on the 6/7/18 the nurse charted "Resident A x O x 2 [alert and oriented x 2] able to make needs known". On 6/10/18 another nurse documented "Resident in bed alert and verbally responsive able to make needs known". On 6/13/18 the MDS coordinator charted "Care plan meeting with IDT [interdisciplinary team]. Care plan reviewed and up to date. No resident attendance due to cognitive deficit. No family RSVP". On 6/21/18 at 1:00 PM A review of Resident Care #11's care plan revealed that under the focus area of activities it states Resident #11 is capable of self-directed activities of choice. On 6/26/18 at 1:00 PM interview with DON was conducted and she was asked about the discrepancy between the MDS and the care plan	F 657		

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F 657	Continued From page 63 as well as the nurses notes. She stated that the MDS was correct and the patient cannot say anything but yes. She doesn't always mean yes she sometimes just says yes. She further stated that one of the nurses did not usually work on 1 south had documented incorrectly that she was alert and orientated and verbally responsive. The other nurse was also incorrect in his documentation. The DON went on further to say the documentation that sates Resident did not attend the care plan was correctly documented by the MDS coordinator, however the care plan was incorrect in stating that Resident is sometimes understood and is capable of self-directed activities of choice. Administration was made aware of the issues with the care plans and no further information was provided. 4. Resident #5 a 66 yr. old female was admitted on 1/25/17 with diagnoses of but not limited to anemia, CAD (coronary artery disease), hypertension (high blood pressure, CVA (stroke), depression and psychotic disorder. Resident # 5's most recent MDS (Minimum Data Set) dated 6/4/18 was coded as quarterly. She was coded as having a BIMS (Basic Interview of Mental Status) score of 15, indicating no cognitive impairment. She was coded as needing physical assistance of 1 staff member for activities of daily living. She was coded as being at risk for pressure ulcers however she was also coded as	F 657		

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F 657	Continued From page 64 having no open areas or pressure ulcers. She is also coded as being always incontinent of bowel and bladder. On 6/21/18 a clinical record review was conducted and it was found that for the month of May 2018 the Medication Administration Record (MAR) was missing documentation of administration for 12 doses of routinely scheduled narcotic pain medication. (May 6th at 6:00 AM -until May 10th 6:00 AM) Care plan was not updated to include during this time. Resident #5 had orders for (as needed) PRN Tylenol and Ibuprofen that was utilized during the three days that she did not receive her scheduled narcotic pain medication. Pain assessments were not conducted during this time. No interventions were put in place. On 6/26/18 and interview with the DON (director of nursing) who stated " During the time the medication was not given the doctor had been contacted by the staff and had not yet sent over the hard script [paper prescription] which is why she missed the medication". The DON and unit manager also stated they recognized that pain assessments and interventions were not put in place nor was the care plan updated. On 6/26/18 Administration was made a ware and no new information was provided.	F 657		

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F 657	Continued From page 65	F 657		

5. Resident #72 was admitted to the facility on 7-17-15. Diagnoses for Resident #72 included but were not limited to; Traumatic Brain Injury and quadriplegia.

Resident #72's most recent Minimum Data Set (an assessment protocol) was a quarterly assessment, with an Assessment Reference Date of 5-3-18. The MDS coded Resident #72 as alert, oriented to person, place, time and situation, with no cognitive impairment. The Minimum Data Set further coded Resident #72 as being totally dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was coded as at risk for skin breakdown, and having currently, 2 acquired wounds, while in the facility. They were; (1) unstageable deep tissue injury on the right buttock, and (2) a stage 3 wound on the lower right leg shin.

On initial tour of the facility on 6-19-18 at approximately 11:30 a.m. Resident #72 was interviewed and observed. The Resident was laying in a "Clinitron Bed" which is a specialty skin pressure removal bed used for individuals with skin breakdown from pressure. The bed is constantly filled with blowing air which moves tiny soft beads inside the mattress creating a floating sensation for the user, and no steady pressure point on the body of a user. The Resident's feet were uncovered and were noted to be propped on a pillow. The mattress was covered with 2 sheets, and had a border around it which resembled the bumper rail around a billiards or

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F 657	Continued From page 66 pool table, which set up above the mattress approximately 4-6 inches. With the Resident's calves elevated on the pillow, it allowed the Resident's heels to lie directly on the bumper which was harder than the mattress, and forced the soles of the Resident's feet against the hard plastic foot board of the bed. Brown yellow and tan spots of creamy drainage were noted on the bumper of the mattress in the foot area. On the floor, against the wall at the foot of the bed was a pile of 2-3 foam wedges, and 2-3 pillows, which the Resident stated were to position him with while he was in bed. These positioning devices were also stained with the same color drainage observed to be on the bumper at the foot of the bed. The Resident was asked if he was comfortable with his feet pushed against the foot board, and he responded that he slid down in the bed often, and had to wait for nurses to pull him up. He stated he loved the bed, however, needed to be pulled up to get his feet "right" "every couple hours". A review of Resident #72's clinical record was conducted during the survey. The review revealed documents titled "Skin". The Director of Nursing (DON) provided these records and stated "these are the May and June 2018 weekly skin checks, these are all we have". The documents revealed skin assessments completed by nursing staff on May 1, 7, 14, 21, 28, and 6-18-18. No skin checks were completed from 5-28-18 through 6-18-18. The documents revealed the following; 5-1-18 - 2 different wounds right lower leg, no open lesions on the foot. No preventative, or protective foot care. 5-7-18 - DTI (deep tissue injury) right buttock, 3	F 657		

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F 657	Continued From page 67 areas right lower leg, no open lesions on the foot. No preventative, or protective foot care. 5-14-18 - DTI (deep tissue injury) right buttock, 3 areas right lower leg, no open lesions on the foot. No preventative, or protective foot care. 5-21-18 - DTI (deep tissue injury) right buttock, 2 areas right lower leg, no open lesions on the foot. No preventative, or protective foot care. 5-28-18 - DTI right buttock, and right lower leg, no open lesions on the foot. No preventative, or protective foot care. 6-18-18 - Blister right elbow, right lower leg wound. No preventative, or protective foot care. Nursing progress notes were reviewed and revealed no wound had been identified on the bottom (sole) or plantar surface of the left foot. A nutrition assessment was ordered on 5-24-18 to be completed by the Registered Dietician. The nutrition assessments were reviewed, and the most recent assessment was completed March 2018. The DON was asked to produce the May nutrition assessment, she stated "there was none." The current care plan "starting 5-8-18" was reviewed and revealed an intervention which read "(Resident name) has a Clinitron Air Mattress, ensure air mattress is inflated and operating appropriately." "Goal date 7-31-18." No instruction was given in the care plan as to how the bed should be used, what settings should be maintained, what linens could be used, if any, and if other positioning devices should be used with the bed. No direction was given as to use of the bed. Interventions for "Floating of legs and heels remained on the care plan, and had not been removed/revised when the Clinitron bed was	F 657		

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F 657	Continued From page 68 installed. No foot wound was documented in the care plan. The treatment nurse and Wound doctor were asked if they had been trained on the use of the bed, and they both stated no, however, they stated that the Hill ROM representative came and set up the bed, and if they had a problem the representative would come out and fix it. They were asked what the representatives response time to their call for help would be, and they stated they were unsure. The treatment nurse, and Administrator were asked for the manufacturers instructions guide for use of the bed. The Administrator delivered a 2 page flyer printed from the Hill ROM computer site on 6-21-18, and stated "this is all we have." The flyer did not explain how to use the bed. Research of the Clinitron bed was conducted by the surveyor online, on the Hill ROM eLearning site and revealed that only one bed sheet should be used, not 2, and all other support devices such as pillows under feet defeat the therapeutic results of the bed, as they create pressure points, and barriers between the patient, and the bed, which is designed to relieve pressure by coming into contact with the Resident's skin. The site further stated the "air wall" (bumper) is firm and not fluidized with beads (would create pressure points). The directions for use were detailed and required added education necessary to learn the manipulation of the bed controls, and therapeutic use of the bed. The device was not self explanatory. On 6-21-18 at 9:45 a.m., a wound care observation was conducted with the South unit nursing manager and the wound doctor (other	F 657		

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F 657	Continued From page 69 #5). Resident #72 was laying in bed and the doctor and wound nurse were asked why the Resident had drainage on the air wall of the bed. They lifted the Resident's foot and revealed a new wound measuring 1.5 centimeters x 1.8 centimeters circular wound which was 45% necrotic according to the wound doctor. An interview was conducted at that time, and the wound doctor and the wound nurse both stated that pressure ulcers should not be found at necrotic eschar. The wound was not identified nor prevented prior to eschar formation and thus found at "unstageable". The wound was further encouraged to form by pressure on the plantar surface of the foot caused by the inappropriate placing of pillows in the bed under both feet for "floating" purposes which pushed the feet on top of the bumper/air wall surrounding the mattress, and pressing them onto the foot board of the bed causing pressure. The the "SOC Quality Assurance & Performance Improvement" (QAPI) facility form for wounds was reviewed and revealed the facility Administration was only aware of the "right lower leg stage 2 wound, and the unstageable right buttock wound for Resident #72. The form stated that both wounds were avoidable, and facility acquired. It is notable to mention that the Resident had 3 other wounds, 1) Resident's left ankle, lateral left Achilles tendon, and top of left foot at the ankle juncture which had all begun as blisters. These wounds were not mentioned in the QAPI report, nor on the care plan.	F 657		

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F 657	Continued From page 70 The facility administration was informed of the findings during an end of day briefing on 6-21-18 at approximately 4:00 p.m. The facility did not present any further information about the findings up to the time of exit on 6-27-18	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 observation, staff interview, and closed record review the facility staff failed to meet professional standards of quality for 2 (Residents #477 and #95) of 61 residents in the survey sample. 1. The facility staff failed to meet professional standards of quality when an LPN (Licensed Professional Nurse) delegated the application of a hot compress to a CNA (certified nursing assistant) which resulted in second degree burns on Resident #477's hand. 2. The facility staff failed implement a physician's order to increase Pro-stat from once per day to three times per day for Resident #95; and provided the wrong diet to the Resident on 6-19-18 for the lunch meal. Findings included: 1. Resident #477 was admitted to the facility on 6/7/17 with diagnoses that include and were not	F 658	1. Resident # 477 was discharged from facility. House audit of diet orders to ensure nutrition orders for supplements and diet were correct and active by Director of Dining on 7/27/18. Resident # 95 received a comprehensive nutritional assessment on 7/20/18 and care plan revised on 7/27/18. 2. All residents living in the facility have the right to appropriate care provided within professional standards. Residents with orders for a warm/hot compress are at risk for potential harm for deficient practice. All residents are at risk for inaccurate diet, nutrition and supplement orders. 3. The Clinical Manager or designee completed skin assessments on each resident by 7/27/18. There were no burns identified on any resident. All resident diets, nutrition and supplement orders were reviewed to ensure accurate coding in the diet office software program by Dining Director, Dieititian or designee by 7/27/2018. LTC Consultants, Staff Development, or designee will educate nursing staff on Scorp of Practice of Certified Nursing Assistants and Licensed Nursing will receive training	

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F 658	Continued From page 71 limited to: Osteomyelitis of the vertebra (infection in the bones of neck), bilateral upper extremities paralysis, Type 2 diabetes, drug abuse, respiratory failure, viral hepatitis C, cystitis (urinary tract infection), urinary retention, and encephalopathy (damage or malfunction of the brain). A complaint investigation was conducted and the complainant had documented that "the resident complained of pain to his left hand. He requested a warm compress. The CNA [certified nursing assistant] heated a washcloth in the microwave and placed it in a plastic bag and applied it to the resident's [#477] hand. The resident sustained blisters to his left second, third and fifth digits [fingers]. He was sent to the hospital for evaluation and treatment". On 6/20/18 at 11:30 AM a review of an investigative summary regarding the burn injury to Resident #477 prepared by the facility was reviewed and noted: "Investigation (Assessment) On October 28, 2917 [2017], [Resident #477] complained of pain to his left hand. His assigned nurse requested the CNA to apply warm compress to [Resident #477's] left hand. The CNA heated the wet washcloth in the microwave and placed cloth into a plastic bag and applied to patient's hand. The staff members involved were immediately removed from the schedule while the facility conducted an investigation. Conclusion/Recommendations: A licensed staff nurse delegated a non-licensed staff a task that is not in accordance to their scope of practice, by applying a warm compress	F 658	on Scope of Practice of CNAs and appropriate delegation of tasks. EMR Training Facilitator or designee will educate facility staff on process for entering, activating, and/or implementing physician orders. All microwaves have reminders adhered on the door panel not to warm up any medical devices and personal care items (i.e. washcloths, towels, etc). 4. Administrator and/or DON will audit rounding tools/observations to assure staff are performing within their Scope of Practice and resident's needs are being met, 10% of weekly tallies x 4 weeks, then 5% for 4 weeks. Dining Services Director or designee wil audit residents diet, nutrition and supplement orders weekly 10% x 4 weeks then 5% per week per month. Results of the audits will be reviewed for patterns and / or trends and reported to QAPI for 3 months for input and guidance 5. Compliance date: 8/12/18	

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F 658	Continued From page 72 to a resident". On 6/21/18 at 1:00 PM a review of the facility document titled Incident Abstract Report related to the burn injury was completed. The report was dated 10/31/17 and documented "Event Description Nursing issues: heating pad protocol, catheter care, personal care," The report asks the question did the deviation reach the patient to which "Y Yes - Reached Patient" was documented. On 6/25/18 at 1:42 PM an attempt was made to call LPN #2 (licensed practical nurse) who was caring for Resident #477 on the date of the burn injury with a message left for LPN #2 to return call regarding burn injury incident for Resident #477. On 6/25/18 at 4:50 PM a telephone interview was conducted with CNA #1 who was caring for Resident #477 on 10/28/17. He stated the LPN #2 "told him to apply heat to Resident #477's left hand". CNA #1 stated he "heated a wet washcloth in the microwave oven for 30 seconds and placed the cloth in a plastic bag", and he "placed a towel on Resident #477's hand". CNA #1 was asked if he had been trained in the use of heat for residents and he stated he had not. When asked what prompted him to apply the hot pack to Resident #477 he stated "the nurse told me to do it, I just do what she tells me to do. I had done it couple of times before." CNA #1 was asked if he was aware that Resident #477 had very limited movement in his upper extremities which made it more difficult for him to move away from the hot washcloth. CNA #1 stated he was aware that Resident #477 has limited movement in his hands and arms.	F 658		

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F 658	Continued From page 73 On 6/26/18 at approximately 1:00 PM a second attempt to call LPN #2 was made and a message was left for her to return the call regarding the burn incident for Resident #477. No return call were received prior to the end of the survey. On 6/26/18 at 1:51 PM an interview was conducted with RN #1 in regard to LPN #2. RN #1 confirmed that she authored the disciplinary action and termination for LPN #2 related to her failure to follow facility policy. When asked specifically what LPN #2 had failed to do RN #1 responded that it "is against policy to put any wet item into the microwave and then apply it to a patient. Only food goes into the microwave". RN #1 further explained that there is a "sticker on the all the microwaves" about what can be put into the microwave. RN #1 confirmed that the warning sticker has been on the microwaves since she "started employment at the facility in August of 2017", 2 months prior to the burn injury to Resident #477. During the same interview RN #1 was asked what actions she would have expected to take place if a warm compress was indicated for a resident. RN #1 responded that the nurse should have notified the physician about what was going on with the resident. RN #1 stated that if an order had been obtained for a warm compress from the physician "we could have gone to the hospital to get a real heat pack instead of a washcloth." RN #1 added that LPN #2 should not have instructed CNA #1 to apply the heat, and that CNA #1 "needed to question anything he is asked to do if he has a concern about being correct or not company policy." RN #1 was asked if the application of heat was within the scope of practice for a CNA she state no, it is not, the LPN	F 658		

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F 658	Continued From page 74 should never have instructed him to do that. RN #1 stated that CNA #1 had been suspended for 3 days, in serviced upon his return and was placed on probation for a year following the incident. When asked what the in servicing was for she replied that CNA's should question anything that seems wrong or "does not follow company policy." On 6/26/18 at 1:55 PM an observation of the microwave ovens behind the nurse's station on Units 1, 3, and 4 noted each had a red sticker prominently placed on the microwave door which measured approximately 4 inched square. The red sticker reads: "Microwave is for heating food and drinks only. Please DO NOT heat any medical supplies in this microwave. Those actions have the potential to burn our patients." On 6/26/18 at 3:30 PM review of in service records titled " SBAR CNA scope of practice" and was dated 11/1/17 was conducted. It read: "S - Situation CNA's may perform duties beyond their scope of practice which endangers residents and CNA's. B - Background Recently an unorthodox hot pack was administered by a CNA who did not realize this action was beyond his/her scope of practice, a resident became injures from this action. A - Assessment CNA's are encouraged [to] have a questioning attitude. And not to perform any action that requires a nurse to assess the patient first. If there is a risk for harm ask your supervisor! R - Recommendation If you are performing an unfamiliar task, ask your supervisor if this is appropriate for you to be doing? We want to be	F 658		

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F 658	Continued From page 75 flexible and help others; however, we must think about resident safety first!" On 6/27/18 at 4:10 PM an interview was conducted with the DON (Director of Nursing) RN #2. When asked what her expectation of the nursing staff if warm compress was indicated for a resident to which she replied "if someone needs heat we would call the doctor to clarify the order. Now we have disposable hot packs". When asked if staff had been trained on the application of warm compresses she stated the licensed nursing staff has now been in serviced. The DON was asked if CNA's were ever allowed to apply hot compresses to a resident she replied no. The Commonwealth of Virginia REGULATIONS GOVERNING THE PRACTICE OF NURSING VIRGINIA BOARD OF NURSING, Revised Date: April 8, 2015 Title of Regulations: 18 VAC 90-20-10 et seq. Statutory Authority: §§ 54.1-2400 and Chapter 30 of Title 54.1 of the Code of Virginia addresses the scope of practice for a Licensed Professional Nurses was conducted and noted: The following sections of the Board of Nursing Regulations govern what nursing tasks can be appropriately delegated by a Registered Nurse to unlicensed persons (which may include CNAs). PART VII. DELEGATION OF NURSING TASKS AND PROCEDURES. 18VAC90-20-420. Definitions. Delegation" means the authorization by a nurse to an unlicensed person to perform selected nursing tasks and procedures in accordance with this	F 658		

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F 658	Continued From page 76 part. 18VAC90-20-460. Nursing tasks that shall not be delegated. A. Nursing tasks that shall not be delegated are those which are inappropriate for a specific, unlicensed person to perform on a specific patient after an assessment is conducted as provided in 18VAC90-20-440. B. Nursing tasks that shall not be delegated to any unlicensed person are: 1. Activities involving nursing assessment, problem identification, and outcome evaluation which require independent nursing judgment; Regulations governing the scope of practice for a Certified Nursing Assistant was conducted. According to Regulations Governing Certified Nursing Assistants the Virginia Board of Nursing set forth regulations titled: 18 VAC 90-25-10 et seq. Statutory Authority: §§ 54.1-2400 and Chapter 30 of Title 54.1 of the Code of Virginia Revised Date: July 1, 2017 "18VAC90-25-100. Disciplinary provisions for nurse aides. For the purpose of establishing allegations to be included in the notice of hearing, the board [Board of Nursing] has adopted the following definitions: 2. Unprofessional conduct shall mean, but shall not be limited to: a. Performing acts beyond those authorized for practice as a nurse aide or an advanced certified nurse aide as defined in Chapter 30 (§54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, and beyond those authorized by the Drug Control Act (§ 54.1-3400 et seq.) or by provisions for	F 658		

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F 658	Continued From page 77 delegation of nursing tasks in 18VAC90-20-420 et seq." The facility staff failed to meet professional standards of quality when an LPN delegated the application of a hot compress to a CNA which resulted in second degree burns to Resident #477. 2. Resident #95 was admitted to the facility on 6-30-16. Current diagnoses included; Altered mental status, nutrition deficiency, vitamin D deficiency, and urinary tract infection. The current MDS (Minimum Data Set) was a significant change assessment with an ARD (assessment reference date) of 5-11-18. Staff assessment of mental status coded the Resident with severely impaired cognition. The Resident was coded as having no behaviors, and needing extensive to total assistance of 1-2 staff members for all activities of daily living. he Resident was also coded as needing to be fed. The MDS coded the Resident as having no swallowing disorder, no weight loss, and on a mechanically altered diet, and edentulous (no teeth). The quarterly assessment due for this assessment reference date was changed to a significant change assessment due to "Resident's weight and overall decline", as stated in nursing notes by MDS staff on 5-23-18. On 6-19-18 at approximately 12:00 p.m. during initial tour of the facility Resident #95 was sitting in a reclined chair, in the dining area of the south	F 658		

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F 658	Continued From page 78 unit with a meal tray in front of her and she was staring at the food, which was an untouched pureed diet. A staff member was asked if the Resident would feed herself, and she replied, "I don't know, but I will help her", and she began to feed the Resident. On 2-9-18 the Resident went out to the hospital after a fall and laceration to the head which was repaired in the emergency room, and the Resident was readmitted to the facility the same day. The Resident had a wet cough and refused to eat throughout the next 24 hours and was again sent to the emergency room. The Resident returned on 2-15-18 (5 days later) and was given a pureed diet and was being fed. On 2-15-18 The Resident had a "Pre-Albumin" blood test, and the result was low at 13 (malnutrition). Normal range is 15-36, and the Resident was diagnosed with "under weight, inadequate caloric intake, at risk of further weight loss, weight loss 6.8% in less than 30 days. No further nutrition assessment occurred until 3 months later on 5-14-18 and the Resident had lost 9.8% of her weight by 3-13-18. On 2-18-18 a Speech therapy consult was ordered by the physician, and was begun on 2-20-18. The consult states "No recent weight loss." On 2-25-18 the Resident's weight had dropped 8 lbs (pounds) since the 2-1-18 weight, and on 2-26-18 the doctor ordered "Pro-stat AWC 17 grams- 100 kcal (calories) per 30 ml (milliliters) liquid for nutritional deficiency one time daily. On 2-27-18 The physician changed the pro-stat	F 658		

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F 658	Continued From page 79 order to increase it to three times per day, as documented in the physician progress notes, instead of once per day. That order was never instituted, and the Resident remained on Pro-stat once per day through the time of survey. The diet order was also changed this day and was "Mechanical soft ground with thin liquids." The Resident's weights were documented in the facility for 2018 as follows; 1-2-18 120 lbs 2-1-18 120.20 lbs 2-25-18 112 lbs 3-1-18 110 3-13-18 108.2 3-20-18 108 3-29-18 108.2 4-2-18 108.2 5-4-18 109.4 6-7-18 108.5 The Resident's current care plan was reviewed, and even though many areas in the clinical record including nursing notes, the MDS, and speech therapy notes indicated the Resident needed to be fed by staff, the care plan still documented an intervention that the resident would feed herself. The care plan also documented the intervention of supplements per doctor's orders would be administered, which also did not happen, as Pro-stat was only given once per day and not three times per day as had been ordered. The Resident was ordered to have a mechanical ground diet with honey thickened liquids, and was observed consuming a pureed diet at lunch on 6-19-18 during initial tour of the facility. No nutrition evaluation was completed from 2-26-18, until 5-14-18 (approx 3 months later) and the	F 658		

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F 658	Continued From page 80 Resident had already experienced a 9.8% weight loss between 2-1-18 and 3-13-18. (approx 6 weeks). On 6-21-18 at the end of day debrief at 4:00 p.m. the Director of Nursing, and Administrator were made aware of the issues, and asked to bring any information available to explain the lack of professional services provided for this Resident. No further information was supplied by the time of exit on 6-28-18.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 7 of 61 residents (Resident #20, 62, 5, 11, 124, 23 and 567) in the survey sample who were unable to carry out activities of daily living receives the necessary services. 1. The facility staff failed to ensure that fingernail care was provided to Resident #20. 2. The facility staff failed to provide necessary fingernail care for Resident #62. 3. The facility staff failed to provide bathing services for Resident #5. 4. The facility staff failed to provide bathing services for Resident #11.	F 677	1. Resident # 20 and # 62 had their nails trimmed and cleaned by nursing on 7/25/18 for both residents Resident # 5 and # 11 were provided personal care to include shower/bath as soon as issue was identified. Resident # 23 and # 124 received appropriate incontinence care as soon as the issue was identified Resident # 576 was discharged from facility on 11/23/17 2. Residents of the facility who are unable to carry out activities of daily living are identified to be at risk and to be affected by this deficient practice. 3. Residents of the facility will receive a shower/bath or bed bath of their preference at a minimum of twice weekly or whenever needed and will include nail care according to their preference. License nurse or designee to provide education to Certified Nursing Assistants on Standards of practice and process for provision of nail care, bathing and ADLs	

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F 677	Continued From page 81 5. The facility staff failed to ensure Activities of Daily Living (ADL's) was provided for Resident #124. 6. The facility staff failed to ensure Activities of Daily Living (ADL's) was provided for Resident #23. 7. The facility staff failed to provide 2 baths per week for Resident #576. The findings include: 1. Resident #20 was originally admitted to the facility on 07/23/14. Diagnosis for Resident #20 included but not limited to *Cerebrovascular Disease. *Cerebrovascular Disease is a medical emergency. Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die (https://medlineplus.gov/stroke.html). The most recent Minimum Data Set (MDS) was a quarterly assessment with a quarterly assessment with a Reference Date (ARD) of 03/27/18 coded the resident on the Brief Interview for Mental Status (BIMS) with cognitive skills for daily decision making severely impaired - never/rarely made decisions. The resident was not coded for rejection of care to include Activities of Daily Living (ADL). Resident #20 was coded to require total assistance of two staff for personal hygiene. Resident #20's Comprehensive Care Plan documented resident with self-care deficit - total care required with bathing, hygiene, dressing and	F 677	4. DON or designeed will audit resident's records to assure ADL care had been provided 10% x 4 weeks and 5% x 4 weeks. Results of audits reviewed for patterns and/or trends and reported at QAPI x 3 months for additional input and/or guidance. 5. Date of compliance: 8/12/18	

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F 677	Continued From page 82 grooming. The goal will be odor free, dressed and out of bed daily. Some of the intervention/approaches to manage goal included: Clean and manicure fingernails as needed. On 06/23/18 at 11:05 a.m., resident was observed in recliner chair. Her right hand was observed on her right leg. Her fingernail observed to be long with a black substance underneath all five nails. On the same day at 4:10 p.m., the resident's fingernails remained unchanged. On 06/24/18 at approximately 1:15 p.m., resident right hand fingernails remained unchanged. An interview was conducted with License Practical Nurse (LPN) #7 who stated, "Her nails really do need to be cleaned and trimmed; let me get her Certified Nursing Assistant (CNA)." The surveyor asked the LPN, "Who is responsible for trimming and cleaning the resident's fingernails, she replied "The CNA's when they are providing ADL care. An interview was conducted with the Director of Nursing (DON) on 6/26/18 at approximately 9:30 a.m., who stated, "The CNA's are when they providing care should. The should be cleaning the residents fingernails on a daily basis." -The facility's policy titled Job Aid - Life Care - Activities of Daily Living - Definitions (Revision 1/22/18. -Policy Statement: To define ADL terms and promote maintenance or improvement of resident's current function.	F 677		

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F 677	Continued From page 83 -Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal hygiene. 2. Resident #62 was originally admitted to the facility 12/28/16 and has never been discharged from the facility. The current diagnoses are intracerebral hemorrhage. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/25/18 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired daily decision making abilities. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with personal hygiene and bathing. On 6/19/18 at approximately 2:00 p.m., resident #62 was observed self propelling in the hallway. The resident reached her hand out to persons passing by to hold their hand. As the surveyor approached Resident #62, the fingernails were observed. The left thumb nail was approximately 3 inches beyond the tip of the thumb. It had jagged edges along the inner side with a thickening to the under side and up the middle of the thumb nail. The thumb nail tip was also	F 677		

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F 677	Continued From page 84 uneven and chipped. All nails on the left hand were discolored and had a brownish debris beneath them. Resident #62's person centered care plan dated 5/1/18 had a problem which read; Self care deficit - assistance required with bathing, hygiene, dressing, toileting and grooming related to impaired mobility. The goal read; (name of resident) will bathe and dress self with supervision and cues over the next 90 days, 8/7/18. Another goal read; will be odor free and have a clean/neat appearance. One of the interventions read; Clean and manicure finger nails as needed. On 6/22/18 at approximately 4:00 p.m., the Director of Nursing (DON) was asked about Resident #62's left thumb nail. The DON stated they were aware of the of the long left thumb nail but it was too hard and thick for the nursing staff to cut and file therefore; they had asked the podiatrist to cut it but he stated he didn't service finger nails. The DON didn't share other avenues they were pursuing. Resident #62 was observed again on 6/25/18 at approximately 12:45 p.m. propelling in the hallway and holding her left hand up. The nail to the left thumb had broken but remained somewhat attached with a piece of string hanging from it. On 6/26/18, Resident #62 was observed with a trimmed left thumb nail approximately 1 inch above the nail tip. The DON stated she was unaware of how the nail got trimmed but she	F 677		

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F 677	Continued From page 85 would find out. On 6/27/18 at approximately 2:40 p.m., the DON presented a nurse's note dated 6/27/18 which read; "Late entry for 6/26/18. Resident noted with discomfort from the left thumb nail and complained it snagged on things. Nail trimmed and filed. No further complaint voiced. Procedure tolerated with no complaint". On 6/28/18 at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing, Director of Operations, 2 visiting Administrators and the Dietitian. An opportunity was given to the facility staff to provide additional information but; none was presented. The facility's policy titled; Life Care Activities of Daily Living (ADLs) with a revision date of 1/22/18. The policy stated; It is the policy of the facility to ensure residents abilities in ADLs do not diminish unless circumstance of the individual's clinical condition demonstrates unavoidability. ADLs include; 1. hygiene - bathing, dressing, grooming, oral care and nail care. 3. Resident #5 a 66 yr. old female was admitted on 1/25/17 with diagnoses of but not limited to anemia, CAD (coronary artery disease), hypertension (high blood pressure, CVA (stroke), depression and psychotic disorder.	F 677		

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F 677	Continued From page 86 Resident # 5's most recent MDS (Minimum Data Set) dated 6/4/18 was coded as quarterly. She was coded as having a BIMS (Basic Interview of Mental Status) score of 15, indicating no cognitive impairment. She was coded as needing physical assistance of 1 staff member for activities of daily living. She was coded as being at risk for pressure ulcers however she was also coded as having no open areas or pressure ulcers. She is also coded as being incontinent of bowel and bladder. On 6/20/18 a review of resident clinical record was conducted and it was noted that Resident #5 did not get bathed on 6/15/18 it was noted on the TAR (treatment administration record) that Resident did not get bathed due to "Insufficient Staffing" . This resident also did not get bathed on ..... On 6/22/18 at 9:45 AM (licensed practical nurse) LPN #4 was contacted via telephone and an interview was conducted with LPN #4 about her documentation of "Insufficient Staffing" for reason Resident #5 did not get bathed. LPN #4 stated that she correctly documented the events and the resident had not been bathed because the 3-11 staff was short that day and so when she arrived at work at 11:00 PM Residents still were not touched that is they had not been changed or put to bed yet. LPN #4 stated the 11-7 shift was short by 2 (certified nursing assistants) CNA's and that they all had to immediately start changing Residents and putting them to bed. She further elaborated saying "We had only 2 CNA's and an orientee however the orientee cannot take her own assignment because she is just learning so the	F 677		

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F 677	Continued From page 87 nurses had to help Even with us helping everyone was not in bed until around 2:00 AM or 3:00 AM." LPN #4 stated "We are supposed to have 4 CNA's we are happy if we have 3 but we should have 4. When there is only 2 it is just too much for anyone to do 20 + residents each. It started getting bad in March around the 17th and its steadily getting worse. People are leaving or being let go" On 6/26/18 at 10:30 AM DON (director of nursing) was interviewed about bathing policies and she submitted the the facility policy stating Residents should receive 2 baths a week unless they request more. Administration was made aware on 6/26/18 at 4:00 PM and no further information was provided. 4. Resident #11 is a 71 yr. old female admitted to the facility on 10/20/17 with diagnoses of but not limited to Atrial Fibrillation, CAD (coronary artery disease), deep vein thrombosis, hypertension (high blood pressure), diabetes, aphasia (inability to speak), CVA (stroke), seizure disorder, Hemiplegia (one sided weakness) and anxiety disorder. Resident # 11's most recent MDS dated 6/8/18 was coded as a quarterly. She was coded as having a BIMS score of 0, indicating severe cognitive impairment. She was coded as needing	F 677		

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F 677	Continued From page 88 extensive assistance of 2+ staff members for all activities of daily living. She is transferred using a mechanical lift and 2 staff members. MDS also codes Resident in the section Makes self understood "Rarely/Never Understood" she is also coded under Ability to Understand Others as "Rarely/Never Understood" On 6/21/18 at 11:50 AM a review of clinical record was conducted and it was found that for the month of June 2018 the Resident had an order written in the (Treatment Administration Record) TAR as Shower Twice weekly on Tues and Friday by 3-11 shift. The following entries were made in the TAR: Fri -6/01/18 - Not administered Tue.-6/05/18 - Not administered Tue -6/12/18 - Not administered Fri - 6/15/18 - Not administered On 6/25/18 at 10:30 AM DON (director of nursing) was interviewed about bathing policies and she submitted the the facility policy stating Residents should receive 2 baths a week unless they request more. Administration was made aware on 6/26/18 at 4:00 PM and no further information was provided.	F 677		

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F 677	Continued From page 89	F 677		

5. Resident #124 was admitted to the nursing facility on 10/20/14 with diagnoses that included high blood pressure, diabetes mellitus, paralytic syndrome and history of falling.

Resident #124's most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/1/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the skills need for daily decision making. The resident was not assessed to have any mood or behavioral problems. Resident #124 was coded totally dependent on two staff for transfers, bed mobility and personal hygiene. She was assessed totally dependent on one staff for toilet use and bathing. The resident was impaired on both sides of lower extremities and one side upper extremity. She required stabilization from staff for all surface to surface transfers. The resident was coded as non-ambulatory and used a wheelchair as her primary mobility device. She was able to fully understand staff and was fully understood. The resident was assessed as frequently incontinent of bladder and had a colostomy. The resident was not coded to resist care to include ADL assistance.

The care plan dated 6/12/18 indicated Resident

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F 677	Continued From page 90 #124 was identified with ADL care needs to be provided by staff and some ADLs with supervision, was at risk for falls and would receive the necessary assistance for bladder incontinence. The goals set for the resident by the staff was that the resident would maintain the highest level of psychosocial well-being, transfer with assist without falls and was dependent on staff with assistance for in and out of bed transfers via mechanical lift. Some of the interventions to implement these goals included anticipate her needs, always use mechanical lift with two staff for all transfers and monitor for incontinence, provide hygiene after voiding with mild soap and water, change pads and briefs as needed, as well as check for areas of redness related to urinary incontinence. On 6/26/18 at 10:10 a.m., Resident #124 stated she sat in urine over 5.5 hours waiting to be cleaned up and put to bed on the evening shift (3/11) 6/25/18. She stated she told the Certified Nursing Assistant (CNA) staff around 7:00 p.m., and was told there was not enough staff to put her to bed and clean her up. She said she was not placed back to bed and provided incontinence care until 12:20 a.m. of the next shift (6/26/18). The resident added, " I was so hurt because I wearing a designer dress my son gave me and it was ruined sitting in urine. I took it to the activities department to use their washer because I was afraid of the the industrial machines for general wash. I told them to throw away the Hoyer (brand name for mechanical lift pad) pad in the incinerator because it was saturated with urine." The facility policy and procedure titled Activities of Daily Living dated 1/22/18 indicated it was the	F 677		

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F 677	Continued From page 91 policy of the facility to ensure that residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal (pad changing, cleansing) and oral hygiene. On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit. 6. Resident #23 was admitted to the nursing facility on 8/21/13 with diagnoses that included diabetes mellitus, high blood pressure and major depressive disorder. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/15/18 and coded the resident with a score of 15 out of a possible score of 15 which indicated Resident #23 had intact cognitive skills for daily decision making. The resident was not assessed to refuse care to include ADL assistance. The resident was assessed to require extensive assistance from one staff for dressing and was totally dependent on one staff for toilet use and bathing. The care plan dated 6/20/18 indicated Resident #23 had a left ankle fracture with boot in place, was at risk for falls, and that she required assistance from staff for activities of daily living (ADL) needs to include dressing, personal hygiene, bathing and toileting. The goal set for the resident by the staff was that she would be free from further injuries, she would receive assistance from staff to meet all ADL needs. Some of the interventions the staff would use to accomplish these goals included assist as	F 677		

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F 677	Continued From page 92 needed for transfers, monitor for incontinence and change briefs and pads as needed, as well as provide hygiene after voiding and bowel movements to prevent skin breakdown and clean and dry skin if wet or soiled. On 6/26/18 at 10:40 a.m., Resident #23 stated on the 3/11 shift at 9:00 p.m. she was set up to have the routine personal care and the Certified Nursing Assistant (CNA) and told by the CNA that she would return at 9:30 p.m. The resident stated she was in bed and had completed some of her peri-care and as per her routine the CNA would return 30 minutes later to wash her buttocks and apply a new brief and bed pad. She stated she called around 9:30 p.m. when the CNA did not return and again at 10:30 p.m. She said she was re-soiled herself, was cold and had stuffed the clean towel between her legs to absorb the urine. The Call Bell Response log verified the call times as stated by the resident. According to the resident, the CNA returned around 11:15 p.m. and finished the ADL care. The resident stated this was not an isolated event and it happens frequently. She said she reports these occurrences to the Director of Nursing (DON), Unit Manager and or the Administrator. On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit.	F 677		

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F 677	Continued From page 93 7. Resident #567 was discharged from the facility, and so the clinical documents were reviewed as a closed record. Resident #576 was admitted to the facility on 10-17-17, and was discharged to the hospital 11-23-17. The Resident did not return. Diagnoses for Resident #576 included but were not limited to; Traumatic spinal cord injury, quadriplegia, dialysis, anemia, and insulin dependant diabetes mellitus. Review of the facility Admission assessment dated 10-17-17, revealed no wounds on admission, and the Resident was assessed as "at risk" of skin breakdown due to immobility. Resident #576's most comprehensive Minimum Data Set (an assessment protocol) was a 14 day assessment, with an Assessment Reference Date of 11-7-17. The MDS coded Resident #576 with no cognitive impairment. The Minimum Data Set further coded Resident #576 as being totally dependent, on 1 staff member for all Activities of Daily Living care (ADL's) including bathing. The Resident was coded as at risk for skin breakdown, and having currently, 9 acquired wounds, while in the facility. The Resident was coded as no behaviors, and no refusals of care. Nursing notes were reviewed and revealed that the 9 wounds were all first identified and found at the same time on 11-6-17 by the wound nurse when the Resident's TED hose (compression stockings were removed. The progress notes document the wound measurements, stages, treatments ordered, and results of one Albumin blood test which was 3.5. The nursing notes	F 677		

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F 677	Continued From page 94 documented no refusals of care. Weekly Skin assessment sheets were reviewed and documented the following; 10-23-17 no wounds. 11-4-17 crease of buttocks not a pressure sore. 11-8-17 wound not a pressure sore no location 11-13-17 sacrum pressure sore. 11-20-17 no wounds ADL documents were reviewed and revealed that after a bath on the afternoon of 11-8-17, the Resident did not receive another bath until 11-16-17 (8 days later). The director of nursing (DON) was asked what standard practice was used for bathing Residents, she stated at least twice weekly. She was shown the facility bathing documentation, and made aware that this Resident only received one bath during the week immediately following 9 wounds being identified on 11-6-17, she stated I saw it, that was unacceptable. No other hygiene was documented. The care plan was reviewed and revealed no problem areas or interventions for behaviors or refusals of care. The physician's orders were reviewed and revealed no preventative care for skin breakdown ordered for this Resident prior to multiple wound identification. The facility administration was informed of the findings during an end of day briefing on 6-21-18 at approximately 4:00 p.m. The facility did not present any further information about the findings up to the time of exit on 6-27-18.	F 677		

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F 677	Continued From page 95 COMPLAINT DEFICIENCY F 684 Quality of Care SS=D 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 record review, and family and staff interview, the facility staff failed to provide one resident (Resident #103) with physician ordered oxygen in the survey sample of 61 residents. The findings included: Resident #103 was admitted to the facility on 10/31/14 with diagnoses which included hypertension, GERD, hemiplegia, Chronic Respiratory Failure, Tracheostomy, Gastrostomy Status, Pneumothorax, seizures, and CVA. The facility staff failed to provide physician ordered. A re-entry Minimum Data Set (MDS) dated 2/19/18 for Resident #103 indicated this resident is not able to communicate with speech. This resident is not able to make self understood or understand others. In the area of Cognitive Patterns for daily decision making this resident is assessed as being severely impaired. In the area of Activities of Daily Living (ADL) this resident is assessed as being totally dependent on staff. In	F 677 F 684	1. The respiratory Therapist caring for Resident # 103 on 4/10/18 was educated on providing physician prescribed orders for Oxygen for transport to off-site appointment by Respiratory Manager on 7/20/18. Respiratory Manager educated and communicated with the transport company regarding the transport safety check list requirement on 7/20/18. 2. Residents receiving orders for oxygen that are transported out to appointments are at risk for harm by this deficient practice 3. A Medical Transport Checklist for Transfer Care of Ventilated patients was developed by the Respiratory Manager Respiratory Manager or designee provided education to facility staff on the appropriate use of this form; communicate with the transport company; and educated the family and the Respiratory Therapist on the use of Oxygen requirement for resident transporting to off site appointment. 4. Respiratory Manager or designee will audit resident records of ventilated residents for transport safety checklist completion 2x per week x 4 weeks the 1x per week x 4 weeks. Results of audits will be reviewed for patterns and/or trends and reported to QAPI monthy x 3 months for input and guidance. 5. Date of compliance: 8/12/18	

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F 684	Continued From page 96 the area of Special Treatments, Procedures, and Programs -Respiratory Treatment- this resident was assessed for receiving oxygen therapy, suctioning and tracheostomy care. A Care Plan dated 5/30/18 indicated: Problem- Resident is at risk for ineffective airway clearance due to tracheostomy as a result of acute respiratory failure. Intervention- Provide humidified oxygen to maintain O2 (oxygen) level as ordered. Assess for evidence of respiratory distress, trachypnea, nasal flaring and increased use of accessory muscles. Assess for changes in mental status; lethargy, confusion, restlessness and irritability. Provide humidified oxygen to maintain FiO2 (fraction of inspired oxygen) at 28%. A Physician's order indicated: oxygen orders per protocol continuous. Tracheal Suctioning PRN and chronic trach collar with humidification to keep o2 saturations greater than 95%, Therapeutic Range: Pulse Oximetry Every shift due to demonstrated unstable oxygen saturation levels. During a family interview on 6/19/18 at 4:30 P.M. Resident #103's sister stated: "On April 10, 2018 her sister was sent out on a doctors appointment and didn't have an oxygen tank with her." The sister stated, upon arrival to the appointment she noticed her sister not breathing well and gasping for air." She stated, she asked the transportation driver where was her oxygen tank and why didn't they bring her oxygen? The family member stated, the driver informed her that the Respiratory Therapist (RT) stated, she did not need it because she was going around the corner for her doctors appointment.	F 684		

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F 684	Continued From page 97 During an interview on 6/26/18 at 2:15 P.M. with the Respiratory Therapy Manager, she stated, Resident #103 was sent out to an appointment without her oxygen on 4/10/18. The Respiratory Therapy Manager stated as a result of the incident a Medical Transport Checklist for Transfer Care of Ventilated Patients was developed. The check off list included the following guide lines: "1. Paramedic verifies o2 tank is greater than 1500 PSI is attached to ventilator on/before arrival to unit. 2200 psi if o2 if patient greater than 50% Fio2. 2. Paramedic verifies that suction is set -up/functioning in ambulance. (Ask them) 3. Paramedic requests Respiratory Therapist (RT) to bedside upon transport's arrival unless RT already present, for verbal hand-off of ventilator settings and any other significant patient information. Trach size_____ Back ups given_____ . 5. Transport team places patient on Cardiac Monitor / Spo2 (saturated percent of oxygen) monitor." The facility staff failed to provide Resident #103 with physician's ordered oxygen.	F 684		
F 686 SS=H	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	F 686	1. Resident #576 was discharged from the facility on 11/23/17. The additional sheets and pillows were removed from Resident # 72's bed as soon as the issue was identified,	

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F 686	Continued From page 98 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 clinical record review, staff interviews, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure residents entering the facility did not develop pressure ulcers unless they were unavoidable, or those residents that did develop them received the necessary treatment to promote healing, prevent infection and prevent new ulcers from developing for 3 out of 61 residents (R#18,#72 and #576) in the survey sample. 1. For Resident #18, the facility staff failed to accurately assess, treat, and monitor a sacral pressure ulcer that was incorrectly identified as a Stage I pressure ulcer upon readmission to the facility on 12/5/17. Review of hospital discharge paperwork revealed identification of an unstageable sacral pressure ulcer upon hospital discharge. No treatment had been initiated prior to the pressure ulcer being later identified as an unstageable pressure ulcer by the facility staff, which required surgical intervention resulting in harm. In addition, Resident #18 acquired a DTI (Deep Tissue Injury) to the right plantar area of his foot on 12/27/17. 2. For Resident #72, the staff failed to identify a wound on the plantar surface of the left foot until	F 686	the resident was repositioned to assure pressure relief. Resident # 72 and # 18 received a comprehensive nutritional assessment 7/20/18. The weekly wound assessment were completed on 7/23/18 for residents #72 and #18 to include accurate assessment, staging and appropriate treatments. 2. All residents are at risk for potential impaired skin integrity. Skin assessments will be completed on current residents by 7/30/18, and any skin concerns identified will be appropriately be assessed staged and practitioners will be notified for appropriate treatment plan. 3. LTC Consultant, Wound Ostomy Care Nurse (WOCN), Wound Treatment Associate, and/or designee will educate licensed nursing staff and validate competencies on identification, assess-ments, treatment, documentation, and monitoring of pressure injury and other skin conditions. The WOCN or designee will educate the nursing staff, including CNAs on prevention of impaired skin integrity and the facility's policy and practice of completion of weekly skin assessments and weekly wound documentation. A schedule for weekly skin assessments will be developed and scheduled in accordance with bath preferences of the resident. Newly acquired pressure injuries will be logged into the facility risk management tool (STARs) and will be reported in the morning meeting for follow-up. New pressure injuries and	

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F 686	Continued From page 99 it was 45% eschar (hard black dead tissue) and found by surveyors during wound care observations, due to observed exudate on the foot of the bed. The wound doctor was present, and unable to stage the wound. 3. For Resident #576, the facility staff failed to identify 9 unstageable wounds (4 of the 9 had slough and eschar present) until they were all found at one time on 11-6-17 during wound rounds with the wound nurse. The findings included: 1. Resident #18 was originally admitted to the nursing facility on 11/9/17 with diagnoses that included right subdural hematoma, severe traumatic brain injury, closed facial fractures and mandible fracture, vegetative state, and enteral feedings via a gastrostomy tube (GT). The resident was seen in the Emergency Department (ED) on 11/10/17 and readmitted on 12/5/17. Resident #18 was readmitted to the nursing facility on 12/5/17 with a sacral pressure ulcer assessed as a *Stage I. In addition the facility staff failed to assess the wound every 7 days per facility protocol until 13 days later at which time the wound had progressively worsened and ultimately led to wound management by a specialized wound care physician. All of the aforementioned issues constituted harm for Resident #18. Minimum Data Set (MDS) assessment analysis: The MDS assessment in effect at the time of Resident #18 initial, first entry dated 11/9/17 indicated no skin issues. In correlation with this	F 686	pressure injuries that do not demonstrate improvement toward healing will be reviewed in the weekly interdisciplinary standards of care meeting to ensure appropriate interventions and treatments are being carried out. Notifications will be made to the physician regarding changes in the resident's skin integrity and/or pressure injuries. Life Care VP Medical Affairs (MD) will review the facility's protocols for treatment of pressure injuries and make recommedations to QAPI Committee. 4. Risk assessments will be completed weekly x 4 weeks on new admissions, on readmission, quarterly and with significant change in residents condition; this information will be used to develop a person centered plan of care to prevent and/or treat pressure injuries. Weekly skin observations will be completed and documented and practitioners will be notified of changes in skin integrity for appropriate interventions/treatments to be implemented as ordered and planned Clinical Managers or designee will audit weekly skin assessments and required risk assessments for completion and accuacy; 10% x 4 weeks, then 5% monthly x 2 months. The Clinical Manager and/or designee will complete 3 observations (rounding) per week x 6 weeks of residents who have identified pressure injuries that are ordered and care plan interventions (including use of speciality bed/mattress per manufacture's instruction)	

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F 686	Continued From page 100 MDS assessment, the hospital discharge summary dated 11/9/17 also indicated no skin issues. The discharge MDS assessment dated 11/10/17 with return anticipated, one day in the building, the resident was assessed to have one *Stage II pressure ulcer. Resident #18 was coded with short and long term memory problems and severely impaired in the skills for daily decision making. The resident was non-verbal and not able to understand staff. The resident was totally dependent on one staff for all activities of daily living (ADL). The hospital wound care notes dated 11/23/17 indicated the resident's sacral ulcer progressed to a *Stage 3 and on 12/3/17 the hospital wound care notes indicated the pressure ulcer had further progressed to 4x3 centimeter unstageable, open with slough (soft adherent necrotic tissue). The resident was re-admitted to the nursing facility on 12/5/17. The Admission MDS assessment with an assessment reference date of 12/12/17 indicated the resident had a one Stage 1 sacral pressure ulcer. The facility admission nursing note entered by Licensed Practical Nurse (LPN) #6 dated 12/5/17 indicated Resident #18 had one Stage I pressure ulcer 2 cm by 1 cm. The significant change in status MDS assessment dated 1/5/18 assessed the resident as having two pressure ulcers: one unstageable pressure ulcer with slough and/or eschar (hard black necrotic tissue), as well as one unstageable deep tissue injury (DTI). The quarterly MDS assessment dated 3/26/18	F 686	are interventions being carried out; variances in findings will be reviewed with the assigned staff person and corrections made as appropriate. The WOCN and / or licensed designee will complete 2 wound treatments observations weekly x 4 weeks to ensure that treatments are carried out in a manner consistent with the order and to promote wound healing and that assessment of the wound is accurately documented. Variances observed during treatment observations will be investigated and feedback provided to the responsible staff member; corrections/clarification will be made as needed. These audits will be given to the DON or designee for tracking and trending and further action as needed. A summary of the above audits will be provided to the QAPI committee for additional oversight and recommendation x 3 months 5. Date of compliance: 8/12/18	

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F 686	Continued From page 101 and the quarterly MDS assessment dated 6/18/18 assessed Resident #18 as having one Stage IV pressure ulcer. During an interview with the facility MDS coordinator and the Regional Corporate MDS coordinator on 6/26/18 at 3:00 p.m., they stated they get their information from the nurse's notes in order to complete the MDS and although they felt the most recent MDS's dated 3/26/18 and 6/18/18 were accurate representations of Resident #18 current sacral wound, the admission nurse's note assessment of the sacral wound as a Stage I was not accurate, thus the 12/12/17 MDS assessment was not an accurate assessment of the sacral wound. They stated they follow through with care planning based on the MDS assessment. The re-admission nursing assessment dated 12/5/17 scored the resident with a 6 on the Braden Scale Pressure Sore Risk assessment which indicated the resident was at "very high risk" for the development of pressure ulcers. The care plan dated 12/14/17 indicated the resident had a Stage I pressure ulcer and the goal set by the staff for the resident was that it would decrease over the review period (3/12/18). Some of the interventions to accomplish this goal include assess and record the size of the ulcer, perform a complete assessment and record, perform nutritional screening and assessment and to implement the protocol for Stage I pressure ulcer and was at risk for having pressure ulcers. The nursing staff were to use pillows and or wedges to reduce pressure on heels and pressure points, and turn and position, as well as a pressure reducing mattress	F 686		

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F 686	Continued From page 102 (standard mattress for all residents) and pad when sitting. The nursing staff would also check skin for redness, skin tears, swelling or additional breakdown. The resident was incorrectly care planned in the area of actual alteration in skin integrity and should have been care planned for an unstageable pressure ulcer to the sacrum. The facility pressure ulcer protocol was reviewed and included: Stage I pressure: turn/reposition/offload, use personal cleanser, skin barrier cream and no dressing, Prostat (protein supplement to increase wound healing) 30 ml daily not ordered). Unstageable pressure ulcer protocol could include the following: -Without foul odor-apply/pack with hydrogel moistened sterile Kerlex into wound as the topical treatment covered with sterile 4x4 or ABD's secured with retention tape and cover with transparent film. -With foul odor-pack with 1/4 Dakins moistened Kerlix into the wound bed-packing into undermining/tunneling if present and cover with the same dressing as without foul odor. All Stage III and above pressure ulcers require Prostat AWC 30 ml BID, labs (CBC, CMP, Pre-Albumin), low air loss mattress. The resident was not ordered Prostat until after the wound care specialist physician evaluated the resident. The prealbumin level per COWCN recommendations collected on 1/29/18 was 23 (20-40=normal range). The albumin level per COWCN recommendations collected on 1/29/18 was 3.4 (3.5-5.0=normal).	F 686		

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F 686	Continued From page 103 The LPN #6 that assessed Resident #18's sacral area upon readmission to the nursing facility on 12/5/17 was interviewed on 6/28/18 at 12:10 p.m. She reviewed her nursing note entry and checked the time of the assessment to be 9:30 p.m., and stated she was called over to the unit to admit the resident and possibly did a "quick sweep" and did not take the time she should have because they were so busy. She said she followed the facility's skin care protocol and did not implement any treatment other than skin barrier cream and turning and positioning. She reviewed the hospital skin assessment and wound care notes and stated there was no way the pressure ulcer would have been a Stage I and reiterated how busy she was admitting a patient at 9:30 p.m. She added she did not have the resident anymore after the admission, which was verified through review of subsequent nurse's notes to be an accurate statement. She stated total body weekly skin assessments should have captured further assessments of the area and any treatment changes, plus Certified Nursing Assistants (CNA) should have passed on to the licensed nurse if there were any problems with the skin. LPN #6 stated she had extensive training on pressure ulcer assessment prevention and treatment, as well as the Skin Dyad Program with wound care protocols. The LPN added that the wound care nurse should have come behind her and looked at the resident's skin. There was not wound care nurse assessment documented at the time of LPN #6's assessment. The next weekly assessment to be completed by the licensed nurse for would have been 12/12/17, which was not completed for Resident #18.	F 686		

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F 686	Continued From page 104 A weekly wound assessment was completed by LPN #7 12/17/17 where it was documented in the nurse's notes that the CNA informed her of a blister on the resident's right lower leg and it was at that time she completed a full body assessment and documented an unstageable sacral ulcer. This LPN was interviewed about this assessment on 6/22/18 at 12:05 p.m. She stated she was not made aware of the unstageable sacral area, but once she assessed it as unstageable she would have initiated the pressure ulcer protocol for unstageable pressure ulcer, but called the physician to inform him of the condition of the sacral ulcer. She stated he gave the following order "daily cleanse sacral area with normal saline, apply *Santyl (topical debridement ointment), and cover with *Mesalt (Sodium Chloride Impregnated Gauze) and *Allevyn (an adhesive dressing to support moist wound healing)." This was the first treatment to the sacral pressure ulcer since admission on 12/5/17, 13 days later. The CWOCN RN (Certified Wound Ostomy Continence Nurse Registered Nurse) makes her first assessment of the sacral pressure ulcer on 12/27/17, as unstageable, unable to gage the depth due to amount of slough in wound bed, 90% adherent slough, 10% smooth red nongranulating tissue. A right plantar *DTI (Deep Tissue Injury) was identified, deep purple intact skin, as well as the right calf reabsorbing serous blister, as well as a excoriation of the left ear with skin prep treatment daily and as needed. The CWOCN RN changed the order on 12/27/17 to the sacral pressure ulcer to a more aggressive treatment to cleanse the area with normal saline, apply calmoseptine to peri-wound, apply nickel thick Santyl, cover with 4x4/*ABD (abdominal pad	F 686		

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F 686	Continued From page 105 dressing), secure with tape (skin prep where tape will be applied) daily and as needed. May cover with opsite as needed. The wound care nurse set up recommendations for a low air loss mattress which was indicated for residents with advanced stage wounds Stage III or greater. Albumin and prealbumin levels (nutritional metrics) were ordered, bed extension was set up with the maintenance department. The CWOCN RN documented that she educated the nursing staff on the importance of repositioning and preventing pressure ulcers. The CWOCN RN was not available for interview and no longer worked for the facility. Prior to the wound care nurse evaluating the resident's wounds there were no weekly skin condition progress notes. There were no weekly skin assessments, per review of the clinical record, 7 days later on Jan 3, 2018, Jan 10, 2018. The resident was admitted to the local hospital on 1/16/18 for a planned procedure and readmitted to the nursing facility on 1/23/18. On 1/25/18 the wound care regimen was changed again to even a more aggressive treatment due to to continued deterioration of the sacral wound, now 100% slough in the wound bed with undermining and peri wound with excoriation. *Dakin's solution 1/4 topical two times a day starting 1/24/18 with *Calmaseptine to peri-wound, nickel thick Santyl to wound bed, pack with 1/4 Dakins moistened gauze, cover with 4x4/ABD, secure with tape (skin prep wherever tape will be). *Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong	F 686		