STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 06/11/19 through 06/14/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 06/11/19-06/14/19. Nine complaints were investigated during this survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 bed facility was 165 at the time of survey. The survey sample consisted of 64 current resident record reviews and seven closed records.	F 000	To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578	F578 1. Resident #158 has expired. Resident #144, #135, #29, #156, #140, #64, #72, #40, #155, #163, #122, #85, #80, #98, #39, #57, #134, #125, #33, #138, #30, #113, #112, #58, #136, #87, #96, #50 and #76 and/or the RP (resident representative) will be provide written information and the opportunity to formulate advance directives.	7/14/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacie Shine LNHA | TITLE: Executive Director | (X6) DATE: 7/3/19

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

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F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to evidence that residents and/or the RR (resident representative) were provided with written information and the opportunity to formulate advance directives on admission, and that follow up was conducted, to ascertain if the resident or RR wished to formulate, make changes or maintain, the existing advance directive as written, for thirty of 71, sampled residents, (Residents #144, #135, #29, #156, #140, #64, #72, #40, #155, #163, #122, #85, #80, #98, #39, #57, #134, #125, #33, #138, #30,	F 578	2. An audit will be conducted to ensure residents and/or the RP are provided written information and the opportunity to formulate advance directives, make changes or maintain the existing advance directive as written. 3. Social Service Workers will be re-educated by the Administrator/ Designee on providing residents and/or the RP written information and the opportunity to formulate advance directives upon admission and that follow up to be conducted, to ascertain if the resident or RP wished to formulate, make changes or maintain the existing advance directive. 4. Audits will be conducted by the Administrator/Designee to ensure residents and/or the RP are provided with written information and the opportunity to formulate advance directives upon admission and that follow up is conducted, to ascertain if the resident or RP wished to formulate, make changes or maintain the existing advance directive weekly times four weeks then monthly for	

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F 578	Continued From page 2 #113, #112, #58, #136, #87, #158, #96, #50 and #76). The findings include: 1. The facility staff failed to evidence that advance directives (1) were reviewed and/or addressed with Resident #144 (and/or the resident's representative) and failed to ensure periodic reviews were conducted. Resident #144 was admitted to the facility on 1/14/12. Resident #144's diagnoses included but were not limited to heart failure, pain and diabetes. Resident #144's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/29/19, coded the resident as being cognitively intact. Review of Resident #144's clinical record revealed a physician's order dated 10/24/17 for a full code status (full resuscitation). Resident #144's clinical record failed to evidence that advance directives were addressed reviewed with Resident #144 (and/or the resident's representative) upon admission and failed to reveal evidence periodic reviews were conducted. On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern and asked to provide any further information. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 and OSM #15	F 578	three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 7/14/19	

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F 578	Continued From page 3 were asked about the facility process followed for resident advance directives. OSM #8 stated, "We meet within 72 hours (of admission) or as soon as we can or when they want. We meet with the resident, any family members they want there, therapy, nursing and activities. We ask if they have anything in place. First, we talk about code status. They come over with a code status from the hospital. We review and ask if they want to change or keep the same. Then we ask if they have any kind of advance directive in place or living will or any document that would indicate their wishes and if they do not, then we explain what that would look like. If we were to find you unresponsive what would you want done' then we give them a form they can fill out if they want and that goes on the chart." When asked about residents who are admitted with an advance directive, OSM #8 stated, "We make sure we get a copy and have on their chart and put on file." When asked if they periodically review advance directives with residents, OSM #8 stated, "We conduct quarterly care plan meetings and advance directives are reviewed then." OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list (including Resident #144). On 6/14/19 at approximately 9:30 a.m., an interview was attempted with Resident #144 but the resident was not available. The facility policy, Advance Directives" from Lippincott Nursing Procedures, Eighth Edition, 2019. Page 9 documented, "The Patient-Self Determination Act of 1990 requires health care facilities to provide information about the patient's	F 578		

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F 578	Continued From page 4 right to choose and refuse treatment. An advanced directive is a legal document used as a guideline for providing life-sustaining medical care to a patient with an advanced disease or disability who is no longer able to indicate his or her own wishes. Advance directives include living wills and health care proxies ....If the patient has an advance directive: Review the advance directive with the patient and confirm that it still reflects the patient's wishes. Place the advance directive in the medical record so that it's easily accessible to all health care providers. Notify the practitioner and the rest of the health care team that the patient has an advance directive so that it can be used to guide care .... Document the procedure that the patient has an advance directive ....If the patient doesn't have an advance directive: Provide the patient with verbal and written information about advance directives so that the patient can make an informed decision about developing one. Answer patient's questions about advance directives or have a social worker or patient representative discuss advance directives with the patient to provide accurate information. Assist in the assessment of the patient's level of competency to ensure that the patient can make decisions .... As necessary, determine the need for a multidisciplinary conference to provide the patient and the patient's family with complete, comprehensive, and accurate information to prevent them from receiving conflicting or confusing information from various health care providers. Encourage patient to discuss developing an advance directive with family. If the patient would like to make an advance directive, assist the patient and family with coming to terms with the patient's decisions. If indicated, have the patient sign the advance directive and obtain witness signatures as	F 578		

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required by law ....Document the procedure and note that the patient doesn't have an advance directive. Special considerations: ....The patient may revoke or change an advance directive at any time ....The patient can revoke an advance directive either orally or in writing.
Documentation: Document the presence of an advance directive and that the practitioner was notified of its presence. Include the name of the practitioner and the time of notification. Include the name, address, and telephone number of the health care agent ...If the patient doesn't have an advance directive, document that the patient was given written information concerning rights under state law to make decisions regarding health care. If the patient refuses information on an advance directive, document this refusal using the patient's own words, in quotes, if possible. Record any conversations with the patient regarding this decision making. Document that proof of competence was obtained."

As of the survey exit, there was no documented evidence that the facility offered and provided information regarding advance directives or conducted periodic reviews of Advance Directives with Resident #144.

(1) Advance Directives Summary: "What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. They give you a way to tell your wishes to family, friends, and health care professionals and to avoid confusion later on.
A living will tells which treatments you want if you are dying or permanently unconscious. You can accept or refuse medical care. You might want to

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F 578	Continued From page 6 include instructions on ·The use of dialysis and breathing machines ·If you want to be resuscitated if your breathing or heartbeat stops ·Tube feeding ·Organ or tissue donation A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions for you if you are unable to do so. "This information was obtained from the website: https://medlineplus.gov/advancedirectives.html 2. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #135 (and/or the resident's representative) and failed to ensure periodic reviews were conducted. Resident #135 was admitted to the facility on 11/2/18. Resident #135's diagnoses included but were not limited to paralysis, difficulty swallowing and personal history of traumatic brain injury. Resident #135's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/28/19, coded the resident as being cognitively intact. Review of Resident #135's clinical record revealed a physician's order dated 5/6/19 for the resident to not be resuscitated. Further review of Resident #135's clinical record failed to reveal evidence advance directives were reviewed and/or addressed with Resident #135 (and/or the resident's representative) upon admission to the facility. The clinical record also failed to reveal evidence of periodic reviews. On 6/12/19 at 1:56 p.m., ASM (administrative	F 578		

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staff member) #1 (the administrator) was aware of the above concern and asked to provide any further information.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list (including Resident #135).

On 6/14/19 at approximately 9:30 a.m., an interview was attempted with Resident #135 but the resident was not able to answer questions.

As of the survey exit, there was no documented evidence that the facility offered and provided information regarding advance directives or conducted periodic reviews of Advance Directives with Resident #135.

3. The facility staff failed to evidence that advance directives were periodically reviewed with Resident #29 (and/or the resident's representative).

Resident #29 was admitted to the facility on 10/19/09. Resident #29's diagnoses included but were not limited to stroke, major depressive disorder and chronic pain. Resident #29's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/22/19 coded the resident as being cognitively intact.

Review of Resident #29's clinical record revealed an advance directive dated 11/30/09. A

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F 578	Continued From page 8 physician's order dated 10/2/18 documented for the resident to not be resuscitated. Further review of Resident #29's clinical record failed to reveal periodic reviews of the advance directive were conducted with Resident #29 (and/or the resident's representative). On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was aware of the above concern and asked to provide any further information. On 6/12/19 at 4:56 p.m., when asked what should be done if the resident has an advance directive in place on admission, OSM #8 stated, "We make sure we get a copy and have on their chart and put on file." When asked if they periodically review advance directives with residents, OSM #8 stated, "We conduct quarterly care plan meetings and advance directives are reviewed then." OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list (including Resident #29). On 6/14/19 at approximately 9:30 a.m., an interview was conducted with Resident #29. The resident confirmed the facility staff had not completed periodic reviews of the advance directives with him. As of the survey exit, there was no documented evidence that the facility conducted periodic reviews of Advance Directives with Resident #29. 4. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #156 (and/or the	F 578		

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F 578	Continued From page 9 resident's representative). Resident #156 was admitted to the facility on 4/27/19. Resident #156's diagnoses included but were not limited to muscle weakness, diabetes and major depressive disorder. Resident #156's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/3/19, coded the resident as being cognitively intact. Review of Resident #156's clinical record revealed a physician's order dated 4/27/19 for a full code (full resuscitation). Further review of Resident #156's clinical record failed to reveal evidence that advance directives were reviewed and/or addressed with Resident #156 (and/or the resident's representative) upon admission. On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was aware of the above concern and asked to provide any further information. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list (including Resident #135). On 6/14/19 at approximately 9:30 a.m., an interview was conducted with Resident #156. The resident stated she was given information on advance directives when admitted; however, there was no documentation to evidence this in the resident's clinical record.	F 578		

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As of the survey exit, there was no documented evidence that the facility offered and provided information regarding advance directives to Resident #156.

5. The facility staff failed to evidence that advance directives were reviewed periodically with Resident #140 (and/or the resident's representative).

Resident #140 was admitted to the facility on 9/5/07. Resident #140's diagnoses included but were not limited to diabetes, major depressive disorder and chronic kidney disease. Resident #140's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/2/19, coded the resident as being cognitively intact.

Review of Resident #140's clinical record revealed a power of attorney form dated 2/6/98. A physician's order dated 4/19/19 documented a full code (full resuscitation). Further review of Resident #140's clinical record failed to reveal facility staff had conducted periodic reviews of the advance directives with Resident #140 (and/or the resident's representative).

On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was aware of the above concern and asked to provide any further information.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). When asked what should be done if the resident has an advance

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directive in place on admission, OSM #8 stated, "We make sure we get a copy and have on their chart and put on file." When asked if they periodically review advance directives with residents, OSM #8 stated, "We conduct quarterly care plan meetings and advance directives are reviewed then." OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list (including Resident #140).

On 6/14/19 at approximately 9:30 a.m., an interview was attempted with Resident #140. The resident was not in the room.

As of the survey exit, there was no documented evidence that the facility conducted periodic reviews of advance directives with Resident #140.

6. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #64 (and/or the resident's representative [RR]) on admission, and failed to ensure periodic reviews were conducted.

Resident #64 was admitted to the facility on 2/12/18, with diagnoses including, but not limited to multiple sclerosis, pressure ulcers, migraines, and depression. The most recent MDS (Minimum Data Set) an annual assessment with an ARD (Assessment Reference Date) of 2/27/19, coded the resident as cognitively intact in ability to make daily life decisions.

Review of the clinical record revealed an undated "Virginia Advance Directive For Health Care" form, which contained a URL [Uniform Resource

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Locator (1)] showing the document was printed from the electronic record web address during the prior hospitalization. The form also contained the internal patient identification and medical record label of the prior hospital, indicating this form was obtained from Resident #64's hospital record. The URL was dated 2/12/18.

Further review of the clinical record failed to reveal any evidence that the contents of this form was discussed with the resident and/or RR upon admission to the facility, and periodically thereafter, to ascertain if the information contained within continued to be the resident's wishes or did she wish to make any changes.

On 6/14/19 at 10:36 AM, in an interview with Resident #64, when asked if she recalled that the information of her Advance Directives had ever been reviewed with her since admission to the facility, she stated she could not recall.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). When asked what should be done if the resident has an advance directive in place on admission, OSM #8 stated, "We make sure we get a copy and have it on their chart and put it on file." When asked if they periodically review advance directives with residents, OSM #8 stated, "We conduct quarterly care plan meetings and advance directives are reviewed then." OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list including Resident #64.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 578	Continued From page 13 No further information was presented by the facility for Resident #64. On 6/14/19 at 5:04 PM the Administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. (1) URL - Uniform Resource Locator: a protocol for specifying addresses on the Internet. Information obtained from https://www.dictionary.com/browse/uniform--resource--locator 7. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #72 (and/or the resident's representative) on admission, and failed to ensure periodic reviews were conducted. Resident #72 was admitted to the facility on 4/27/18, with diagnoses including, but not limited to, amnesia, dementia, dysphagia, and osteoporosis with history of fracture. The most recent MDS (Minimum Data Set) an annual assessment with an ARD (Assessment Reference Date) of 3/4/19 coded the resident as moderately impaired in ability to make daily life decisions. A review of the clinical record failed to reveal any evidence of an Advance Directive being completed for Resident #72. Further review of the clinical record failed to reveal any evidence that written and verbal information for an Advance Directive was	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 14 provided to the resident and/or resident representative (RR) upon admission. There was no documented evidence that the opportunity to develop an advanced directive was provided upon admission, and that periodically thereafter information and opportunity were provided to ascertain if the resident and/or their RR wished to develop one. The resident was not capable of being interviewed and could not be asked if she recalled if information/opportunity to develop and Advance Directive was provided upon and since admission. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents, whose names were documented on a list, including Resident #72. No further information was provided by the facility for Resident #72. On 6/14/19 at 5:04 PM the Administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. 8. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #40 (and/or the resident's representative) on admission, and failed to ensure periodic reviews were conducted.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	**3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060**

(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 578	Continued From page 15 Resident #40 was admitted to the facility on 11/3/17; diagnoses included but are not limited to dementia, non-pressure wounds, dysphagia, affective disorder, and anxiety. The most recent MDS (Minimum Data Set) a quarterly assessment with an ARD (Assessment Reference Date) of 3/26/19 coded the resident as severely impaired in ability to make daily life decisions. A review of the clinical record failed to reveal any evidence of an Advance Directive being completed for Resident #40. Further review of the clinical record failed to reveal any evidence that written and verbal information for an Advance Directive was provided to the resident and/or resident representative (RR) upon admission. There was no documented evidence that the opportunity to develop an advanced directive was provided upon admission, and that periodically thereafter information and opportunity were provided to ascertain if the resident and/or their RR wished to develop one. The resident was not capable of being interviewed and could not be asked if she recalled if information and opportunity to develop and Advance Directive was provided upon and since admission. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 16 multiple sampled residents, whose names were documented on a list, including Resident #40. The facility did not provide anything further for Resident #40. On 6/14/19 at 5:04 PM the Administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. 9. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #155 (and/or the resident's representative) on admission, and failed to ensure periodic reviews were conducted. Resident #155 was admitted to the facility on 9/3/13, with diagnoses that included, but are not limited to, dementia, aphasia, pressure injury, high blood pressure, and depression. The most recent MDS (Minimum Data Set) a quarterly assessment with an ARD (Assessment Reference Date) of 6/1/19, coded the resident was coded as severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a "Durable Medical Power of Attorney and Advance Directive" form dated 1/10/15. Further review of the clinical record failed to reveal any evidence that the contents of this form was discussed with the resident and/or RR periodically to ascertain if the information contained within continued to be the resident's wishes or did she wish to make any changes.	F 578		

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F 578	Continued From page 17 The resident was not interviewable and could not be asked if she recalled if information, opportunity to develop, and Advance Directive was provided upon and since admission. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). When asked what should be done if the resident has an advance directive in place on admission, OSM #8 stated, "We make sure we get a copy and have it on their chart and put it on file." When asked if they periodically review advance directives with residents, OSM #8 stated, "We conduct quarterly care plan meetings and advance directives are reviewed then." OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list, including Resident #155. The facility did not provide any additional information for Resident #155. On 6/14/19 at 5:04 PM the Administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. 10. The facility staff failed to evidence that Resident #163 and/or their Responsible Party (RP) was provided with written information and the opportunity to formulate advance directives at the time of admission and that periodic reviews were conducted with the resident and/or their RP to ascertain if they wished to formulate advance directives.	F 578		

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F 578	Continued From page 18	F 578		

Resident #163 was admitted to the facility on 1/12/12; diagnoses included but are not limited to paranoid schizophrenia, insomnia, diabetes, and major depressive disorder. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 5/5/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making.

A review of the clinical record failed to reveal any evidence of an Advance Directive being completed for Resident #163.

Further review of the clinical record failed to reveal any evidence that written and verbal information for an Advance Directive was provided to the resident and/or resident representative (RR) upon admission. There was no evidence that the opportunity to develop one was provided upon admission, and that periodically thereafter information and opportunity were provided to ascertain if at any time the resident and/or their RR wished to develop one.

The resident was not interviewable and could not be asked if she recalled if information, opportunity to develop, and Advance Directive was provided upon and since admission.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

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F 578	Continued From page 19 The facility did not provide anything for Resident #163, who was on this list. On 6/14/19 at 12:32 PM, ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided by the end of the survey. 11. The facility staff failed to evidence that Resident #122 and/or their Responsible Party (RP) was provided with written information and the opportunity to formulate advance directives at the time of admission and that periodic reviews were conducted with the resident and/or their RP to ascertain if they wished to formulate advance directives. Resident #122 was admitted to the facility on 1/14/19, with the diagnoses of, but not limited to major depression, generalized anxiety disorder and high blood pressure. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 4/16/19, coded the resident as scoring a 3 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. On 6/12/19 at 9:46 AM, a review of the clinical record revealed a "Durable Do Not Resuscitate Order," dated 12/19/18, that documented in part, "I further certify: 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment ...If you	F 578		

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F 578	Continued From page 20 checked 2 above ...: C. The patient has not executed a written advanced directive ..." A review of the clinical record failed to reveal any evidence of an Advance Directive being completed for Resident #122. Further review of the clinical record failed to reveal any evidence that written and verbal information for an Advance Directive was provided to the resident and/or resident representative (RR) on admission. There was no evidence that periodically thereafter information and opportunity were provided to ascertain if at any time the resident and/or their RR wished to develop one. The resident was not capable of being interviewed and could not be asked if she recalled if information and opportunity to develop and Advance Directive was provided upon and since admission. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. The facility did not provide anything for Resident #122, who was on this list. On 6/14/19 at 12:32 PM, ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Regional Director of Clinical Services were made aware of	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 21 the findings. No further information was provided by the end of the survey. 12. The facility staff failed to evidence that Resident #85 and/or their Responsible Party (RP) was provided with written information and the opportunity to formulate advance directives at the time of admission and that periodic reviews were conducted with the resident and/or their RP to ascertain if they wished to formulate advance directives. Resident #85 was admitted to the facility on 9/10/18, with the diagnoses including but not limited to, dementia with behavioral disturbances, unspecified psychosis and retention of urine. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 4/4/19, coded the resident as scoring a 7 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for daily decision making. A review of the clinical record failed to reveal any evidence of an Advance Directive being completed for Resident #85. Further review of the clinical record failed to reveal any evidence that written and verbal information and an opportunity to formulate an Advance Directive was provided to the resident and/or resident representative (RR) upon admission. There was no documented evidence a periodic review was conducted to ascertain if the resident or RR wished to formulate an advanced directive.	F 578		

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F 578	Continued From page 22 The resident was not interviewable and could not be asked if she recalled if information or an opportunity to develop and Advance Directive was provided on and or since admission. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. The facility did not provide anything for Resident #85, who was on this list. On 6/14/19 at 12:32 PM, ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided by the end of the survey. 13. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #80 (and/or the resident's representative) and failed to ensure periodic reviews were conducted. Resident #80 was admitted to the facility on 08/20/2015. Resident #80's diagnoses included hypertension (high blood pressure), dementia, depression, and asthma. Her most recent Minimum Data Set (MDS) Assessment a Quarterly Assessment with an Assessment Reference Date (ARD) of 04/03/2019, coded the resident as scoring a five on the Brief Interview for Mental Status (BIMS), indicating significant	F 578		

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F 578	Continued From page 23 impairment. Review of the clinical record revealed that while documentation of the resident's Code Status was found, there was no documentation in the medical record of Resident #80's Advanced Directives. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. The next morning, the morning of 06/13/2019, facility staff returned without documentation of Advanced Directive information for Resident #80. 14. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #98 (and/or the resident's representative) and failed to ensure periodic reviews were conducted. Resident #98 was admitted to the facility on 03/22/2018. Resident #98's diagnoses included Anemia (low levels of red blood cells), Hypertension, Dementia, and Depression. Her most recent MDS Assessment a Significant Change Assessment with an ARD of 03/20/2019, coded the resident with a BIMS score of five, indicating severe impairment. Record Review, failed to reveal documentation of Resident #98's Advanced Directives.	F 578		

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F 578	Continued From page 24 On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. The next morning, the morning of 06/13/2019, facility staff returned without documentation of Advanced Directive information for Resident #98. 15. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #39 (and/or the resident's representative) and failed to ensure periodic reviews were conducted. Resident #39 was admitted to the facility on 07/20/2018. Resident #39's diagnoses included Heart Failure(1), Hypertension, and Dementia. His most recent MDS Assessment was a Quarterly Assessment with an ARD of 02/20/2019, scored the resident at a 4 on the BIMS, indicating significant impairment. Record Review, failed to reveal documentation of Resident #39's Advanced Directives. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were	F 578		

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documented on a list.

The next morning, the morning of 06/13/2019, facility staff returned without documentation of Advanced Directive information for Resident #39.

1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. The weakening of the heart's pumping ability causes: Blood and fluid to back up into the lungs, the buildup of fluid in the feet, ankles and legs - called edema, and tiredness and shortness of breath. - https://medlineplus.gov/heartfailure.html

16. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #57 (and/or the resident's representative) and failed to ensure periodic reviews were conducted.

Resident #57 was admitted to the facility on 09/28/2016. Their diagnoses included Hypertension, Diabetes, Anxiety, and Depression. Resident #57's most recent MDS Assessment a Quarterly Assessment with an ARD of 03/30/2019, coded the resident as scoring a 9 on the BIMS, indicating moderate impairment.

Record Review revealed no documentation of Resident #57's Advanced Directives.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8

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(recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

The next morning, the morning of 06/13/2019, facility staff returned without documentation of Advanced Directive information for Resident #57.

17. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #134 (and/or the resident's representative) and failed to ensure periodic reviews were conducted.

Resident #134 was admitted to the facility on 03/01/2017. Their diagnoses included Anemia, Hypertension, Dementia, and Depression. Resident #134's most recent MDS a Quarterly Assessment with an ARD of 04/27/2019 scored the resident at an 8, indicating moderate impairment.

Record Review revealed no documentation of Resident #57's Advanced Directives.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

The next morning, the morning of 06/13/2019, facility staff returned without documentation of

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F 578	Continued From page 27 Advanced Directive information for Resident #134. 18. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #125 (and/or the resident's representative) and failed to ensure periodic reviews were conducted. Resident #125 was admitted to the facility on 01/04/2019. Their diagnoses included anemia, hypertension, diabetes, and dementia. Resident #125's most recent MDS Assessment was a Significant Change Assessment with an ARD of 04/21/2019. The BIMS was not performed, as Resident #125 is rarely or never understood. Record Review revealed no documentation of Resident #57's Advanced Directives. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. The next morning, the morning of 06/13/2019, facility staff returned without documentation of Advanced Directive information for Resident #125. 19. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #33 (and/or the resident's representative) and failed to ensure periodic reviews were conducted.	F 578		

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F 578	Continued From page 28 Resident #33 was admitted to the facility on 01/31/2017. Their diagnoses included hypertension, diabetes, and dementia. Resident #33's most recent MDS Assessment was a Quarterly Assessment with an ARD of 02/15/2019 scored the resident on the BIMS at 3, indicating profound impairment. Record Review revealed no documentation of Resident #57's Advanced Directives. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. The next morning, the morning of 06/13/2019, facility staff returned without documentation of Advanced Directive information for Resident #33. Administrative Staff Member (ASM) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/14/2019. No further documentation was provided. 20. The facility staff failed to evidence information was provided on developing an advance directive on admission and that follow up review to develop an advance directive for Resident # 138 was provided. Resident # 138 was admitted to the facility on 04/11/18 with diagnoses that included but were not limited to dementia (1), depressive disorder,	F 578		

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(2), and dysphagia (3). Resident # 138's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 04/29/19, coded Resident # 138 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions.

Review of the clinical record and the EHR (electronic health record) for Resident # 138 failed to evidence an advanced directive. Further review of the clinical record revealed a "Durable Do Not Resuscitate Order" for Resident # 87 dated 02/23/2018.

The comprehensive care plan dated 05/02/2019 for Resident # 138 documented, "Focus. Patient has an advance directive as evidenced by Do not Resuscitate. Date initiated: 05/02/2019." Under "Interventions" it documented, "Follow facility protocol for identification of code status. Date initiated 05/02/2018. Review code status quarterly. Date initiated: 05/02/2018."

The facility's "Progress Notes" dated 04/11/18 through 04/14/18 failed to evidence Resident # 138 was offered an advance directive. Further review of the facility's progress notes dated 04/15/19 through 06/11/19 failed to evidence the facility provided periodic reviews to develop an advance directive for Resident # 138.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with

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F 578	Continued From page 30 multiple sampled residents whose names were documented on a list. On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 21. The facility staff failed to evidence information was provided on developing an advance directive on admission and that follow up review to develop an advance directive for Resident # 30 was provided. Resident # 30 was admitted to the facility on	F 578		

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F 578	Continued From page 31 03/23/18 with diagnoses that included but were not limited to dementia (1), depressive disorder, (2), and anxiety (3). Resident # 30's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/12/18, coded Resident # 30 as scoring a ten on the brief interview for mental status (BIMS) of a score of 0 - 15, ten - being moderately impaired of cognition for making daily decisions. Review of the clinical record and the EHR (electronic health record) for Resident # 30 evidenced an advanced directive entitled "Virginia Advance Directive For Health Care" dated "1/9/14." The facility's "Progress Notes" For Resident # 30 dated 03/23/18 through 06/11/19 failed to evidence the facility provided periodic reviews of the advance directive for Resident # 30 to determine if they wanted to make any changes to the advance directive On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). When asked what should be done if the resident has an advance directive in place on admission, OSM #8 stated, "We make sure we get a copy and have it on their chart and put on file." When asked if they periodically review advance directives with residents, OSM #8 stated, "We conduct quarterly care plan meetings and advance directives are reviewed then." OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.	F 578		

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F 578	Continued From page 32 On 06/14/19 at approximately 10:47 a.m., an interview was attempted with Resident # 30 regarding periodic review of the advance directive. Resident # 30 was unavailable at the time. On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. 22. The facility staff failed to evidence information was provided information on developing an advance directive and follow up	F 578		

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provided to develop an advance directive for Resident # 113.

Resident # 113 was admitted to the facility on 05/11/17 with diagnoses that included but were not limited to dementia (1), depressive disorder, (2), and dysphagia (3). Resident # 113's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/09/19, coded Resident # 113 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The POS (physician's order sheet for Resident # 113 dated 06/13/2019 documented, "Full Code. Order Status: Active. Order date: 05/11/2017."

Review of the clinical record and the EHR (electronic health record) for Resident # 113 failed to evidence an advanced directive.

The facility's "Progress Notes" dated 05/23/17 through 06/09/17 failed to evidence Resident # 113 was offered information on developing an advance directive. Further review of the facility's progress notes dated 06/09/17 through 06/11/19 failed to evidence the facility provided periodic reviews to develop an advance directive for Resident # 113.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

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F 578	Continued From page 34 On 06/14/19 at approximately 10:40 a.m., an interview was attempted with Resident # 113 regarding being provided information on developing an advance directive and periodic to develop an advance directive. Resident # 113 was unavailable at the time. On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 23. The facility staff failed to evidence information was provided information on	F 578		

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developing an advance directive and failed to evidence follow up was provided to develop an advance directive for Resident # 112.

Resident # 112 was admitted to the facility on 03/22/18 with diagnoses that included but were not limited to dementia (1), depressive disorder, (2), and anxiety (3). Resident # 112's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/02/19, coded Resident # 112 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The POS (physician's order sheet for Resident # 112 dated 06/13/2019 documented, "Full Code. Order Status: Active. Order date: 03/22/2018."

Review of the clinical record and the EHR (electronic health record) for Resident # 113 failed to evidence an advanced directive.

The facility's "Progress Notes" dated 03/22/18 through 03/29/18 failed to evidence Resident # 112 was offered information on developing an advance directive. Further review of the facility's progress notes dated 06/09/17 through 06/11/19 failed to evidence the facility provided periodic reviews to develop an advance directive for Resident # 112.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were

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documented on a list.

On 06/14/19 at approximately 10:38 a.m., an interview was attempted with Resident # 112 regarding being provided information on developing an advance directive and periodic to develop an advance directive. Resident # 112 was unavailable at the time.

On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

24. The facility staff failed to evidence

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information was provided information on developing and advance directive on admission and failed to evidence follow up provided for development of an advance directive for Resident # 58.

Resident # 58 was admitted to the facility on 11/07/17 with diagnoses that included but were not limited to hypertension (1), depressive disorder, (2), and benign prostatic hyperplasia (3). Resident # 58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/31/19, coded Resident # 58 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The POS (physician's order sheet for Resident # 11 dated 06/13/2019 documented, "Full Code. Order Status: Active. Order date: 11/07/2017."

Review of the clinical record and the EHR (electronic health record) for Resident # 58 failed to evidence an advanced directive.

The facility's "Progress Notes" dated 11/10/17 through 06/11/19 failed to evidence Resident # 58 was offered information on developing an advance directive. Further review of the facility's progress notes failed to evidence the facility provided periodic reviews to develop an advance directive for Resident # 58.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were

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addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

On 06/14/19 at approximately 10:39 a.m., an interview was attempted with Resident # 58 regarding being provided information on developing an advance directive and periodic to develop an advance directive. Resident # 58 was unavailable at the time.

On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

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25. The facility staff failed to evidence information was provided information on developing and advance directive and failed to evidence follow up was provided for the development of an advance directive for Resident # 136.

Resident # 136 was admitted to the facility on 05/06/15 with diagnoses that included but were not limited to hypertension (1), depressive disorder, (2), and bipolar disorder (3). Resident # 136's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/29/19, coded Resident # 136 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The POS (physician's order sheet for Resident # 136 dated 06/13/2019 documented, "Full Code. Order Status: Active. Order date: 06/10/2019."

Review of the clinical record and the EHR (electronic health record) for Resident # 136 failed to evidence an advanced directive.

The facility's "Progress Notes" dated 05/06/15 through 06/11/19 failed to evidence Resident # 136 was offered information on developing an advance directive. Further review of the facility's progress notes failed to evidence the facility provided periodic reviews to develop an advance directive for Resident # 58.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 and OSM #15 were asked the facility process regarding

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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advance directives. OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

On 06/14/19 at approximately 10:39 a.m., an interview was conducted Resident # 136 regarding being provided information on developing an advance directive and periodic follow up to develop an advance directive. When asked if she was given information on developing an advance directive when she was admitted to the facility, Resident # 136 stated, "No." When asked if the facility provided periodic reviews with her to develop an advance directive Resident # 136 stated she didn't know. When asked if she had an advance directive Resident # 136 stated she wasn't sure.

On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks

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or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

26. The facility staff failed to evidence information was provided information on developing and advance directive and failed to evidence follow up was provided for the development of an advance directive for Resident # 87.

Resident # 87 was admitted to the facility on 12/29/2014 with a readmission of 04/26/2018 with diagnoses that included but were not limited to dementia (1), depressive disorder, (2), and anxiety (3). Resident # 87's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/05/19, coded Resident # 87 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition intact for making daily decisions.

The POS (physician's order sheet for Resident # 87 dated 06/13/2019 documented, "DNR (do not resuscitate). Order Status: Active. Order date: 04/27/2018."

Review of the clinical record and the EHR (electronic health record) for Resident # 87 failed to evidence an advanced directive. Further review of the clinical record revealed a "Durable Do Not

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Resuscitate Order" for Resident # 87 datded 12/10/2017.

The facility's "Progress Notes" dated 12/29/2014 through 01/05/15 and 04/26/2018 through 07/06/2018 failed to evidence, Resident # 87 was offered information on developing an advance directive. Further review of the facility's progress notes failed to evidence the facility provided periodic reviews to develop an advance directive for Resident # 87.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

On 06/14/19 at approximately 10:30 a.m., an interview was attempted with Resident # 87 regarding being provided information on developing an advance directive and periodic to develop an advance directive. Resident # 87 was unavailable at the time.

On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was

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F 578	Continued From page 43 obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. 27. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident # 158, and/or the resident representative and failed to ensure periodic reviews were conducted. Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1) and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties.	F 578		

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F 578	Continued From page 44 Review of Resident #158's clinical record revealed a physician's order dated, 1/12/19 for a DNR (no not resuscitate). Further review of the clinical record failed to evidence that advance directives were reviewed and/or addressed with Resident #158's representative and failed to reveal evidence of periodic reviews. On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern and asked to provide any further information. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. As of the survey exit, there was no documented evidence that the facility offered and provided information regarding advance directives or conducted periodic reviews of advance directirons with Resident #158's resident representative. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 578		

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28. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident # 96 and/or their resident representative and failed to ensure follow up was provided.

Resident #96 was admitted to the facility on 1/30/13 with a recent readmission on 4/26/19, with diagnoses that included but were not limited to: anoxic brain damage (occurs when there is not enough oxygen getting to the brain. The brain needs a constant supply of oxygen and nutrients to function.) (1), depression, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/17/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions.

Review of Resident #96's clinical record evidenced a physician order dated 2/26/13 and renewed on 4/27/19 for Full Code Status (full resuscitation). Further review of the clinical record failed to evidence that advance directives were reviewed, and/or addressed with Resident #96's representative, and failed to reveal evidence of periodic reviews.

On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern and asked to provide any further information.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8

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(recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.

As of the survey exit, there was no documented evidence that the facility offered and provided information regarding advance directives or conducted periodic reviews or follow up with Resident #96's resident representative.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/001435.htm.

29. The facility staff failed to evidence that advance directives were reviewed and/or addressed with Resident #50 and/or there resident representative and failed to ensure periodic reviews were conducted.

Resident #50 was admitted to the facility on 11/1/18 with a readmission on 2/19/19, with diagnoses that included but were not limited to: dementia, high blood pressure, and repeated falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/26/19, coded the resident as scoring a "9", indicating that the resident was moderately impaired to

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F 578	Continued From page 47 make daily cognitive decisions. Review of Resident #50's clinical record evidenced a physician order dated 2/19/19 for Full Code Status (full resuscitation). Further review of the clinical record failed to evidence that advance directives were reviewed and/or addressed with Resident #50's representative and failed to reveal evidence of periodic reviews. On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was aware of the above concern and asked to provide any further information. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list. As of the survey exit, there was no documented evidence that the facility offered and provided information regarding advance directives or conducted periodic reviews of advance directives with Resident #96's resident representative. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. 30. The facility staff failed to evidence that advance directives were reviewed and/or	F 578		

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F 578	Continued From page 48 addressed with Resident #76 and/or there resident representative and failed to ensure periodic reviews were conducted. Resident #76 was admitted to the facility on 10/31/17 with diagnoses that included but were not limited to: depression, high blood pressure, anxiety disorder, and COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/11/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Review of Resident #76's clinical record revealed a physician's order dated, 1/31/17 for a DNR (no not resuscitate). Further review of the clinical record failed to evidence that advance directives were reviewed and/or addressed with Resident #76's representative and failed to reveal evidence of periodic reviews. On 6/12/19 at 1:56 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern and asked to provide any further information. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (recently hired social worker) and OSM #15 (another social worker). OSM #8 was asked to provide evidence that advance directives were addressed with and periodically reviewed with multiple sampled residents whose names were documented on a list.	F 578		

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F 578	Continued From page 49 As of the survey exit, there was no documented evidence that the facility offered and provided information regarding advance directives or conducted periodic reviews of advance directirons with Resident #96's resident representative. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m.	F 578		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580	F580 1. Resident #158 physician was notified Apixaban was not available or not administered. Resident #96 physician was notified Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol were not available or not administered. Resident # 76 physician was notified Tramadol was not available or not administered. Resident #92 physician was notified of resident's significant weight gain. 2. An audit of residents on Apixaban, Carvedilol, Keppra Solution, Potassium Chloride Solution and	7/14/19

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F 580	Continued From page 50 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 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the physician with a change in condition and/or when medications were not available for administration as ordered for four of 71 residents in the survey sample, Residents #158, #96, #76 and #92. The facility staff failed to notify the physician when	F 580	Tramadol will be conducted to ensure it is given as ordered by the physician. A review of residents with weight gain will also be conducted to ensure physician notification. 3. Licensed nursing staff will be re-educated by the Director of Nursing(DON)/Designee on notification of physician if Apixaban, Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol is not given as ordered by the physician as well as physician notification of resident's weight gain. 4. Audits of residents who have Apixaban, Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol orders will be conducted by the Director of Nursing (DON)/Designee to ensure notification of physician if Apixaban, Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol are not given as ordered by the physician as well as physician notification of resident's weight gain weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the	

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F 580	Continued From page 51 medications were not available or administered to Resident #158, Resident #96, and Resident #76, and failed to notify the physician when Resident #92 presented with a significant weight gain in March 2019. The findings include: 1. The facility staff failed to notify the physician when medications were not available or administered to Resident #158 as ordered. Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), high blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The physician order dated 4/18/19, documented,	F 580	monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 7/14/19	

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F 580	Continued From page 52 Apixaban (Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation) (4), 5 MG (milligrams); give 5 mg by mouth two times a day related to atrial fibrillation." The June 2019 MAR (medication administration record) documented the above physician's order. On 6/5/19 a "7" was documented in the box for administration. The code for a "7" was documented as "Other/See Nurse Notes." The nurse's note dated, 6/5/19, documented the above physician's order for Apixaban. After the medication the following was documented, "Awaiting meds (medications) form pharmacy." The comprehensive care plan dated, 1/25/19 documented in part, "Focus: Impaired Cardiovascular status related to: hypertension (high blood pressure), A-fib (atrial fibrillation)." The "Interventions" documented, "Medications as ordered by physician and observe use and effectiveness." The contents of the STAT (Immediate-emergency drug box) was requested. The list of the contents of the STAT box failed to evidence the medication was available. An interview was conducted with LPN #1, the unit manager, on 6/13/19 at 9:36 a.m., regarding medications not being available for administration as ordered. LPN #1 stated, "First you check the stat box. If it is not, there you call the pharmacy. You call the MD (medical doctor) to let him know the medication is not available. Then you sign it out that you don't have the medication. The above notes regarding the "awaiting pharmacy" were reviewed with LPN #1.	F 580		

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	**3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060**

(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 53 Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. On 6/14/19 at 11:53 a.m., a request was made for the policy on physician notification for medications not given. This request was made to ASM #2, the director of nursing. At 1:40 p.m., ASM #2 presented the policy, "Medication Administration - General Guidelines" that documented in part, "If two consecutive doses of a vital medication are withheld or refused, the physician is notified." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html. 2. The facility staff failed to notify the physician when medications were not available or not administered to Resident #96 as ordered. Resident #96 was admitted to the facility on 1/30/13 with a recent readmission on 4/26/19,	F 580		

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	495299	A. BUILDING _____ B. WING _____	C 06/14/2019

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F 580	Continued From page 54 with diagnoses that included but were not limited to: anoxic brain damage (occurs when there is not enough oxygen getting to the brain. The brain needs a constant supply of oxygen and nutrients to function.) (1), depression, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/17/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The physician orders documented the following medication orders: - "4/26/19 - Carvedilol Tablet 6.25 MG (milligrams); give 6.25 mg via Peg-tube (feeding tube) two times a day related to hypertension (high blood pressure)." (Used to treat heart failure and high blood pressure) (3) - "5/3/19 - Keppra Solution (used to treat seizures) (4) 100 MG/ML (milligrams per milliliter) Give 5 ml via Peg-tube every 12 hours related to other convulsions (seizures) 100mg/ml = give 5 ml equal 500 mg." - "5/3/19 - Potassium Chloride Solution (For the prevention of hypokalemia [low potassium] in patients who would be at particular risk if hypokalemia were to develop, e.g., digitalized patients or patients with significant cardiac	F 580		

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F 580	Continued From page 55	F 580		

arrhythmias.) (5) 20 MEQ/15 ML (mill equivalent/milliliters) (10 %) give 15 ml via Peg-tube one time a day related to heart failure.

- "4/27/19 - Tramadol HCL (hydrochloride) Tablet; Give 50 mg via Peg-tube two times a day related to other chronic pain.

The May 2019 MAR documented the above physician's orders. The following medications were not administered on the following dates:
"Carvedilol - 5/22/19 - morning dose; 5/23/19 - morning dose; 5/24/19 - morning dose.
"Keppra - 5/22/19 - morning dose; 5/24/19 - morning dose.
"Potassium Chloride - 5/22/19 - morning dose; 5/23/19 - morning dose; 5/24/19 - morning dose.
"Tramadol - 4/27/19 - morning dose; 4/28/19 - morning dose; 4/28/19 - evening dose; 4/29/19 - morning dose; 4/29/19 - evening dose.

The nurse's notes documented the above ordered medication orders. The notes documented the following on the following dates:
"Carvedilol - 5/22/19 at 8:05 a.m. - "Awaiting pharmacy."
"Carvedilol - 5/23/19 at 8:03 a.m. - "Awaiting pharm (pharmacy)."
"Carvedilol - 5/24/19 at 8:06 a.m. - "Awaiting pharmacy."
"Keppra - 5/22/19 at 8:06 a.m. - "Awaiting pharmacy."
"Keppra - 5/24/19 at 8:07 a.m. - "Awaiting pharmacy."
"Potassium Chloride - 5/22/19 at 8:07 a.m. - "Awaiting pharmacy."
"Potassium Chloride - 5/23/19 at 8:11 a.m. - "Awaiting pharmacy."
"Potassium Chloride - 5/24/19 at 8:08 a.m. -

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F 580	Continued From page 56 "Awaiting pharmacy." "Tramadol - 4/27/19 at 9:37 a.m. - "Awaiting arrival from pharmacy." "Tramadol - 4/28/19 at 9:38 a.m. - "Awaiting arrival from pharmacy." "Tramadol - 4/28/19 at 9:00 p.m. - "Waiting for delivery." "Tramadol - 4/29/19 at 12:29 p.m. - "Pharmacy." "Tramadol - 4/29/19 at 5:26 p.m. - "On order." "Tramadol - 5/22/19 at 8:05 a.m. - Awaiting pharmacy." The comprehensive care plan dated, 1/14/17 and revised on 2/20/19, documented in part, "Focus: At risk for complications related to blood thinning medications use for: atrial fibrillation." The "Interventions" documented in part, "Monitor medication regime for medications which increase effects." The comprehensive care plan dated, 1/4/17 and revised on 2/20/19, documented in part, "Needs Pain management and monitor related to: generalized pain." The "Interventions" documented in part, "Give Pain Medications as ordered." The comprehensive care plan dated, 2/7/19 and revised on 2/20/19, documented in part, "At risk for injuries r/t (related to) seizures." The comprehensive care plan dated, 5/1/17, and revised on 2/20/19, documented in part, "Focus: Impaired Cardiovascular status related to heart failure, AFIB (atrial fibrillation)." The "Interventions" documented in part, "Medications as ordered by physician and observe use and effectiveness."	F 580		

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F 580	Continued From page 57 The contents of the STAT (emergency drug box) was requested. The list of the contents of the STAT box failed to evidence the medication was available. An interview was conducted with LPN #4 on 6/13/19 at 9:27 a.m. LPN #4 was asked about the process staff follows when a medication is not available on the medication cart. LPN #4 stated, "I put it in the nurse's note that the meds (medications) are awaiting pharmacy and then follow up with the pharmacy." When asked if they have a backup, stat box, LPN #4 stated, "Yes, it's usually used for antibiotics." An interview was conducted with LPN #1, the unit manager; on 6/13/19 at 9:36 a.m., LPN #1 was asked about the process staff follows when a medication is not available on the medication cart at the time of the scheduled dose. LPN #1 stated, "First you check the stat box. If it is not, there you call the pharmacy. You call the MD (medical doctor) to let him know the medication is not available. Then you sign it out that you don't have the medication. The above notes that documented, "awaiting pharmacy" were reviewed with LPN #1. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. On 6/14/19 at 11:53 a.m., a request was made for the policy on physician notification for medications not given. This request was made to ASM #2, the director of nursing. At 1:40 p.m., ASM #2 presented the policy, "Medication	F 580		

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F 580	Continued From page 58 Administration - General Guidelines" that documented in part, "If two consecutive doses of a vital medication are withheld or refused, the physician is notified." No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/001435.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697042.html. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a699059.html. (5) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=48f93dac-79f0-4df7-ab17-a9bcb3d28f90 3. The facility staff failed to notify the physician when medications were not available or not administered to Resident #76 as ordered. Resident #76 was admitted to the facility on 10/31/17 with diagnoses that included but were not limited to: depression, high blood pressure, anxiety disorder, and COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1).	F 580		

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The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/11/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

The physician order dated, 4/26/19, documented, "Ultram (tramadol) (used to treat moderate to moderately severe pain) (2) 50 MG (milligrams) give 1 tablet by mouth three times a day related to acute pain due to trauma."

The April 2019 MAR (medication administration record) documented the above physician's order. On 4/26/19 a "7" was documented in the box for administration. The code for a "7" was documented as "Other/See Nurse Notes." This was documented for the 8:00 a.m. dose and the 1:00 p.m. dose.

The nurse's note dated 4/26/19 at 10:49 a.m. documented the above medication order. The note documented, "Awaiting arrival from pharmacy." The nurse's note dated, 4/26/19 at 12:44 p.m. documented, "awaiting from pharmacy."

The comprehensive care plan dated, 4/10/19, failed to evidence documentation for the treatment of pain.

The contents of the STAT (emergency drug box) was requested. The list of the contents of the STAT box failed to evidence the medication was available.

An interview was conducted with LPN (licensed

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F 580	Continued From page 60 practical nurse) #1, the unit manager, on 6/13/19 at 2:28 p.m. regarding the process staff follows if a pain medication is not available for administration as ordered by the physician. ,LPN #1 stated, "I would first contact the doctor for a new order for something in the stat box and then call the pharmacy to have it sent over stat." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html 4. The facility staff failed to notify Resident #92's physician when the resident presented with a significant weight gain in March 2019. Resident #92 was admitted to the facility on 6/13/18. Resident #92's diagnoses included but were not limited to diabetes, heart failure and anxiety disorder. Resident #92's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/5/19, coded the resident as being cognitively intact. Section K inaccurately coded Resident #92 as having a weight loss of five percent or	F 580		

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F 580	Continued From page 61 more in the last month or weight loss of ten percent or more in the last six months. Review of Resident #92's clinical record revealed the following weights: 10/18/18- 147.4 pounds 3/18/19- 169.2 pounds (14.79 percent gain since 10/18/18) 4/1/19- 166 pounds (12.62 percent gain since 10/18/18) A nutritional assessment dated 3/18/19 and signed by a dining services employee documented a weight gain greater than five percent in 30 days, greater than seven and a half percent in 90 days or greater than ten percent in 180 days. The nutritional assessment further documented, "Diet is nas (no added salt) regular. CBW (Current body weight) 169.2# (pounds), BMI (body mass index) 32, PO (by mouth) intake 50-75%. no (sic) recent labs. Skin: burn to left hand. No pressure areas noted. resident (sic) is on a nas regular diet with good po intake. will (sic) continue to monitor per policy." Review of nurses' notes, nurse practitioner notes and physician notes for March 2019 failed to reveal documentation that Resident #92's physician (and/or the nurse practitioner) was made aware of the above significant weight gain. Resident #92's comprehensive care plan dated 6/21/18 documented "(Name of Resident #92) is at risk for imbalanced nutrition and hydration r/t (related to) therapeutic diet, dx (diagnosis) of burn, MDD (major depressive disorder), COPD (chronic obstructive pulmonary disease), magraine (sic), hemiplegia (paralysis), HTN (high blood pressure), constipation, GERD	F 580		

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F 580	Continued From page 62 (gastroesophageal reflux disease). Hx (History) of significant weight change..." The care plan failed to document information regarding physician notification of significant weight gain. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked if the physician should be notified of a significant weight gain. LPN #6 stated, "Yes." When asked why, LPN #6 stated, "Because we need to figure out why because weight gain can be edema (swelling) or a medication causing, or a lot of different things." LPN #6 was made aware that Resident #92 presented with a significant weight gain in March 2019 and there was no evidence that the physician was made aware. On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 6/14/19 at 1:40 p.m., ASM #2 confirmed the facility did not have a policy regarding physician notification. No further information was presented prior to exit.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584	F584 1. The pillowcase was removed from Resident #135 bed. The pillows were removed from Resident #51 former room and #30 bed.	7/14/19

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F 584	Continued From page 63 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to maintain a clean, comfortable,	F 584	2. An audit of residents' pillowcases and pillows was conducted to ensure pillowcases and pillows are in good repair. 3. Facility staff and Health Care Services employees will be re-educated by the Administrator/ Designee on ensuring pillowcases and pillows are in good repair. 4. Audits will be conducted by Carekeepers to ensure pillowcases and pillows are in good repair weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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homelike environment for three of 71 residents in the survey sample, Residents #135, #51 and #30.

1. The facility staff failed to maintain Resident #135's pillowcase in good repair.

2. The facility staff failed to maintain a pillow in Resident #51's former room in good repair.

3. The facility staff failed to maintain Resident # 30 bed pillows in good repair.

The findings include:

1. Resident #135 was admitted to the facility on 11/2/18. Resident #135's diagnoses included but were not limited to paralysis, difficulty swallowing and personal history of traumatic brain injury. Resident #135's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/28/19, coded the resident as being cognitively intact. Section G coded Resident #135 as being totally dependent for bed mobility and transfers.

On 6/11/19 at 1:38 p.m. and 6/12/19 at 7:51 a.m., Resident #135 was observed lying in bed. The seam of the resident's pillowcase was torn approximately two inches.

On 6/13/19 at 8:37 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 was asked about the facility process for maintaining pillowcases in good repair. CNA #3 stated she disposes of torn pillowcases when she changes them. CNA #3 stated she changes pillowcases twice a week on shower days. She stated she also changes them when the cases are soiled. When asked if torn pillowcases are

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F 584	Continued From page 65	F 584		

homelike, CNA #3 stated torn pillowcases are not homelike and she would not sleep on torn pillowcases.

On 6/14/19 at 11:05 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

On 6/14/19 at 1:10 p.m., ASM #2 confirmed the facility did not have a policy regarding a clean, comfortable, homelike environment.

No further information was presented prior to exit.

2. The facility staff failed to maintain a pillow in Resident #51's former room in good repair.

Resident #51 was admitted to the facility on 9/8/11. Resident #51's diagnoses included but were not limited to pain, diabetes and difficulty swallowing. Resident #51 was discharged ON 5/29/19. Resident #51's most recent MDS (minimum data set) (prior to discharge), a quarterly assessment with an ARD (assessment reference date) of 3/29/19, coded the resident as being cognitively intact. Section G coded Resident #51 as requiring extensive assistance of one staff with bed mobility, dressing and personal hygiene.

On 6/6/19, the Office of Licensure and Certification received a complaint that alleged Resident #51's pillow was torn and tattered.

On 6/11/19 at 2:37 p.m. and 6/12/19 at 9:44 a.m., observation of the pillow in Resident #51's former room was conducted. No other resident currently

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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
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resided in the room and the bed was unmade. The pillow was not in a pillowcase and it was lying on the unmade bed. The pillow contained a vinyl covering. One side of the pillow contained a torn area (approximately two inches long by one half inch wide) with the cloth inside of the vinyl covering exposed. The other side of the pillow contained a torn area (approximately 16 inches long by one inch wide) with the cloth inside of the vinyl covering exposed.

On 6/13/19 at 8:37 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 was asked about the facility process for maintaining pillows in good repair. CNA #3 stated, "When I change my pillowcases, if my pillows are not in good condition, I remove them and get new pillows." CNA #3 stated she changes pillowcases on shower days (twice a week) and if the pillowcase is soiled. CNA #3 was asked how a pillow can be cleaned if it is torn. CNA #3 stated, "You can't. That's why I dispose of them." When asked if torn pillows are homelike, CNA #3 stated torn pillows are not homelike and she would not sleep on torn pillows.

On 6/14/19 at 11:05 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

On 6/14/19 at 1:10 p.m., ASM #2 confirmed the facility did not have a policy regarding a clean, comfortable, homelike environment.

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

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3. The facility staff failed to maintain Resident # 30 bed pillows in good repair.

Resident # 30 was admitted to the facility on 03/23/18 with diagnoses that included but were not limited to dementia (1), depressive disorder, (2), and anxiety (3). Resident # 30's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/12/18, coded Resident # 30 as scoring a ten on the brief interview for mental status (BIMS) of a score of 0 - 15, ten - being moderately impaired of cognition for making daily decisions.

On 06/11/19 at 4:40 p.m., 06/12/19 at 11:35 a.m., and 06/13/19 at 8:07 a.m., observations were conducted of Resident # 30's room. Observations of the bed revealed two bed pillows on his bed. Observations of the pillows revealed the plastic covering was torn in several places on each pillow.

On 06/13/19 at 10:43 a.m., an interview was conducted with Resident # 30 regarding the use of his bed pillows. Resident # 30 stated he uses the recliner and doesn't use the pillows.

On 06/13/19 at 10:45 a.m., an interview was conduct with LPN (licensed practical nurse) # 5, unit manager for Wing-B, regarding the expected condition of resident's pillows. LPN # 5 stated, "Good condition. Not torn, no hole, no stains. Some have a plastic covering over them." After observing Resident # 30's pillows LPN # 5 stated, "I would take the plastic covering off the pillows and they can be washed in the washing machine." When asked if the condition of the pillows presented a homelike atmosphere, LPN #

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F 584	Continued From page 68 5 stated, "In that condition no." When asked if Resident # 30 used the bed pillows, LPN # 5 stated, "Not aware if resident uses the pillows." On 06/13/19 at 10:52 a.m., an interview was conducted LPN # 10. When asked if Resident # 30 used the bed pillows while he is in his recliner, LPN # 10 stated, "He uses the pillows occasionally." On 06/12/19 at approximately 5:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.	F 584		

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F 607 F 607 SS=D	Continued From page 69 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement abuse policies for two of ten employee records (OSM [other staff member] #9 and OSM #10). The facility staff failed to implment the abuse policy to obtain reference checks at the time of hire for Other Staff Member (OSM) #10 and OSM #9. The findings include: The facility staff failed to implement abuse policies for the screening and hiring of new employees regarding obtaining reference checks for two of 10 employee records reviewed; Other Staff Member (OSM) #10 and OSM #9. On 6/13/19 at 9:43 AM, a review of 10 employee records was conducted. These were of employees hired between February 2019 and May 2019. The following concerns were	F 607 F 607	F607 1. Reference checks have been completed for OSM (Other Staff Member) hired on 5/28/19 and 2/6/19. 2. An audit will be conducted of housekeepers' personal files to ensure reference checks have been completed. 3. Housekeeping Manager (HCSG) and HR Manager will be re-educated by the Administrator/Designee on ensuring reference checks have been completed. 4. Audits will be conducted by the Carekeepers to ensure reference checks have been completed on OSM weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	7/14/19

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F 607	Continued From page 70 identified; 1. There were no reference checks for OSM (Other Staff Member) #9 (a housekeeper) who was hired on 5/28/19. 2. There were no reference checks for OSM #10 (a housekeeper) who was hired on 2/6/19. On 6/14/19, at 10:24 AM, an interview with OSM #6, the Human Resources Director, was conducted. OSM #6 was asked about the process followed for obtaining reference checks for newly hired employees. OSM #6 stated, "Interview candidate. After the interview, if they are to be hired, a drug screen and background check are done. I take the resume and the verification for references to the receptionist and she calls the references. If she can't, then I try to." OSM #6 was asked who is responsible for obtaining the reference checks. OSM #6 stated, "The receptionist and myself." When was asked about the timeframe for obtaining the reference checks, OSM #6 stated, "We literally try to have them back before the employee starts. So when they come in, we know about them." When OSM #6 was asked why it is important to obtain references, she stated, "So we can make sure the employee is capable to work in the facility. We try to do the work references and then the personal references. At least two personal if unable to get the work references. If the application is done on the computer, they don't always sign and we can't fax it over to them." On 6/14/19, at 10:38 AM, an interview with OSM #5, the Account Manager for the contracted company used for the housekeeping department was conducted. OSM #5 was asked about the	F 607		

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F 607	Continued From page 71 process for obtaining reference checks on newly hired employees. OSM #5 stated, "Normally, I will get it from the participant. Normally, when they provide the references, I am depending on them to give the correct information. If information is correct, I follow thru and call the phone numbers of previous employees or co-worker." OSM #5 was asked who is responsible for obtaining the reference checks. OSM #5 stated, "I am as account manager." When OSM #5 was asked about the timeframe for obtaining the reference checks. OSM #5 stated, "I try to get it within the first 10 days, between the times of starting the paperwork process with Human Resources. We try to call and reference them. Sometimes it takes a week for the paperwork process and during that time is when I call the references." When OSM #5 was asked why it is important to obtain references, he stated, "Hopefully, you get a pretty good perspective of the applicant you are trying to hire. Hopefully, by contacting the references, you get some type of idea the applicant is qualified for the position you are hiring for." On 6/14/19, at 10:47 AM, an interview with ASM (Administrative Staff Member) #1, the Administrator, was conducted. ASM #1 was asked about the process followed for obtaining reference checks on newly hired employees. ASM #1 stated, "Either Human Resources will attempt to call the references listed on the application sheets or we will give it to the receptionist. The receptionist will make those calls. I just instructed recently, because the receptions says it is difficult and will call three days in a row, I instructed the Human Resources Director, if unable to get the reference, they are to call the potential employee for other references to	F 607		

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F 607	Continued From page 72 call." When asked who is responsible for obtaining the references, ASM #1 stated, "Human Resources Manager, it is her responsibility to make sure they are completed." When asked about the timeframe for obtaining the reference checks, ASM #1 she stated, "We prefer them to be done prior to being hired. But I know occasionally it will be on the date of hire." When was asked why it is important to obtain references, ASM #1 stated, "We definitely want employees that have good standing with other employers. We want to hire positive and caring employees. Calling the references to see about their character is important." A review of the facility policy, "Abuse Policies and Elder Justice Act Guidance," documented in part, " ...II. Screening: Persons applying for employment with Facility will be screened for a history of abuse, neglect, or mistreating residents to include: A. References from previous or current employers ..." On 6/14/19 at 12:32 PM, ASM #1, the Administrator, ASM #2, the Director of Nursing, and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided by the end of the survey.	F 607		
F 608 SS=C	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the	F 608	F608 1. Facility posting has been updated to reflect the notice of employee rights to report a reasonable suspicion of a crime. 2. Each employee/resident has the potential of being affected.	7/14/19

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F 608	Continued From page 73 Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post notice of employee rights regarding reporting a suspicious crime. The findings include: On 6/13/19 at 10:15 a.m. and 2:23 p.m., a tour of the facility (including the employee break room, time clock and an alcove with birdcages) was conducted. No notice of employee rights regarding reporting a suspicious crime were observed.	F 608	3. Administrator re-educated by Regional Nurse Consultant/Designee on ensuring notice posted of employee rights to report a reasonable suspicion of a crime. 4. Audits will be conducted by the Administrator/Designee to ensure a notice of employee rights to report a reasonable suspicion of a crime is posted weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 608	Continued From page 74 On 6/14/19 at 7:45 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. ASM #1 showed this surveyor a poster on the wall regarding resident rights and phone numbers for local advocacy agencies. The poster did not contain notice of employee rights regarding reporting a suspicious crime. ASM #1 was made aware this poster did not meet the regulatory requirements. The facility policy titled, "POLICY & PROCEDURE FOR REPORTING SUSPECTED CRIMES UNDER THE FEDERAL ELDER JUSTICE ACT" documented, "it is the Facility policy to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act (ACA)...c. post a notice in a conspicuous location that informs all 'covered individuals' of their reporting obligation under the EJA to report a suspicion of a crime to the SSA (state survey agency) and local law enforcement; and their right to file a complaint with the state survey agency if they feel the the (sic) Facility has retaliated against an employee who reported a suspected crime under this statute..." No further information was presented prior to exit.	F 608		
F 623 SS=E	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	F 623	F623 1. Facility will provide written notification to the resident/ representative and/or Ombudsman regarding the reason for a facility initiated transfer.	7/14/19

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F 623	Continued From page 75 language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (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;	F 623	2. Each residents has the potential of being affected. 3. Medical Record staff, Licensed Nurses and Business Office Manager will be re-educated by the Administrator/Designee on providing written notification to the resident/ representative and/or Ombudsman regarding the reason for a facility initiated transfer. 4. Audits will be conducted by the Administrator/Designee to ensure written notification to the resident/ representative and/or Ombudsman regarding the reason for a facility initiated transfer has been completed weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 623	Continued From page 76 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the 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	F 623		

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F 623	Continued From page 77 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide written notification to the resident/representative and/or ombudsman regarding transfers to the hospital for six of 71 residents in the survey sample, Residents #70, #140, #92, #50, #157, and #96. 1. Resident #70 was transferred to the hospital on 5/6/19. The facility staff failed to provide written notification of the transfer to Resident #70 and/or the resident's representative. 2. Resident #140 was transferred to the hospital on 4/16/19. The facility staff failed to provide written notification of the transfer to Resident #140 and/or the resident's representative. 3. Resident #92 was transferred to the hospital on 3/28/19. The facility staff failed to provide written notification of the transfer to Resident #92 and/or the resident's representative. 4. The facility staff failed to provide written notification to the resident and/or resident representative for Resident #50's transfer to the hospital on 2/15/19.	F 623		

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	495299	A. BUILDING _____ B. WING _____	C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 623	Continued From page 78 5. The facility staff failed to provide written notification to the resident and/or resident representative for Resident #157's transfer to the hospital on 4/10/19. 6. The facility staff failed to provide written notification to the resident and/or resident representative for Resident # 96's transfer to the hospital on 4/25/19. The findings include: 1. Resident #70 was transferred to the hospital on 5/6/19. The facility staff failed to provide written notification of the transfer to Resident #70 and/or the resident's representative. Resident #70 was admitted to the facility on 11/27/15. Resident #70's diagnoses included but were not limited to paralysis, diabetes and pain. Resident #70's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/10/19, coded the resident's cognition as moderately impaired. Review of Resident #70's clinical record revealed the resident was transferred to the hospital on 5/6/19. Further review of Resident #70's clinical record failed to reveal written notification of the transfer was provided to the resident and/or the representative. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (social worker) and OSM #15 (another social worker). OSM #8 and OSM #15 were asked if they provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to	F 623		

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F 623	Continued From page 79	F 623		

the hospital. OSM #8 stated the social workers do not.

On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked if nurses provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. LPN #6 stated the nurses verbally inform the residents if they are alert and oriented and call the representatives. When asked if written notification is provided, LPN #6 stated she provides verbal notification, but has never provided written notification.

On 6/14/19 at 11:05 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

On 6/14/19 at 1:40 p.m., ASM #2 stated the facility did not have a policy regarding hospital transfers.

No further information was presented prior to exit.

2. Resident #140 was transferred to the hospital on 4/16/19. The facility staff failed to provide written notification of the transfer to Resident #140 and/or the resident's representative.

Resident #140 was admitted to the facility on 9/5/07. Resident #140's diagnoses included but were not limited to diabetes, major depressive disorder and chronic kidney disease. Resident #140's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD

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F 623	Continued From page 80 (assessment reference date) of 5/2/19, coded the resident as being cognitively intact. Review of Resident #140's clinical record revealed the resident was transferred to the hospital on 4/16/19 for increased blood sugar and altered mental status. Further review of Resident #140's clinical record failed to reveal written notification of the transfer was provided to the resident and/or the representative. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (social worker) and OSM #15 (another social worker). OSM #8 and OSM #15 were asked if they provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. OSM #8 stated the social workers do not. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked if nurses provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. LPN #6 stated the nurses verbally inform the residents if they are alert and oriented and call the representatives. When asked if written notification is provided, LPN #6 stated she provides verbal notification, but has never provided written notification. On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.	F 623		

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F 623	Continued From page 81 On 6/14/19 at 1:40 p.m., ASM #2 stated the facility did not have a policy regarding hospital transfers. No further information was presented prior to exit. 3. Resident #92 was transferred to the hospital on 3/28/19. The facility staff failed to provide written notification of the transfer to Resident #92 and/or the resident's representative. Resident #92 was admitted to the facility on 6/13/18. Resident #92's diagnoses included but were not limited to diabetes, heart failure and anxiety disorder. Resident #92's most recent MDS, a quarterly assessment with an ARD of 4/5/19, coded the resident as being cognitively intact. Review of Resident #92's clinical record revealed the resident was transferred to the hospital on 3/28/19 for slower speech and altered mental status. Further review of Resident #92's clinical record failed to reveal written notification of the transfer was provided to the resident and/or the representative. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (social worker) and OSM #15 (another social worker). OSM #8 and OSM #15 were asked if they provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. OSM #8 stated the social workers do not. On 6/13/19 at 10:31 a.m., an interview was	F 623		

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F 623	Continued From page 82	F 623		

conducted with LPN (licensed practical nurse) #6. LPN #6 was asked if nurses provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. LPN #6 stated the nurses verbally inform the residents if they are alert and oriented and call the representatives. When asked if written notification is provided, LPN #6 stated she provides verbal notification, but has never provided written notification.

On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

On 6/14/19 at 1:40 p.m., ASM #2 stated the facility did not have a policy regarding hospital transfers.

No further information was presented prior to exit.
4. The facility staff failed to provide written notification to the resident and/or resident representative for Resident #50's transfer to the hospital on 2/15/19.

Resident #50 was admitted to the facility on 11/1/18 with a readmission on 2/19/19, with diagnoses that included but were not limited to: dementia, high blood pressure, and repeated falls.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/26/19, coded the resident as scoring a "9", indicating that the resident was moderately impaired to

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F 623	Continued From page 83 make daily cognitive decisions. The nurse's note dated, 2/15/19 at 1:19 p.m. documented in part, "Situation: Resident was found lying on the floor in her room. Background: Resident is one-person assist, alert and verbal with some confusion. Assessment: Resident stated she was trying to go somewhere but isn't sure where. Vital signs WNL (within normal limits); unable to move left leg. Response: sending resident to (name of hospital) for eval (evaluation) and treatment." Further review of the clinical record failed to evidence any written notification to the resident and/or resident representative regarding this hospital transfer. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (social worker) and OSM #15 (another social worker). OSM #8 and OSM #15 were asked if they provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. OSM #8 stated the social workers do not. An interview was conducted with LPN (licensed practical nurses) #1, on 6/13/19 at 2:41 p.m. When asked if the staff provide the resident and/or the resident representative with anything in writing explaining why they are being transferred to the hospital and why their needs cannot be met here at the facility, LPN #1 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical	F 623		

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F 623	Continued From page 84 services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. 5. The facility staff failed to provide written notification to the resident and/or resident representative for Resident #157's transfer to the hospital on 4/10/19. Resident # 157 was admitted to the facility on 8/17/17 with a recent readmission on 4/12/19, with diagnoses that included but were not limited to: dementia, depression fractured hip, and anxiety disorder. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The nurse's note dated, 4/10/19 at 2:52 p.m. documented, "Situation: Resident fell out of wheelchair; it is unknown how she fell. Staff stated a loud thump was heard followed by screaming. Background: Dementia. Assessment: Upon assessment, remains alert and responsive. However, resident sustained hematoma to right side of head. Resident appears to be in pain and pain med (medication) was offered. However, resident pushed writer's hand away and refused medication. Response: MD (medical doctor) notified. RP (responsible party) notified. Sent out to ER (emergency room) for evaluation."	F 623		

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F 623	Continued From page 85 Further review of the clinical record failed to evidence any written notification to the resident and/or resident representative regarding this hospital transfer. On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (social worker) and OSM #15 (another social worker). OSM #8 and OSM #15 were asked if they provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. OSM #8 stated the social workers do not. An interview was conducted with LPN (licensed practical nurses) #1, on 6/13/19 at 2:41 p.m. When asked if the staff provide the resident and/or the resident representative with anything in writing explaining why they are being transferred to the hospital and why their needs cannot be met here at the facility, LPN #1 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. 6. The facility staff failed to provide written notification to the resident and/or resident representative for Resident # 96's transfer to the hospital on 4/25/19. Resident #96 was admitted to the facility on	F 623		

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1/30/13 with a recent readmission on 4/26/19, with diagnoses that included but were not limited to: anoxic brain damage (occurs when there is not enough oxygen getting to the brain. The brain needs a constant supply of oxygen and nutrients to function.) (1), depression, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/17/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions.

The nurse's note dated, 4/25/19 at 10:00 a.m. documented in part, "Resident transferred to (name of hospital) for a peg tube replacement."

Further review of the clinical record failed to evidence any written notification to the resident and/or resident representative regarding this hospital transfer.

On 6/12/19 at 4:56 p.m., an interview was conducted with OSM (other staff member) #8 (social worker) and OSM #15 (another social worker). OSM #8 and OSM #15 were asked if they provide written notification, explaining why the transfer is necessary, to residents and/or their representatives when residents are transferred to the hospital. OSM #8 stated the social workers do not.

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F 623	Continued From page 87 An interview was conducted with LPN (licensed practical nurses) #1, on 6/13/19 at 2:41 p.m. When asked when a resident is transferred to the hospital do you provide the resident and/or the resident representative with anything in writing of why they are being sent out to the emergency room and why their needs cannot be met here at the facility, LPN #1 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/001435.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 623		
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, facility document review, and clinical record review, it was determined the facility staff failed to complete quarterly MDS (minimum data set) assessments	F 638	F638 1. Quarterly assessments have been completed for resident #1, #2 and #3. 2. An audit will be conducted to ensure quarterly assessment have been completed timely.	7/14/19

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F 638	Continued From page 88 for three of 71 residents in the survey sample, Residents #1, #2, and #3. 1. The facility staff failed to complete Resident #1's quarterly MDS assessment at least every 92 days. The last MDS assessment completed was the admission assessment with an assessment reference date of 1/18/19. 2. The facility staff failed to complete Resident # 2's quarterly MDS assessment at least every every 92 days. The resident's most recent completed MDS was a quarterly assessment with an ARD (assessment reference date) of 01/16/2019. 3. The facility staff failed to complete Resident # 3's quarterly MDS assessment at least every every 92 days. The resident's most recent completed MDS assessment was an admission assessment with an ARD of 02/01/19. The findings include: 1. The facility staff failed to complete Resident #1's quarterly MDS assessment at least every 92 days. The last MDS assessment completed was the admission assessment with an assessment reference date of 1/18/19. Resident #1 was admitted to the facility on 12/31/18 with diagnoses that included but were not limited to: Huntington's disease (An abnormal hereditary condition characterized by progressive involuntary rapid, jerky motions and mental deterioration, leading to dementia.) (1), dementia, depression and high blood pressure.	F 638	3. MDS Coordinators will be re-educated by the Regional MDS Consultant/Designee on completing quarterly assessments timely. 4. Audits will be conducted by the Administrator/Designee to ensure quarterly assessment have been completed timely weekly for four weeks then monthly for three months. Results of the visits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 638	Continued From page 89 The most recent completed MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/18/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. Review of the electronic clinical record failed to evidence any documentation of a quarterly assessment completed after the 1/18/19 admission assessment. An interview was conducted with RN (registered nurse) # 2, the MDS coordinator; on 6/14/19 at 8:45 a.m., RN #2 was asked to view the electronic clinical record, under the MDS section. RN #2 verified there is a missing MDS assessment for this resident. RN #2 stated, "We have had staffing concerns in the MDS department. I will get this scheduled today." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 11:02 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 276. 2. The facility staff failed to complete Resident # 2's quarterly MDS assessment at least every every 92 days. The resident's most recent	F 638		

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F 638	Continued From page 90 completed MDS was a quarterly assessment with an ARD (assessment reference date) of 01/16/2019. Resident # 2 was admitted to the facility on 01/03/19. Resident #1's diagnoses included but were not limited to muscle weakness, difficulty walking and vitamin deficiency. Review of Resident # 2's clinical record revealed the most recently completed MDS assessment was a quarterly MDS assessment with an ARD of 01/16/2019. On 06/14/19 at 9:19 a.m., an interview was conducted with RN (registered nurse) # 2, MDS coordinator. After reviewing the MDS assessments under the facility's "Point Click Care" computer program, RN # 2 stated that the quarterly assessment for Resident # 2 was overdue. When asked how they ensure the assessments are completed timely, RN # 2 stated, "When completing an assessment we schedule the next required assessment." Chapter two of the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual documented, "The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of	F 638		

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F 638	Continued From page 91 any type." On 06/13/19 at approximately 5:05 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. 3. The facility staff failed to complete Resident # 3's quarterly MDS assessment at least every every 92 days. The resident's most recent completed MDS assessment was an admission assessment with an ARD of 02/01/19. Resident # 3 was admitted to the facility on 01/25/19. Resident #1's diagnoses included but were not limited to muscle weakness, high blood pressure and pain. Review of Resident # 2's clinical record revealed the most recently completed MDS was a quarterly MDS with an ARD of 01/16/2019. On 06/14/19 at 9:19 a.m., an interview was conducted with RN (registered nurse) # 2, MDS coordinator. After reviewing, the MDS assessments under the facility's "Point Click Care" computer program RN # 2 stated that the quarterly assessment for Resident # 2 was overdue. When asked how they ensure the assessments are completed timely, RN # 2 stated, "When completing an assessment we schedule the next required assessment." On 06/13/19 at approximately 5:05 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.	F 638		

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F 641 F 641 SS=D	Continued From page 92 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 staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for two of 71 residents in the survey sample, Resident #30 and # 92. 1. The facility staff failed to attempt the BIMS (Brief Interview for Mental Status) interview and the Mood interview for Resident #30's quarterly MDS assessment with an ARD (assessment reference date) of 3/12/19. 2. The facility staff failed to accurately code Resident #92's weight gain on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/5/19. Instead, the resident was coded as having a weight loss. The findings include: 1. Resident # 30 was admitted to the facility on 03/23/18 with diagnoses that included but were not limited to dementia (1), depressive disorder, (2), and anxiety (3). Section B of Resident #30's most recent MDS, a quarterly assessment with an ARD of 3/12/19, documented the resident was understood. Section C of the MDS assessment "C0100. Should Brief Interview for Mental Status	F 641 F 641	F641 1. BIMS interviews and Mood interviews will be conducted timely. Resident #92 quarterly assessment has been modified to reflect resident's weight gain. 2. An audit of quarterly assessments will be conducted to ensure BIMS and MOOD interviews are conducted timely and residents with a weight gain are coded correctly. 3. MDS Coordinators and Social Services Workers will be re-educated by Regional MDS Consultant/ Designee on conducting BIMS and Mood interviews timely and coding residents with weight gain correctly. 4. Audits will be conducted by the Administrator/Designee to ensure BIMS and MOOD interviews are conducted timely and residents with a weight gain are coded correctly weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	7/14/19

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(C0200-C0500) be Conducted?" coded Resident # 30 with a dash mark. Further review of Section C reveled dash marks for all questions. The staff assessment for mental status was coded with dash marks. Section D of the MDS for "D0100 Should Resident Mood Interview be Conducted?" coded Resident # 30 with a dash mark. Further review of Section D reveled dash marks for all questions. The staff assessment for mood was coded with dash marks.

On 06/13/19 at 2:09 p.m., an interview was conducted with RN (registered nurse) # 2, MDS coordinator. After reviewing sections C and D of the MDS assessment with an ARD of 3/12/19 for Resident # 30, RN # 2 stated, "The interview wasn't done and I dashed it. When asked who was responsible for completing Sections C and D, RN # 2 stated, "It is completed by social services."

On 06/13/19 at 2:23 p.m., an interview was conducted with OSM (other staff member) # 15. When asked about the sections of the MDS assessment they are responsible for completing, OSM # 15 stated, " Sections C, D, E, Q and sometimes V." After reviewing sections C and D of the MDS for Resident # 30 dated 3/12/19, OSM # 15 was asked if the interviews were completed. OSM # 15 stated, "I'll get back to you."

On 06/13/19 at 3:21 p.m., OSM #15 stated, "There is no evidence the interviews were done for sections C & D." When asked what guidance they follow for completing sections C and D of the MDS assessments, OSM # 2 stated, "The RAI (resident assessment instrument) manual."

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F 641	Continued From page 94 The CMS (Centers for Medicare & Medicaid Services) RAI manual documented the following: "SECTION C: COGNITIVE PATTERNS. Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. Steps for Assessment 1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700-C1000, Staff Assessment of Mental Status. 3. Review Language item (A1100), to determine if the resident needs or wants an interpreter. ·If the resident needs or wants an interpreter, complete the interview with an interpreter. Coding Instructions ·Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. ·Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words... SECTION D: MOOD Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and	F 641		

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undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan. Steps for Assessment 1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine whether the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). 3. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1). o If the resident needs or wants an interpreter, complete the interview with an interpreter. Coding Instructions o Code 0, no: if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). o Code 1, yes: if the resident interview should be conducted

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because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Continue to item D0200, Resident Mood Interview (PHQ-9©)."

On 06/13/19 at approximately 5:05 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.
2. The facility staff failed to accurately code Resident #92's weight gain on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/5/19. Instead, the resident was coded as having a weight loss.

Resident #92 was admitted to the facility on 6/13/18. Resident #92's diagnoses included but were not limited to diabetes, heart failure and anxiety disorder. Resident #92's most recent MDS, a quarterly assessment with an ARD of 4/5/19, coded the resident as being cognitively intact.

Review of Resident #92's clinical record revealed the following weights:
10/18/18- 147.4 pounds
3/18/19- 169.2 pounds (14.79 percent gain since 10/18/18)
4/1/19- 166 pounds (12.62 percent gain since 10/18/18)

A nutritional assessment dated 3/18/19 and signed by a dining services employee documented a weight gain greater than five percent in 30 days, greater than seven and a half percent in 90 days or greater than ten percent in

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F 641	Continued From page 97 180 days. Further review of Resident #92's quarterly MDS with an ARD of 4/5/19 revealed Section K that inaccurately coded Resident #92 as having a weight loss of five percent or more in the last month or weight loss of ten percent or more in the last six months. Resident #92 was coded as not having a weight gain. On 6/12/19 at 12:05 p.m., an interview was conducted with RN (registered nurse) #2 (MDS coordinator). Resident #92's weights and MDS were reviewed. RN #2 stated Resident #92's MDS inaccurately coded the resident as having a weight loss when weight gain should have been coded. RN #2 stated the MDS staff references the RAI (resident assessment instrument) manual when coding MDS assessments. On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The CMS (Centers for Medicare and Medicaid Services) RAI manual documented, "K0310: Weight Gain 1. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. 2. If the current weight is more than the weight in the observation period 30 days ago, calculate the percentage of weight gain. 3. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180	F 641		

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F 641	Continued From page 98 days ago. 4. If the current weight is more than the weight in the observation period 180 days ago, calculate the percentage of weight gain. Coding Instructions Mathematically round weights as described in Section K0200B before completing the weight gain calculation. ·Code 0, no or unknown: if the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. · Code 1, yes on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as 1. ·Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician..." No further information was presented prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655	F655 1. Residents with incentive spirometer upon admission will be addressed on the resident's baseline care plan.	7/14/19

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F 655	Continued From page 99 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655	2. Each resident admitted with an incentive spirometer has the potential to be affected. 3. Licensed Nurses and Unit Managers will be re-educated by DON/Designee on ensuring residents admitted with an incentive spirometer is addressed on the resident's baseline care plan. 4. Audits will be conducted by DON/Designee to ensure residents admitted with an incentive spirometer is addressed on the resident's baseline care plan weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 655	Continued From page 100 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to develop a complete baseline care plan for one of 71 residents in the survey sample, Resident #27. The facility staff failed to address Resident #27's use of an incentive spirometer (1) on the resident's baseline care plan. The findings include: Resident #27 was admitted to the facility on 7/24/18, and was readmitted to the facility on 6/7/19. Resident #27's diagnoses included but were not limited to asthma, chronic pain syndrome and anxiety disorder. Resident #27's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 3/11/19, coded the resident as being cognitively intact. Section G coded Resident #27 as requiring supervision with bed mobility and transfers. Review of Resident #27's clinical record failed to reveal a physician's order for an incentive spirometer. Review of Resident #27's baseline care plan, implemented on the readmission date of 6/7/19, failed to reveal documentation regarding an incentive spirometer. On 6/11/19 at 12:10 p.m. and 4:46 p.m., Resident #27 was observed in the bedroom. An incentive spirometer was observed sitting on the nightstand beside the bed. On 6/11/19 at 4:46 p.m., an interview was conducted with Resident #27. Resident #27 confirmed she uses the incentive	F 655		

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F 655	Continued From page 101 spirometer. Resident #27 stated she used the incentive spirometer more during the previous week but did use it once during the previous day. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked if a resident's care plan should include the use of an incentive spirometer. LPN #6 stated, "Yes." When asked why, LPN #6 stated, "So that everybody knows what the use is for, why it's being used and ensure compliance." On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy regarding bedside spirometry failed to document specific information regarding care planning. No further information was presented prior to exit. (1) "An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. How to use an Incentive Spirometer Many people feel weak and sore after surgery and taking big breaths can be uncomfortable. A device called an incentive spirometer can help you take deep breaths correctly. By using the incentive spirometer every 1 to 2 hours, or as instructed by your nurse or doctor, you can take	F 655		

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F 655	Continued From page 102 an active role in your recovery and keep your lungs healthy." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its 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.	F 656	F656 1. Resident #158 has expired; Resident #50's fall mat is in place and bed in low position when resident is in bed; Residents #157's care plan has now been revised to reflect Hospice services; Resident #217 has expired; Resident #161's care plan has now been revised to reflect the use of a psychotropic medications; and Resident #144's care plan is being followed for wound care for left gluteal fold and sacral pressure injury. 2. An audit of residents with oxygen, falls mats, Hospice, pressure injuries and psychotropic medications will be reviewed to ensure care plan followed and implemented. 3. Licensed Nurses, Unit Managers and MDS Coordinators will be re-educated by DON/Designee on following and implementing	7/14/19

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F 656	Continued From page 103 (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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for six of 71 residents in the survey sample, Residents #158, #50, #157, #217, #161 and #144. 1. a. The facility staff failed to implement the care plan for the use of oxygen for Resident #158. b. The facility staff failed to develop a care plan for the services of hospice for Resident #158. 2. The facility staff failed to implement the care plan for the prevention of falls for Resident #50. 3. The facility staff failed to develop a care plan to address Resident #157's hospice services. 4. The facility staff failed to implement the care plan for the treatment of pressure injuries for Resident #217. 5. The facility staff failed to develop a care plan for the use of psychotropic medications for Resident #161.	F 656	comprehensive care plans for resident with oxygen, falls mats, Hospice, pressure injuries and psychotropic medications. 4. Audits will be conducted by DON/Designee to ensure following and implementing comprehensive care plans for resident with oxygen, falls mats, Hospice, pressure injuries and psychotropic medications weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 656	Continued From page 104 6. a. The facility staff failed to implement Resident #144's comprehensive care plan for left gluteal fold (an area associated with the buttocks) wound care on 6/8/19. b. The facility staff failed to implement Resident #144's comprehensive care plan for sacral (1) pressure injury wound care on 6/8/19. The findings include: 1. a. The facility staff failed to develop a care plan to address Resident # 158's use of oxygen. Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1) high blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one or	F 656		

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more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility and being on hospice care.

Observation was made of Resident #158 on 6/11/19 at 4:42 p.m. The resident was in bed with oxygen on via a nasal cannula (a two-prong tube that inserts into the nose). The oxygen concentrator was set at 4L/min (liters per minute). A second surveyor verified this.

Observation was made of Resident #158 on 6/12/19 at 8:15 a.m. The resident was in bed with oxygen on via a nasal cannula. The oxygen concentrator was set at 4L/min.

The physician order dated, 1/10/19, documented, "O2 (oxygen) via NC (nasal cannula) at 2LPM (liters per minute) every shift."

The TAR (treatment administration record) for June 2019 documented the above physician order for oxygen. The oxygen was signed off as having been administered at 2 LPM.

Review of the comprehensive care plan failed to evidence a care plan to address the use of oxygen.

An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 6/13/19 at 2:20 p.m. When asked the purpose of the care plan, LPN #1 stated, "It's the individualized plan of care for that resident." When asked who develops the care plans, LPN #1 stated, "We all do." When asked if physician prescribed oxygen should be addressed on the care plan, LPN #1

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F 656	Continued From page 106 stated, "Yes." LPN #1 reviewed Resident #158's care plan for oxygen and stated it's (oxygen) not there. The facility policy, "The RAI (resident assessment instrument) and Care Planning" taken from the RAI Manual, version October 2016, documented in part, "The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. b. The facility staff failed to develop a comprehensive care plan to address the hospice	F 656		

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F 656	Continued From page 107 services for Resident #158. The physician order dated, 4/29/19, documented, "Name of Hospice Provider." Review of the comprehensive care plan dated 4/15/19, failed to evidence documentation of hospice care for Resident #158. An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 6/13/19 at 2:20 p.m. When asked the purpose of the care plan, LPN #1 stated, "It's the individualized plan of care for that resident." When asked who develops the care plans, LPN #1 stated, "We all do." When asked if a resident is receiving hospice care should the care plan address the hospice care, LPN #1 stated, "Yes." LPN #1 was asked to review the care plan for Resident #158. When asked if she saw hospice care and services on the care plan, LPN #1 stated, "No, Ma'am." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. 2. The facility staff failed to implement the care plan for the prevention of falls for Resident #50. Resident #50 was admitted to the facility on 11/1/18 with a readmission on 2/19/19, with diagnoses that included but were not limited to: dementia, high blood pressure, and repeated	F 656		

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F 656	Continued From page 108 falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/26/19, coded the resident as scoring a "9", indicating that the resident was moderately impaired to make daily cognitive decisions. The resident was coded in Section G - Functional Status, as requiring extensive assistance of one or more staff members for all of her activities of daily living. The comprehensive care plan dated, 11/13/18 and reviewed on 4/26/19, documented in part, "Focus: (Resident #50) is at risk for fall related to: history of falls, dementia, use of wheelchair, history of right femur fx (fracture)." The "Interventions" documented in part, "Bed in low position. Fall mat." Observation was made of Resident #50 on 6/11/19 at 11:53 a.m. during the initial screening. The resident was noted to be in bed, alert with confusion. Her bed was elevated to the waist level of this surveyor. The fall mat was leaning against the wall under the light, not on the floor next to the bed. The "MDS Kardex" documented in part, "Accidents - Fall Risk: fall mat at bedside." An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 6/13/19 at 2:20 p.m. When asked the purpose of the care plan, LPN #1 stated, "It's the individualized plan of care for that resident." When asked who develops the care plans, LPN #1 stated, "We all do." LPN #1 was asked if the interventions on a	F 656		

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F 656	Continued From page 109 resident's care plan include fall mats and bed in low position, and it's not done, is that following the care plan. LPN #1 stated, "No, Ma'am." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. 3. The facility staff failed to develop a care plan to address Resident #157's hospice services. Resident # 157 was admitted to the facility on 8/17/17 with a recent readmission on 4/12/19, with diagnoses that included but were not limited to: dementia, depression fractured hip, and anxiety disorder. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician's order dated 4/26/19, documented, "Admit to (Name of Hospice Services)." Review of the comprehensive care plan dated, 2/12/19, failed to evidence a care plan to address	F 656		

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F 656	Continued From page 110 the hospice care being provided to Resident #157. An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 6/13/19 at 2:20 p.m. When asked the purpose of the care plan, LPN #1 stated, "It's the individualized plan of care for that resident." When asked who develops the care plans, LPN #1 stated, "We all do." LPN #1 was asked if a resident receiving hospice care should have a care plan to address the hospice services. LPN #1 stated, "Yes." LPN #1 was asked to review the care plan for Resident #158. When asked if she saw hospice care on the care plan, LPN #1 stated, "No, Ma'am." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. 4. The facility staff failed to implement the care plan for the treatment of pressure injuries* for Resident #217. *A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition,	F 656		

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perfusion, co-morbidities and condition of the soft tissue.(3).

Resident #217 was admitted to the facility 9/13/18. She was transferred out of the facility on 10/12/18 and readmitted on 11/6/19. She was transferred to the hospital on 11/18/18. Her diagnoses included but were not limited to: End stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), depression, anxiety disorder, congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (2), diabetes, and amputations of both legs above the knee.

The most recent MDS (minimum data set) assessment, an admission assessment, whit an assessment reference date of 9/24/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Resident #217 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section M - Skin Conditions, the resident was coded as having one stage 3** pressure injuries and two stage 4 pressure injuries.

The comprehensive care plan dated, 10/4/18 documented in part, "Focus: Pressure ulcer Stage 4 present to left and right buttock." The "Interventions" dated 9/14/18, documented in

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part, "Conduct weekly skin inspection. Provide low air loss mattress as ordered. Treatments as ordered. Weekly wound assessment."

The physician order dated, 9/21/18, documented, "Medihoney Wound/Burn Dressing Gel (6), apply to Sacrum topically every day shift for wound care. Cleanse with wound cleanser, apply Medi-Honey, then cover with a dry protective dressing Q (every) day and PRN (as needed)."

The September 2018 TAR (treatment administration record) documented the above order. On 9/22/18 and 9/223/18, the places to document the treatment as completed were blank.

The physician order dated, 9/14/18, documented, "Santyl ointment (a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue.) (4) 250 unit/gm (gram); apply to coccyx topically every day shift for wound care. Cleanse with wound cleanser, apply Santyl, then cover with a dry protective dressing Q day and PRN."

The September 2018 TAR documented the above order. On 9/17/18, the place to document the treatment as completed was blank.

The physician order dated, 9/14/18, documented, "Santyl ointment 250 Unit/gm - apply to left ischium topically every day shift for wound care. Cleanse with 1/4 Dakin's solution (To prevent and treat infections of the skin and tissue) (7) apply Santyl, then lightly pack with Dakin's soaked Kerlix, then cover with a dry protective dressing Q day and PRN."

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F 656	Continued From page 113 The September 2018 TAR documented the above order. On 9/17/18, 9/22/18 and 9/23/18, the places to document the treatment as completed were blank. The October 2018 TAR documented the above order. On 10/8/18, the place to document the treatment as completed was blank. The physician order dated, 9/14/18, documented, "Apply skin prep (5) to right buttock Q shift every shift for preventive care." The September 2018 TAR documented the above order. On 9/17/18 - day shift; 9/20/18 - night shift; 9/22/18 - day shift; and 9/30/18 - night shift, the places to document the treatment as completed were blank. The October 2018 TAR documented the above order. On 10/5/18 - night shift; 10/6/18 - evening and night shift; 10/7/18 - evening shift; 10/12/18 - night shift, the places to document the treatment as completed were blank. The nurse's note dated, 9/14/18 at 12:03 a.m. documented in part, "Resident arrived from (name of hospital) via stretcher...Has stage 4 pressure ulcer on left buttock and stage 2 pressure ulcer on sacrum. The wound care doctor saw the resident on 9/19/18. He documented the wounds: Sacrum - stage 3 pressure wound - 0.4 x 0.4 x 0.2 cm (centimeters) Left buttock (ischium) - stage 4 pressure wound - 3 x 3.4 x 1.8 cm.	F 656		

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F 656	Continued From page 114 An interview was conducted with LPN (licensed practical nurse) # 5, the unit manager; on 6/14/19 at 7:55 a.m., LPN #5 was shown the above TARs. LPN #5 was asked what the blanks on the TAR mean. LPN #5 stated, "If it ain't signed off it didn't happen." An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 6/13/19 at 2:20 p.m. When asked the purpose of the care plan, LPN #1 stated, "It's the individualized plan of care for that resident." When asked who develops the care plans, LPN #1 stated, "We all do." When asked if a care plan documents, "Treatments as ordered" and the treatments were not completed, is that following the care plan, LPN #1 stated, "No, it's not." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (3) Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth	F 656		

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

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F 656	Continued From page 115 of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (3) Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (3) This information was obtained from the following website: https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (4) This information was obtained from the following website: http://www.rxlist.com/santyl-drug.htm. (5) Skin Prep - applies easily, even on awkward areas and moves naturally with patients' skin and won't crack or peel. Best of all, the Skin Prep wipes allow your skin to "breathe" so tapes and films adhere better. The wipes may increase intervals between dressing changes. The Protective Dressing helps to increase the adhesion of tapes and wafers. The Skin Prep also protects fragile skin and reduces adhesive removal trauma. This information was obtained from the following website: www.allegromedical.com	F 656		

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F 656	Continued From page 116 (6) Medihoney - Wound healing. Applying honey preparations directly to wounds or using dressings containing honey seems to improve healing. Several small studies describe the use of honey or honey-soaked dressings for various types of wounds, including wounds after surgery, chronic leg ulcers, abscesses, burns, abrasions, cuts, and places where skin was taken for grafting. Honey seems to reduce odors and pus, help clean the wound, reduce infection, reduce pain, and decrease time to healing. In some reports, wounds healed with honey after other treatments failed to work. This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/738.html (7) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9906e5fe-7bf5-4d99-8107-c048bb5e42d5. 5. The facility staff failed to develop a care plan for the use of psychotropic medications for Resident #161. Resident #161 was admitted to the facility on 12/13/18 with diagnoses that included but were not limited to: diabetes, dementia, mood disorder, anxiety disorder, and pseudobulbar affect (involuntary or uncontrollable crying or laughing) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/4/19, coded the	F 656		

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resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. Resident #161 was coded as requiting extensive assistance of one or more staff members for all of her activities of daily living.

The physician order dated, 4/30/19, documented, "Seroquel [quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. (2)] Tablet 25 mg (milligram) give 1 tablet by mouth twice a day related to mood affective disorder."

Review of the comprehensive care plan dated, 1/29/18, failed to evidence documentation for the use of an anti-psychotic medication for Resident #161.

An interview was conducted with RN (registered nurse) #2, the MDS coordinator, on 6/14/19 at 9:25 a.m. When asked who develops the care plan, RN #2 stated, "Nursing does interim care plan, when the MDS is completed the IDT (interdisciplinary team) does the care plan. MDS looks it over to assure all of the CAAs (Care Area Assessments) are addressed in the care plan. When asked if a resident on Seroquel should have a care plan to address the use of an anti-psychotic medication, RN #2 stated, "Yes, she should have one." RN #2 reviewed the care plans in the electronic clinical record and stated, "I don't see anything on any of her care plans."

Administrative staff member (ASM) #1, the

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administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m.

No further information was provided prior to exit.

References:
(1)This information was obtained from the following website:
https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Amyotrophic-Lateral-Sclerosis-ALS-Fact-Sheet

(2) This information was obtained from the following website: quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression.
6.a. The facility staff failed to implement Resident #144's comprehensive care plan for left gluteal fold (an area associated with the buttocks) wound care on 6/8/19.

Resident #144 was admitted to the facility on 1/14/12. Resident #144's diagnoses included but were not limited to heart failure, pain and diabetes. Resident #144's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/29/19, coded the resident as being cognitively intact. Section G coded Resident #144 as requiring extensive assistance of two or more staff with bed mobility.

Review of Resident #144's clinical record

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revealed an initial non-decubitus (pressure) skin injury record dated 5/9/19 that documented Resident #144 presented with a left gluteal fold abrasion.

Resident #144's comprehensive care plan dated 5/9/19 documented, "Altered skin integrity non pressure related to: Open Lesions to left gluteal fold related (sic) non compliance of off loading, reposition (sic) in bed, and sitting up long periods of time...Treatments as ordered..."

Further review of Resident #144's clinical record revealed a physician's order dated 6/4/19 for wound care to the left gluteal fold. The order documented to cleanse the area with normal saline or dermal wound cleaners, blot dry, apply zinc barrier to the outer edges of the wound then apply silver alginate (1) to the wound and cover with a foam dressing one time a day.

On 6/11/19 at 2:17 p.m., an interview was conducted with Resident #144. The resident voiced concern that her wound treatments do not always get completed on the weekends. Resident #144 stated she did not go to church this past Sunday (6/9/19) because no one completed her wound care on Saturday (6/8/19) and there was an odor coming from her wounds.

Review of Resident #144's June 2019 TAR (treatment administration record) failed to reveal evidence that the above treatment scheduled for 9:00 a.m. was completed on Saturday 6/8/19 (as evidenced by a blank space on the TAR). Review of nurses' notes for 6/8/19 failed to reveal documentation that wound care was provided for Resident #144.

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F 656	Continued From page 120 On 6/13/19 at 7:48 a.m., a telephone interview was conducted with LPN (licensed practical nurse) #7 (the nurse who cared for Resident #144 during the day shift on 6/8/19). LPN #7 stated weekend wound care is split up between the nurses on different shifts. LPN #7 stated she did not complete Resident #144's wound care on 6/8/19 but another nurse told her she completed the wound care that evening. LPN #7 stated the other nurse is fairly new and she did not know her name. On 6/13/19 at 9:39 a.m., a telephone interview was conducted with LPN #8 (the nurse who cared for Resident #144 during the night shift on 6/8/19). LPN #8 stated wound care was not scheduled for night shift and she did not complete Resident #144's wound care on 6/8/19. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN #6. LPN #6 was asked the purpose of the care plan. LPN #6 stated, "To make sure that we are administering the best care possible for the patient, for the patient's needs." When asked how nurses ensure they implement residents' care plans, LPN #6 stated, "Well we have our kardex that normally has everything we put on the care plan and the nurse can always view the care plan." The nurse who was responsible for caring for Resident #144 during the evening shift on 6/8/19 was not available for interview. On 6/13/19 at 3:36 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the nurse had just terminated her employment at the facility. On 6/13/19 at 5:09 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional	F 656		

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F 656	Continued From page 121 director of clinical services) were made aware of the above concern. The facility policy regarding care planning was an excerpt from the Centers for Medicare and Medicaid Services Resident Assessment Instrument manual. The excerpt documented, "As required at 42 CFR (Code of Federal Regulations) 483.25, the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care." No further information was presented prior to exit. (1) Silver alginate is used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/ b. The facility staff failed to implement Resident #144's comprehensive care plan for sacral (1) pressure injury wound care on 6/8/19. Resident #144 was admitted to the facility on 1/14/12. Resident #144's diagnoses included but were not limited to heart failure, pain and diabetes. Resident #144's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/29/19, coded the resident as being cognitively intact. Section G coded Resident #144 as requiring extensive assistance of two or	F 656		

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F 656	Continued From page 122 more staff with bed mobility. Resident #144's comprehensive care plan dated 10/25/17 documented, "At risk for further skin breakdown/Pressure ulcers (injuries) due to: Pressure Ulcers Present to sacrum...Treatments as ordered..." Review of Resident #144's clinical record revealed a pressure injury weekly assessment dated 5/6/19 that documented a stage four pressure injury (2) on the resident's sacrum. Further review of Resident #144's clinical record revealed a physician's order dated 5/23/19 to cleanse the sacrum wound with normal saline or dermal wound cleanser, blot dry, apply sterile water moist spiral cut hydrofera blue (3) and medihoney (4) and cover with a protective dressing one time a day. On 6/11/19 at 2:17 p.m., an interview was conducted with Resident #144. The resident voiced concern that her wound treatments do not always get completed on the weekends. Resident #144 stated she did not go to church this past Sunday (6/9/19) because no one completed her wound care on Saturday (6/8/19) and there was an odor coming from her wounds. Review of Resident #144's June 2019 TAR (treatment administration record) failed to reveal evidence that the above treatment scheduled for 9:00 a.m. was completed on Saturday 6/8/19 (as evidenced by a blank space on the TAR). Review of nurses' notes for 6/8/19 failed to reveal documentation that wound care was provided for Resident #144.	F 656		

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F 656	Continued From page 123 On 6/13/19 at 7:48 a.m., a telephone interview was conducted with LPN (licensed practical nurse) #7 (the nurse who cared for Resident #144 during the day shift on 6/8/19). LPN #7 stated weekend wound care is split up between the nurses on different shifts. LPN #7 stated she did not complete Resident #144's wound care on 6/8/19 but another nurse told her she completed the wound care that evening. LPN #7 stated the other nurse is fairly new and she did not know her name. On 6/13/19 at 9:39 a.m., a telephone interview was conducted with LPN #8 (the nurse who cared for Resident #144 during the night shift on 6/8/19). LPN #8 stated wound care was not scheduled for night shift and she did not complete Resident #144's wound care on 6/8/19. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN #6. LPN #6 was asked the purpose of the care plan. LPN #6 stated, "To make sure that we are administering the best care possible for the patient, for the patient's needs." When asked how nurses ensure they implement residents' care plans, LPN #6 stated, "Well we have our kardex that normally has everything we put on the care plan and the nurse can always view the care plan." The nurse who was responsible for caring for Resident #144 during the evening shift on 6/8/19 was not available for interview. On 6/13/19 at 3:36 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the nurse had just terminated her employment at the facility. On 6/13/19 at 5:09 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional	F 656		

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F 656	Continued From page 124 director of clinical services) were made aware of the above concern. No further information was presented prior to exit. (1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm (2) "Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This information was obtained from the website: https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 656		

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F 656	Continued From page 125 (3) Hydrofera blue is used to treat wounds. This information was obtained from the website: http://www.hollister.com/~/media/files/pdfs%E2%80%93for%E2%80%93download/wound%E2%80%93care/923166%E2%80%93hfb%E2%80%93family%E2%80%93brochure.pdf (4) Medihoney is used to treat wounds. This information was obtained from the website: http://www.dermasciences.com/medihoney	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, resident representative interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for one of 71 residents in the survey sample, Resident #29. On 5/26/19 during the day shift, the facility staff failed to assist Resident #29 out of bed. The findings include: Resident #29 was admitted to the facility on 10/19/09. Resident #29's diagnoses included but were not limited to stroke, major depressive disorder and chronic pain. Resident #29's quarterly MDS (minimum data set) assessment	F 677	F677 1. Residents will be provided with ADL care. 2. No other residents affected. 3. Nursing staff will be re-educated by DON/Designee to ensure assisting residents out of bed if they so choose. 4. Audits will be conducted by DON/ Designee to ensure nursing staff assist residents out of bed if they so choose weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	7/14/19

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with an ARD (assessment reference date) of 1/22/19 coded the resident as being cognitively intact. Section G coded Resident #29 as requiring extensive assistance of one staff with bed mobility.

On 6/11/19 at 2:05 p.m., an interview was conducted with Resident #29 and his representative. During the interview, Resident #29's representative voiced concern that Resident #29 was not assisted out of bed until after 3:00 p.m. on 5/26/19 because there were only two CNAs (certified nursing assistants) staffed on the unit. When asked how he felt about not being assisted out of bed until after 3:00 p.m., Resident #29 stated it did not make him feel very good.

Review of Resident #29's ADL documentation revealed the resident was not assisted with transfers during the day shift on 5/26/19.

Review of the facility staffing schedule for 5/26/19 and the 5/26/19 facility census revealed five CNAs were scheduled for Resident #29's unit on 5/26/19 but two CNAs called in and no other CNA was transferred to the unit so three CNAs cared for 56 residents.

On 6/13/19 at 3:38 p.m., an interview was conducted with CNA #4 (the CNA who cared for Resident #29 during the day shift on 5/26/19). CNA #4 stated she believed there were three CNAs on Resident #29's unit during the day shift on 5/26/19 and there was a whole lot of residents to be cared for so she did not assist Resident #29 out of bed. When asked why, CNA #4 stated she had so many residents to care for. CNA #4 stated people kept asking her to go to the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 677	Continued From page 127 bathroom and there were so many meal trays to deliver. CNA #4 further stated she could not grab another CNA to help transfer Resident #29 so she cleaned him up but did not assist him with getting out of bed. On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 6/14/19 at 1:40 p.m., ASM #2 stated the facility did not have a policy regarding ADL care. No further information was presented prior to exit.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure three of 71 residents in the survey sample, received care and services in accordance with professional standards and the comprehensive care plan for Residents #158, #96, #157 and #144.	F 684	F684 1. Resident #158 has expired; Resident #96 Digoxin is being administered per physician's orders; Resident #157 Macrobid is being administered per physician's orders; Resident #144 treatment for left gluteal fold is being provided per physician's order. 2. An audit of residents receiving Digoxin, Lasix and Macrobid will be conducted to ensure administered per physician's order. An audit of residents with abrasions will be conducted to ensure treatment per physician's orders.	7/14/19

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F 684	Continued From page 128 1. The facility staff failed to administer medications, Lasix and Digoxin to Resident #158 per the physician orders. 2. The facility staff failed to administer medication, Digoxin, per the physician orders for Resident #96. 3. The facility staff failed to administer an antibiotic per the physician order for Resident # 157. 4. The facility staff failed to provide treatment per physician's order for Resident #144's left gluteal fold (an area associated with the buttocks) abrasion on 6/8/19. The findings include: 1. The facility staff failed to administer medications, Lasix and Digoxin to Resident #158 per the physician orders. Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1) high blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle	F 684	3. Licensed nurse will be re-educated by DON/Designee on administering Digoxin, Lasix and Macrobid and providing treatments to abrasions per physician's orders. 4. Audits will be conducted by DON/Designee on ensuring resident receiving Digoxin, Lasix and Macrobid is administered per physician's orders and providing treatments to abrasions per physician's orders weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 684	Continued From page 129 weakness, sometimes with emotional instability) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The physician order dated, 4/18/19, documented, "Digox Tablet 125 mcg [Digoxin used to treat heart failure and abnormal heart rhythms (arrhythmias). It helps the heart work better and it helps control your heart rate. (4)]; give 125 mcg [microgram] by mouth one time a day related to atrial fibrillation." The physician order dated, 4/16/19, documented, "Lasix [furosemide (generic) is used alone or in combination with other medications to treat high blood pressure. Furosemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. (5)], 40 MG (milligrams) orally one time a day for fluid retention." The April and May 2019, MARs (medication administration record) documented the above physician orders for Digoxin and Lasix. On 4/29/19, and 5/3/19, the Digoxin was documented as not given and the following was documented, "7". The "7" indicated "Other/See Nurse Note." The nurse's note dated, 4/29/19 at 12:10 p.m. documented the above order. After the order "Awaiting from pharmacy" was documented." The nurse's note dated, 5/3/19 at 10:02 a.m. also documented the above order. After the order,	F 684		

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F 684	Continued From page 130 "Awaiting from pharmacy" was documented. The May and June 2019, MARs documented the above physician order for Lasix. On 5/13/19, and 6/6/19, the Lasix was documented as not given and the following was documented, "7". The "7" indicated, "Other/See Nurse Note." The nurse's note dated, 5/13/19 at 9:44 a.m. documented the above order. After the order "Awaiting from pharmacy" The nurse's note dated, 6/6/19 at 10:04 a.m., documented the above order. After the order "Awaiting from pharmacy" was documented. LPN (licensed practical nurse) # 4 wrote this note. The comprehensive care plan dated, 1/25/19 documented in part, "Focus: Impaired Cardiovascular status related to: hypertension (high blood pressure), A-fib (atrial fibrillation)." The "Interventions" documented, "Medications as ordered by physician and observe use and effectiveness." The list of the medications in the stat box was requested. The Stat (Immediate emergency box of medications) box documented, "Lanoxin (Digoxin) 0.125 mg, four doses were available." Note: 125 mcg is equal to 0.125 mg (milligrams). Furosemide tab (tablet) 20 mg (milligrams) five doses were available. An interview was conducted with LPN #4 on 6/13/19 at 9:27 a.m., regarding the process staff follows when medication is not available for administration as prescribed. LPN #4 stated, "I	F 684		

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F 684	Continued From page 131 put it in the nurse's note that the meds (medications) are awaiting pharmacy and then follow up with the pharmacy." When asked if they have a backup, stat box, LPN #4 stated, "Yes, it's usually used for antibiotics." The stat box contents were reviewed with LPN #4. When asked if the Digoxin and Lasix were available in the stat box, LPN #4 stated, "Yes, Ma'am. I should have checked there." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682301.html. (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682858.html. 2. The facility staff failed to administer Digoxin to	F 684		

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F 684	Continued From page 132 Resident #96 per the physician orders. Resident #96 was admitted to the facility on 1/30/13 with a recent readmission on 4/26/19, with diagnoses that included but were not limited to: anoxic brain damage (occurs when there is not enough oxygen getting to the brain. The brain needs a constant supply of oxygen and nutrients to function.) (1), depression, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/17/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The physician order dated, 4/27/19, documented, "Digoxin [used to treat heart failure and abnormal heart rhythms (arrhythmias). It helps the heart work better and it helps control your heart rate. (3)], 125 MCG (micrograms); give 125 mcg via Peg (feeding) tube one time a day related to atrial fibrillation. Administer along with Digoxin 250 mcg to equal 375 mcg daily. Check Apical Pulse prior to administration. Hold for Pulse Rate less than 60 bpm (beats per minute), notify MD (medical doctor)." The physician order dated, 4/27/19, documented, "Digoxin 250 MCG; Give 250 mcg via Peg Tube one time a day related to atrial fibrillation. Administer along with Digoxin 125 mcg to equal	F 684		

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F 684	Continued From page 133 375 mcg daily. Check Apical Pulse prior to administration. Hold for Pulse Rate less than 60 bpm, notify MD." The April and May 2019 MAR (mediation administration record) documented the above orders for Digoxin. Documented on the following dates, 5/22/19 at 8:05 a.m. and 5/24/19 at 8:07 a.m., a "7" was documented in the administration record. The "7" indicated "Other/See Nurse Note." The nurse's noted dated, 5/22/19 at 8:05 a.m. documented the above order for Digoxin 125 MCG. After the medication order the nurse documented, "Awaiting pharmacy." RN (registered nurse) # 1 documented this note. The nurse's noted dated, 5/42/19 at 8:07 a.m. documented the above order for Digoxin 125 MCG. After the medication order the nurse documented, "Awaiting pharmacy." RN (registered nurse) # 1 documented this note 1. The comprehensive care plan dated, 5/1/17, and revised on 2/20/19, documented in part, "Focus: Impaired Cardiovascular status related to heart failure, AFIB (atrial fibrillation)." The "Interventions" documented in part, "Medications as ordered by physician and observe use and effectiveness." The list of the medications in the stat box was requested. The Stat box documented, "Lanoxin (Digoxin) 0.125 mg, four doses were available. Note: 125 mcg is equal to 0.125 mg (milligrams).	F 684		

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F 684	Continued From page 134 An interview was conducted with RN #1 on 6/13/19 at 10:35 a.m. RN #1 was asked to review the above orders for Digoxin. When asked about the process staff follow when medication is not available in the cart for administration, RN #1 stated, "I would normally check the stat box. If we have it on hand, I'd pull it from the box." When asked how many stat boxes are in the building, RN #1 stated, "I believe three." The stat box contents were reviewed with RN #1. When asked if the medication was available for use, RN #1 stated, "Yes, I should have done more research into that. I could have verified the dose with the pharmacy too." The facility policy, "Medication Administration: General Guidelines" documented in part, "If a dose of regularly scheduled medication is withheld, refused or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time or a started dose of antibiotic is needed), the space provided on the front of the MAR (medication administration record) for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive dose of a vital medication are withheld or refused, the physician is notified." One of the responsibilities of the nurse administering medications is to check to ensure the medications are available for administration at the times ordered ... verify the physician's order and check the drugs to be sure they are correct ... if medications are not given for any reason the physician must be notified ...Lippincott Handbook of Nursing Procedures Bethlehem Pa 2008 page	F 684		

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F 684	Continued From page 135 569-570. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/001435.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) This information was obtained from the he following website: https://medlineplus.gov/druginfo/meds/a682301.html. 3. The facility staff failed to administer Resident # 157 an antibiotic per the physician orders. Resident # 157 was admitted to the facility on 8/17/17 with a recent readmission on 4/12/19, with diagnoses that included but were not limited to: dementia, depression fractured hip, and anxiety disorder. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as	F 684		

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F 684	Continued From page 136 requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician order dated, 4/12/19 documented, "Macrobid Capsule (used to treat urinary tract infections) (1) 100 MG (milligrams); give 100 mg by mouth at bedtime related to personal history of urinary tract infections." The April 2019 MAR (medication administration record) documented the above order. On 4/12/19 at 9:00 p.m. a "7" was documented in the box for administration. A "7" indicated "Other/See Nurse Note." The nurse's note dated, 4/12/19 at 8:13 p.m. documented the above order. Following the order , "Awaiting pharmacy" was documented. The comprehensive care plan dated, 11/5/18 and revised on 2/12/19, documented in part, "Focus: Potential for alteration in Hydration related to: daily antibiotic for UTI (urinary tract infection)." The contents of the STAT box list was requested. The list documented, "Nitrofurantoin Cap (capsule) (generic name for Macrobid) 100 mg - four doses were available." An interview was conducted with LPN #4 on 6/13/19 at 9:27 a.m., regarding the process staff follows when medication is not available for administration as prescribed. LPN #4 stated, "I put it in the nurse's note that the meds (medications) are awaiting pharmacy and then follow up with the pharmacy." When asked if they have a backup, stat box, LPN #4 stated, "Yes, it's usually used for antibiotics."	F 684		

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F 684	Continued From page 137 Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682291.html 4. The facility staff failed to provide treatment per physician's order for Resident #144's left gluteal fold (an area associated with the buttocks) abrasion on 6/8/19. Resident #144 was admitted to the facility on 1/14/12. Resident #144's diagnoses included but were not limited to heart failure, pain and diabetes. Resident #144's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/29/19, coded the resident as being cognitively intact. Section G coded Resident #144 as requiring extensive assistance of two or more staff with bed mobility. Review of Resident #144's clinical record revealed an initial non-decubitus (pressure) skin injury record dated 5/9/19 that documented Resident #144 presented with a left gluteal fold abrasion. Further review of Resident #144's clinical record revealed a physician's order dated 6/4/19 for wound care to the left gluteal fold. The order	F 684		

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documented to cleanse the area with normal saline or dermal wound cleaners, blot dry, apply zinc barrier to the outer edges of the wound then apply silver alginate (1) to the wound and cover with a foam dressing one time a day.

On 6/11/19 at 2:17 p.m., an interview was conducted with Resident #144. The resident voiced concern that her wound treatments do not always get completed on the weekends. Resident #144 stated she did not go to church this past Sunday (6/9/19) because no one completed her wound care on Saturday (6/8/19), and there was an odor coming from her wounds.

Review of Resident #144's June 2019 TAR (treatment administration record) failed to reveal evidence that the above treatment scheduled for 9:00 a.m. was completed on Saturday 6/8/19 (as evidenced by a blank space on the TAR). Review of nurses' notes for 6/8/19 failed to reveal documentation that wound care was provided for Resident #144.

Resident #144's comprehensive care plan dated 5/9/19 documented, "Altered skin integrity non pressure related to: Open Lesions to left gluteal fold related (sic) non compliance of off loading, reposition (sic) in bed, and sitting up long periods of time...Treatments as ordered..."

On 6/13/19 at 7:48 a.m., a telephone interview was conducted with LPN (licensed practical nurse) #7 (the nurse who cared for Resident #144 during the day shift on 6/8/19). LPN #7 stated weekend wound care is split up between the nurses on different shifts. LPN #7 stated she did not complete Resident #144's wound care on 6/8/19 but another nurse told her she completed

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F 684	Continued From page 139 the wound care that evening. LPN #7 stated the other nurse is fairly new and she did not know her name. On 6/13/19 at 9:39 a.m., a telephone interview was conducted with LPN #8 (the nurse who cared for Resident #144 during the night shift on 6/8/19). LPN #8 stated wound care was not scheduled for night shift and she did not complete Resident #144's wound care on 6/8/19. The nurse who was responsible for caring for Resident #144 during the evening shift on 6/8/19 was not available for interview. On 6/13/19 at 3:36 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the nurse had just terminated her employment at the facility. On 6/13/19 at 5:09 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 6/14/19 at 1:40 p.m., ASM #2 stated the facility did not have a policy regarding completing treatments as ordered. No further information was presented prior to exit. (1) Silver alginate is used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686	F686 1. Resident #217 has expired. Resident #144 treatment for sacral pressure injury is being provided per physician orders.	7/14/19

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F 686	Continued From page 140 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing of pressure ulcer for two of 71 residents in the survey sample, Residents #217 and #144. 1. The facility staff failed to administer the prescribed physician ordered treatment to Resident #217's pressure injuries* on multiple dates in September 2018 and on 10/18/18. The October 2018 TAR documented the above order. On 10/8/18, for Resident #217. 2. The facility staff failed to provide treatment per physician's order for Resident #144's sacral pressure injury on 6/8/19. The findings include: 1. The facility staff failed to administer the	F 686	2. An audit residents identified with pressure injuries will be conducted to ensure treatments administered per physician's orders. 3. Licensed Nurse will be re-educated by DON/Designee on ensuring resident identified with pressure injuries are administered treatment per physician's orders. 4. Audits will be conducted by DON/Designee to ensure resident identified with pressure injuries are administered treatment per physician's orders weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 686	Continued From page 141 prescribed physician ordered treatment to Resident #217's pressure injuries* on multiple dates in September 2018 and on 10/18/18. . *A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.(3). Resident #217 was admitted to the facility 9/13/18. She was transferred out of the facility on 10/12/18 and readmitted on 11/6/19. She was transferred to the hospital on 11/18/18. Her diagnoses included but were not limited to: End stage renal disease requiring hemodialysis [a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine. (1)], depression, anxiety disorder, congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (2), diabetes, and amputations of both legs above the knee. The most recent MDS (minimum data set) assessment, an admission assessment, whit an assessment reference date of 9/24/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive	F 686		

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F 686	Continued From page 142	F 686		

decisions. In Section M - Skin Conditions, the resident was coded as having one stage 3 pressure injury and two stage 4 pressure injuries.

The physician order dated, 9/21/18, documented, "Medihoney Wound/Burn Dressing Gel*, apply to Sacrum topically every day shift for wound care. Cleanse with wound cleanser, apply Medi-Honey, then cover with a dry protective dressing Q (every) day and PRN (as needed)."

*Medihoney - Wound healing. Applying honey preparations directly to wounds or using dressings containing honey seems to improve healing. Several small studies describe the use of honey or honey-soaked dressings for various types of wounds, including wounds after surgery, chronic leg ulcers, abscesses, burns, abrasions, cuts, and places where skin was taken for grafting. Honey seems to reduce odors and pus, help clean the wound, reduce infection, reduce pain, and decrease time to healing. In some reports, wounds healed with honey after other treatments failed to work. (6)

The September 2018 TAR (treatment administration record) documented the above physician order. On 9/22/18 and 9/223/18, the places to document the treatment as completed were blank.

The physician order dated, 9/14/18, documented, "Santyl ointment [a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue. (4)]
250 unit/gm (gram); apply to coccyx topically every day shift for wound care. Cleanse with wound cleanser, apply Santyl, then cover with a dry protective dressing Q day and PRN."

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F 686	Continued From page 143 The September 2018 TAR documented the above order. On 9/17/18, the place to document the treatment as completed was blank. The physician order dated, 9/14/18, documented, "Santyl ointment 250 Unit/gm - apply to left ischium topically every day shift for wound care. Cleanse with 1/4 Dakin's solution (To prevent and treat infections of the skin and tissue) (7) apply Santyl, then lightly pack with Dakin's soaked Kerlix, then cover with a dry protective dressing Q day and PRN." The September 2018 TAR documented the above physicians order. On 9/17/18, 9/22/18 and 9/23/18, the places to document the treatment as completed were blank. The October 2018 TAR documented the above physician's order. On 10/8/18, the place to document the treatment as completed was blank. The physician order dated, 9/14/18, documented, "Apply skin prep** to right buttock Q shift every shift for preventive care." **Skin Prep - applies easily, even on awkward areas and moves naturally with patients' skin and won't crack or peel. Best of all, the Skin Prep wipes allow your skin to "breathe" so tapes and films adhere better. The wipes may increase intervals between dressing changes. The Protective Dressing helps to increase the adhesion of tapes and wafers. The Skin Prep also protects fragile skin and reduces adhesive removal trauma. (5)	F 686		

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F 686	Continued From page 144 The September 2018 TAR documented the above order for skin prep. On 9/17/18 - day shift; 9/20/18 - night shift; 9/22/18 - day shift; and 9/30/18 - night shift, the places to document the treatment as completed were blank. The October 2018 TAR documented the above order for skin prep. On 10/5/18 - night shift; 10/6/18 - evening and night shift; 10/7/18 - evening shift; 10/12/18 - night shift, the places to document the treatment as completed were blank. The nurse's note dated, 9/14/18 at 12:03 a.m. documented in part, "Resident arrived from (name of hospital) via stretcher...Has stage 4 pressure ulcer on left buttock and stage 2 pressure ulcer (3) on sacrum. The wound care doctor saw the resident on 9/19/18. He documented the following regarding the wounds: Sacrum - stage 3 pressure wound - 0.4 x 0.4 x 0.2 cm (centimeters) Left buttock (ischium) - stage 4 pressure wound - 3 x 3.4 x 1.8 cm. The comprehensive care plan dated, 10/4/18 documented in part, "Focus: Pressure ulcer Stage 4 present to left and right buttock." The "Interventions" dated 9/14/18, documented in part, "Conduct weekly skin inspection. Provide low air loss mattress as ordered. Treatments as ordered. Weekly wound assessment." The wound care nurse at the time of the resident's stay was no longer employed at the facility and was unavailable for interview.	F 686		

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F 686	Continued From page 145 An interview was conducted with LPN (licensed practical nurse) # 5, the unit manager; on 6/14/19 at 7:55 a.m., LPN #5 was shown the above TARs. When asked what the blanks on the TAR meant, LPN #5 stated, "If it ain't signed off it didn't happen." The facility policy, "Pressure Ulcer Record Policy" failed to evidence documentation related to the documentation of completed treatments. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m. On 6/14/19 at 11:53 a.m., a request for the policy for treatments was made to ASM (administrative staff member) #2, the director of nursing. AT 1:40 p.m. ASM #2 state the facility did not have a policy on treatments as ordered. No further information was provided prior to exit. COMPLAINT DEFICIENCY (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (3) Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red,	F 686		

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F 686	Continued From page 146 moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from the following website:	F 686		

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F 686	Continued From page 147 https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (4) This information was obtained from the following website: http://www.rxlist.com/santyl-drug.htm. (5) This information was obtained from the following website: www.allegromedical.com (6) This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/738.html (7) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9906e5fe-7bf5-4d99-8107-c048bb5e42d5. 2. The facility staff failed to provide treatment per physician's order for Resident #144's sacral pressure injury on 6/8/19. Resident #144 was admitted to the facility on 1/14/12. Resident #144's diagnoses included but were not limited to heart failure, pain and diabetes. Resident #144's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/29/19, coded the resident as being cognitively intact. Section G coded Resident #144 as requiring extensive assistance of two or more staff with bed mobility. Review of Resident #144's clinical record revealed a pressure injury weekly assessment dated 5/6/19 that documented a stage four pressure injury (2) on the resident's sacrum. Further review of Resident #144's clinical record revealed a physician's order dated 5/23/19 to cleanse the sacrum wound with normal saline or	F 686		

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F 686	Continued From page 148	F 686		

dermal wound cleanser, blot dry, apply sterile water moist spiral cut hydrofera blue (3) and medihoney (4) and cover with a protective dressing one time a day.

On 6/11/19 at 2:17 p.m., an interview was conducted with Resident #144. The resident voiced concern that her wound treatments are not always completed on the weekends. Resident #144 stated she did not go to church this past Sunday (6/9/19) because no one completed her wound care on Saturday (6/8/19) and that there was an odor coming from her wounds.

Review of Resident #144's June 2019 TAR (treatment administration record) failed to reveal evidence that the above treatment scheduled for 9:00 a.m. was completed on Saturday 6/8/19 (as evidenced by a blank space on the TAR). Review of nurses' notes for 6/8/19 failed to reveal documentation that wound care was provided for Resident #144.

Resident #144's comprehensive care plan dated 10/25/17 documented, "At risk for further skin breakdown/Pressure ulcers (injuries) due to: Pressure Ulcers Present to sacrum...Treatments as ordered..."

On 6/13/19 at 7:48 a.m., a telephone interview was conducted with LPN (licensed practical nurse) #7 (the nurse who cared for Resident #144 during the day shift on 6/8/19). LPN #7 stated weekend wound care is split up between the nurses on different shifts. LPN #7 stated she did not complete Resident #144's wound care on 6/8/19 but another nurse told her she completed the wound care that evening. LPN #7 stated the other nurse is fairly new and she did not know her

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F 686	Continued From page 149 name. On 6/13/19 at 9:39 a.m., a telephone interview was conducted with LPN #8 (the nurse who cared for Resident #144 during the night shift on 6/8/19). LPN #8 stated wound care was not scheduled for night shift and she did not complete Resident #144's wound care on 6/8/19. The nurse who was responsible for caring for Resident #144 during the evening shift on 6/8/19 was not available for interview. On 6/13/19 at 3:36 p.m., ASM (administrative staff member) #2 (the director of nursing) stated the nurse had just terminated her employment at the facility. On 6/13/19 at 5:09 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 6/14/19 at 1:40 p.m., ASM #2 stated the facility did not have a policy regarding completing treatments as ordered. No further information was presented prior to exit. (1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm (2) "Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony	F 686		

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F 686	Continued From page 150 prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This information was obtained from the website: https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (3) Hydrofera blue is used to treat wounds. This information was obtained from the website: http://www.hollister.com/~/media/files/pdfs%E2%80%93for%E2%80%93download/wound%E2%80%93care/923166%E2%80%93hfb%E2%80%93family%E2%80%93brochure.pdf (4) Medihoney is used to treat wounds. This information was obtained from the website: http://www.dermasciences.com/medihoney	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689	F689 1. Resident #50's fall mat is in place and bed in low position while in bed.	7/14/19

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F 689	Continued From page 151 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to implement assistive device interventions, per the plan of care to prevent accidents for one of 71 sampled residents, (Resident #50). Resident #50 was observed in bed with no fall mat down at the bedside and the bed was in an elevated position. The findings include: Resident #50 was admitted to the facility on 11/1/18 with a readmission on 2/19/19, with diagnoses that included but were not limited to: dementia, high blood pressure, and repeated falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/26/19, coded the resident as scoring a "9", indicating that the resident was moderately impaired to make daily cognitive decisions. The resident was coded in Section G - Functional Status, as requiring extensive assistance of one or more staff members for all of her activities of daily living. Observation was made of Resident #50 on 6/11/19 at 11:53 a.m. during the initial screening. The resident was observed in bed. The bed was	F 689	2. An audit of residents with fall mats will be completed to ensure fall mats are in place and bed in low position when residents are in bed. 3. Nursing staff will be re-educated by the DON/Designee on ensuring fall mats are in place and beds in low position when resident is in bed. 4. Audits will be conducted by DON/Designee to ensure fall mats are in place and beds in low position when resident is in bed weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 689	Continued From page 152	F 689		

elevated to the waist level of this surveyor. A fall mat was observed leaning against the wall under the light, and was not on the floor next to the bed.

The comprehensive care plan dated, 11/13/18 and reviewed on 4/26/19, documented in part, "Focus: (Resident #50) is at risk for fall related to: history of falls, dementia, use of wheelchair, history of right femur fx (fracture)." The "Interventions" documented in part, "Bed in low position. Fall mat."

The "MDS Kardex" documented in part, "Accidents - Fall Risk: fall mat at bedside."

An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 6/13/19 at 2:31 p.m. The above observation was shared with LPN #1. LPN #1 stated, "That's a problem. The staff probably fed her breakfast, didn't put the bed back in the low position, and didn't put the fall mat down. She is my big fall risk person. She broke her hip."

An interview was conducted with CNA (certified nursing assistant) #4 on 6/13/19 at 3:49 p.m. regarding how CNAs know which safety devices a resident should have. CNA #4 stated, "We can look in the care plan book in the nurse's station." When asked if the care plan for a resident includes safety devices, such as a fall mat, should they be provided and in place, CNA #4 stated, "Yes, we have to follow the care plan."

The facility policy, "Fall Prevention Program" documented in part, "If the Resident is identified as being at risk for falls, it is noted in the care plan as a problem. Preventive interventions should be listed on the care plan. A fall prevention

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F 689	Continued From page 153 intervention should minimize the Resident's risk for falling and maintain functional independence and mobility." In Fundamentals of Nursing, 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 5. "Client safety is a priority in health care. You need to protect clients from physical and emotional injury by continually assessing for and eliminating safety hazards. Clients fall due to many factors, such as improper transfer techniques, client age, side effects of medications, impaired mobility, or confusion. Learn your agency's fall prevention program for reducing client falls. Programs that use a multidimensional approach in designing fall prevention strategies have the greatest reduction in fall rates." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695	F695 1. Resident #158 has expired. Resident #157 oxygen tubing is stored in a sanitary when not in use. Resident #76 is receiving oxygen per physician's order. Resident #27 has physician order for use of incentive spirometer and mouthpiece is stored in a sanitary manner when not in use.	7/14/19

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F 695	Continued From page 154 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory services consistent with professional standards of practice, the comprehensive person-centered care plan for four of 71 residents in the survey sample, Resident #158, #157, #76 and #27. 1. The facility staff failed to administer oxygen per the physician order for Resident #158. 2. The facility staff failed to store oxygen tubing in a sanitary manner for Resident #157. 3. The facility staff failed to administer oxygen per the physician order for Resident # 76. 4. The facility staff failed to obtain a physician's order for Resident #27's use of an incentive spirometer (1) and failed to ensure the incentive spirometer (1) mouthpiece in a clean and sanitary manner. The findings include: 1. The facility staff failed to administer oxygen per the physician order for Resident #158. Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1) high	F 695	2. An audit of resident with oxygen will be conducted to ensure oxygen tubing is stored in a sanitary manner when not in use and the oxygen rate is administered per physician's orders. An audit of resident using incentive spirometer will be conduct to ensure physician order has been obtained and mouthpiece is stored in a sanitary manner when not in use. 3. Nursing staff will be re-educated by DON/Designee on ensuring oxygen tubing is stored in a sanitary manner when not in use and the oxygen rate is administered per physician's orders. Nursing Staff will also be re-educated on resident using incentive spirometer have physician order obtained and mouthpiece is stored in a sanitary manner when not in use. 4. Audits will be conducted by Carekeepers to ensure oxygen tubing is stored in a sanitary manner when not in use and the oxygen rate is administered per physician's orders weekly for four weeks then monthly for three months. An audit will also be conducted by DON/Designee on resident using incentive spirometer	

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F 695	Continued From page 155 blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility and being on hospice care. Observation was made of Resident #158 on 6/11/19 at 4:42 p.m. The resident was in bed with oxygen on via a nasal cannula (a two-prong tube that inserts into the nose). The oxygen concentrator was set at 4L/min (liters per minute). A second surveyor verified this. Observation was made of Resident #158 on 6/12/19 at 8:15 a.m., the resident was observed in bed with oxygen on via a nasal cannula. The oxygen concentrator was set at 4L/min. The physician order dated, 1/10/19, documented, "O2 (oxygen) via NC (nasal cannula) at 2LPM (liters per minute) every shift."	F 695	have physician order obtained and mouthpiece is stored in a sanitary manner when not in use weekly for four weeks then monthly for three months. Results of the visits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 695	Continued From page 156 The TAR (treatment administration record) for June 2019 documented the above order for oxygen. The oxygen was signed off as having been administered at 2 LPM. Review of the comprehensive care plan dated, 12/6/19, failed to evidence documentation for the use of the oxygen. There was no care plan for hospice care. An interview was conducted with LPN (licensed practical nurse) #4, on 6/12/19 at 3:03 p.m. When asked how a nurse knows the prescribed oxygen rate for a resident, LPN #4 stated, "It's in the doctor's orders." When asked what rate Resident #158's oxygen was on this morning today, LPN #4 stated, "It was between three and four. When her head is low, her O2 level is low. I made sure the hospice nurse put her head back up." LPN #4 was asked what physician's order was for Resident #158's oxygen. LPN #4 stated, "I don't know. I assumed it was what it was set on. Let me check the order." LPN #4 went to the computer and checked the oxygen order for Resident #158, and stated, "It's for 2 L/min." LPN #4 was asked why it's important not to give a resident with COPD too much oxygen. LPN #4 didn't respond and shook her head. Resident #158's diagnosis of COPD was verified with LPN #4. The facility policy, taken for the Lippincott Nursing Procedures, eighth edition, 2019, page 565, documented in part, "Verify the practitioner's orders for oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed... Prolonged high concentrations of oxygen can cause lung injury."	F 695		

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F 695	Continued From page 157 Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. 2. The facility staff failed to store Resident #157's oxygen tubing in a sanitary manner. Resident # 157 was admitted to the facility on 8/17/17 with a recent readmission on 4/12/19, with diagnoses that included but were not limited to: dementia, depression fractured hip, and anxiety disorder. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section O - Special Treatments, Procedures and Programs the resident was not coded as using oxygen while a resident but was coded as receiving hospice care.	F 695		

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F 695	Continued From page 158 Observation was made of Resident #157's room during the initial screening on 6/11/19 at approximately 12:00 p.m. An oxygen concentrator was noted in the room with oxygen tubing wrapped around the water canister for humidification. The nasal cannula part of the tubing was exposed to air. A second observation was made on 6/12/19 at 8:20 a.m. of Resident #157's room. The oxygen tubing remained wrapped around the water canister on the oxygen concentrator for humidification. The nasal cannula was still exposed to the air. The physician order dated, 5/2/19, documented, "Oxygen 2Liters per minute via NC (nasal cannula) as needed for SOB (shortness of breath)." The comprehensive care plan failed to evidence documentation of the use of oxygen or hospice care. An interview as conducted with LPN # 11 on 6/12/19 at 3:15 p.m. When asked if Resident #157 uses her oxygen, LPN #11 stated, "No, not really." LPN #11 was asked to observe Resident #157's room. When asked how the oxygen tubing and cannula should be stored, LPN #11 asked, "it's not in a bag is it?' When asked how it should be stored, LPN #11 stated, "It's supposed to be stored in a bag when not in use." An interview was conducted with LPN #1, the unit manager, on 6/12/19 at 3:19 p.m., regarding the facility process for storing oxygen tubing when it is not in use. LPN #1 stated, "In a plastic bag and	F 695		

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F 695	Continued From page 159 dated." The above observation was shared with LPN #1. The policy presented by the facility for oxygen administration failed to evidence documentation of the storage of the equipment when not in use. In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. 3. The facility staff failed to administer oxygen per the physician order for Resident # 76. Resident #76 was admitted to the facility on 10/31/17 with diagnoses that included but were not limited to: depression, high blood pressure, anxiety disorder, and COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/11/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily	F 695		

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cognitive decisions. In Section O - Special Treatments, Procedures and Programs" coded the resident as having used oxygen while a resident.

Observation was made of Resident #76 during the initial screening on 6/11/19 at approximately 12:05 p.m. Resident #76 was in her bed, asleep. The oxygen concentrator was on and was set at 1.5 LPM (liters per minute).

Observation was made of resident #76 on 6/11/19 at 4:45 p.m. The resident was awake and in bed with her oxygen in use at 1.5 LPM. A second surveyor verified this observation. The resident stated, "It's supposed to be on three."

The physician order dated, 2/12/19, documented, "O2 (oxygen) @ (at) 3L/min (liters per minute) via NC (nasal cannula - a tubing with two prongs that insert into the nose to deliver oxygen) continuously every shift."

The comprehensive care plan dated, 4/24/19, documented in part, "Alteration in Respiratory Status due to Chronic Obstructive Pulmonary Disease (COPD)." The "Interventions" documented in part, "Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response."

An interview was conducted with LPN (licensed practical nurse) #4, on 6/12/19 at 3:03 p.m. When asked how staff a know what the prescribed rate of oxygen is for each resident, LPN #4 stated, "It's in the doctor's orders." LPN #4 verified the physician order for Resident #76 was 3LPM of oxygen. The above observations were shared

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with LPN #4. LPN #4 did not respond.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

4. The facility staff failed to obtain a physician's order for Resident #27's use of an incentive spirometer (1) and failed to ensure the incentive spirometer (1) mouthpiece in a clean and sanitary manner.

Resident #27 was admitted to the facility on 7/24/18 and readmitted to the facility on 6/7/19. Resident #27's diagnoses included but were not limited to asthma, chronic pain syndrome and anxiety disorder. Resident #27's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 3/11/19, coded the resident as being cognitively intact. Section G coded Resident #27 as requiring supervision with bed mobility and transfers.

Review of Resident #27's clinical record failed to reveal a physician's order for an incentive spirometer. Review of Resident #27's baseline care plan, implemented on the readmission date of 6/7/19 failed to reveal documentation regarding an incentive spirometer.

On 6/11/19 at 12:10 p.m. and 4:46 p.m., Resident

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F 695	Continued From page 162 #27 was observed in the bedroom. An uncovered incentive spirometer was observed on a nightstand in the resident's room. The mouthpiece was exposed to potential contaminates in the air. On 6/11/19 at 4:46 p.m., an interview was conducted with Resident #27. Resident #27 confirmed she uses the incentive spirometer. Resident #27 stated she used the incentive spirometer more during the previous week but did use it once during the previous day. When asked if the facility staff has ever provided her a bag to store the incentive spirometer in, Resident #27 stated the staff has not but she has not asked for a bag either. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked if residents should have a physician's order for the use of an incentive spirometer. LPN #6 stated, "I would think so." When asked why, LPN #6 stated, "Usually the order comes from the respiratory therapist to us." When asked how nurses would know when and how to use the incentive spirometer, LPN #6 stated, "You receive an order." LPN #6 was made aware that an incentive spirometer was in Resident #27's room but the resident's clinical record did not contain a physician's order for the incentive spirometer. LPN #6 was asked how incentive spirometers should be stored. LPN #6 stated incentive spirometers could be stored at the bedside. When asked if incentive spirometers should be covered, LPN #6 stated incentive spirometers usually have a casing for the mouthpiece. On 6/13/19 at 11:08 a.m., LPN #6 was shown Resident #27's incentive spirometer. The	F 695		

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F 695	Continued From page 163 incentive spirometer remained on the nightstand with the mouthpiece exposed to potential contaminates in the air. LPN #6 stated that is how incentive spirometers are stored in the hospital setting but confirmed she could not say that the incentive spirometer was not contaminated. When asked how it should be stored, LPN #6 stated it should be stored in a bag. On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy regarding bedside spirometry failed to document specific information regarding obtaining a physician's order. No further information was presented prior to exit. (1) "An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. How to use an Incentive Spirometer Many people feel weak and sore after surgery and taking big breaths can be uncomfortable. A device called an incentive spirometer can help you take deep breaths correctly. By using the incentive spirometer every 1 to 2 hours, or as instructed by your nurse or doctor, you can take an active role in your recovery and keep your lungs healthy." This information was obtained	F 695		

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	495299	A. BUILDING _____ B. WING _____	C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 164 from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for three of 71 residents in the survey sample, Residents #144, #29 and #140. 1. The facility staff failed to assess Resident #144	F 700	F700 1. Resident #144, #29 and #140 has been assessed for risk of entrapment, review of risk and benefits and consents have been obtained. 2. An audit of residents using bedrails will be conducted to ensure assessment for risk of entrapment, review of risk and benefits and consents obtained. 3. Licensed Nurse, Maintenance Department and Social Service Workers will be re-educated by DON/Designee on ensuring assessment for risk of entrapment, review of risk and benefits and consents have been conducted and obtained. 4. Audits will be conducted by DON/Designee to ensure assessment for risk of entrapment, review of risk and benefits and consents have been conducted and obtained weekly for four weeks then monthly for three	7/14/19

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F 700	Continued From page 165 for risk of entrapment, review risks and benefits and obtain informed consent prior to the installation of bed rails. 2. The facility staff failed to assess Resident #29 for risk of entrapment, review risks and benefits and obtain informed consent prior to the installation of bed rails. 3. The facility staff failed to assess Resident #140 for risk of entrapment, review risks and benefits and obtain informed consent prior to the installation of bed rails. The findings include: 1. The facility staff failed to assess Resident #144 for risk of entrapment, review risks and benefits and obtain informed consent prior to the installation of bed rails. Resident #144 was admitted to the facility on 1/14/12. Resident #144's diagnoses included but were not limited to heart failure, pain and diabetes. Resident #144's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/29/19, coded the resident as being cognitively intact. Section G coded Resident #144 as requiring extensive assistance of two or more staff with bed mobility. Review of Resident #144's clinical record revealed a physical therapy screening dated 3/29/18 that documented Resident #144 required bed rails for turning and to scoot up in bed. The screening failed to document an assessment of Resident #140's risk for entrapment.	F 700	months. Results of the visits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 700	Continued From page 166 Review of Resident #144's current physician's order sheet revealed a physician's order dated 2/14/19 for side rails (bed rails) to help with turning and repositioning. Resident #144's care plan dated 2/14/19 documented, "Side rails to help with turning and repositioning." Further review of Resident #144's clinical record failed to reveal an initial assessment for the risk of entrapment, documentation that risks and benefits were reviewed with Resident #144 (or the resident's representative) or documentation of informed consent. On 6/11/19 at 2:17 p.m., Resident #144 was observed in bed. Bilateral quarter rails were observed on the bed. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked to explain the facility process for bed rails. LPN #6 stated nurses first recommend the residents to therapy and therapy staff has to evaluate the resident. LPN #6 stated after therapy staff says yes they do want bed rails for a resident, nurses let the resident and representative know, ensures a physician's order is obtained and calls maintenance staff to install the bed rails. When asked if the risks and benefits of bed rails is explained to the resident/representative, LPN #6 stated, "Usually they discuss in therapy and we come behind and explain." When asked if she could provide evidence that risks and benefits are explained to the resident/representative, LPN #6 stated, "I have never really documented." When asked if facility staff obtains informed consent, LPN #6 stated, "No."	F 700		

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F 700	Continued From page 167 On 6/13/19 at 1:57 p.m., an interview was conducted with OSM (other staff member) #13 (physical therapist). OSM #13 was asked the process for bed rail assessments. OSM #13 stated if a resident is newly admitted, they are evaluated by therapy staff and the therapy staff will complete a bed rail assessment screening if the resident presents as being inappropriate for alternative devices such as a trapeze bar and safety bed pull up. When asked what she assesses, OSM #13 stated either physical therapy or occupational therapy usually assesses shoulder range of motion upper extremity strength, lower extremity range of motion, lower extremity strength and wounds. When asked if she completes an assessment for risk of entrapment, OSM #13 stated, "I can't say. Usually the folks have to be able to use the rails so they have some level of orientation so they can follow a command or they use the rails themselves." OSM #13 acknowledged she does not complete a formal assessment for risk of entrapment but stated if someone is so demented that she feels they, cannot use the rail then they are not given a rail. On 6/14/19 at 11:05 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled, "Side Rail Screening" documented, "It is the policy of the Facility that on admission and quarterly, all residents will be screened for the use of side rails as an enabler vs. restraint..." The policy failed to document information regarding risk for entrapment, reviewing risks and benefits and obtaining	F 700		

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F 700	Continued From page 168	F 700		

informed consent (unless the rail is deemed a restraint).

No further information was presented prior to exit.

2. The facility staff failed to assess Resident #29 for risk of entrapment, review risks and benefits and obtain informed consent prior to the installation of bed rails.

Resident #29 was admitted to the facility on 10/19/09. Resident #29's diagnoses included but were not limited to stroke, major depressive disorder and chronic pain. Resident #29's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/22/19 coded the resident as being cognitively intact. Section G coded Resident #29 as requiring extensive assistance of one staff with bed mobility.

Review of Resident #29's clinical record revealed a physical therapy screening dated 3/1/18 that documented Resident #29 required bed rails to increase independence with rolling to the right and maintaining side lying left as well as sitting on the edge of bed with rail to stabilize.

The current physician's order sheet for Resident #29 revealed a physician's order dated 2/14/19 for side rails (bed rails) to help with turning and repositioning. Resident #29's comprehensive care plan dated 2/14/19 documented, "Side rails to help with turning and repositioning."

Further review of Resident #29's clinical record failed to reveal an initial assessment for the risk of entrapment, documentation that risks and benefits were reviewed with Resident #29 (or the

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F 700	Continued From page 169 resident's representative) or documentation of informed consent. On 6/12/19 at 8:30 a.m., Resident #29 was observed in bed. Bilateral quarterly rails were observed on the bed. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked to explain the facility process for bed rails. LPN #6 stated nurses first recommend the residents to therapy and therapy staff has to evaluate the resident. LPN #6 stated after therapy staff says yes they do want bed rails for a resident, nurses let the resident and representative know, ensures a physician's order is obtained and calls maintenance staff to install the bed rails. When asked if the risks and benefits of bed rails is explained to the resident/representative, LPN #6 stated, "Usually they discuss in therapy and we come behind and explain." When asked if she could provide evidence that risks and benefits are explained to the resident/representative, LPN #6 stated, "I have never really documented." When asked if facility staff obtains informed consent, LPN #6 stated, "No." On 6/13/19 at 1:57 p.m., an interview was conducted with OSM (other staff member) #13 (physical therapist). OSM #13 was asked the process for bed rail assessments. OSM #13 stated if a resident is newly admitted, they are evaluated by therapy staff and the therapy staff will complete a bed rail assessment screening if the resident presents as being inappropriate for alternative devices such as a trapeze bar and safety bed pull up. When asked what she assesses, OSM #13 stated either physical	F 700		

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F 700	Continued From page 170 therapy or occupational therapy usually assesses shoulder range of motion upper extremity strength, lower extremity range of motion, lower extremity strength and wounds. When asked if she completes an assessment for risk of entrapment, OSM #13 stated, "I can't say. Usually the folks have to be able to use the rails so they have some level of orientation so they can follow a command or they use the rails themselves." OSM #13 acknowledged she does not complete a formal assessment for risk of entrapment but stated if someone is so demented that she feels they, cannot use the rail then they are not given a rail. On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to assess Resident #140 for risk of entrapment, review risks and benefits and obtain informed consent prior to the installation of bed rails. Resident #140 was admitted to the facility on 9/5/07. Resident #140's diagnoses included but were not limited to diabetes, major depressive disorder and chronic kidney disease. Resident #140's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/2/19, coded the resident as being cognitively intact. Section G coded Resident #140 as requiring limited assistance of one staff with bed mobility.	F 700		

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F 700	Continued From page 171 Review of Resident #140's clinical record revealed an occupational therapy screening dated 3/1/18 that documented Resident #140 required bed rails on both sides of the bed to increase and maintain independence with bed mobility and transfers. The screening failed to document an assessment of Resident #140's risk for entrapment. Resident #140's comprehensive care plan dated 2/14/19 documented, "Side rails to help with turning and repositioning." Review of Resident #140's current physician's order sheet revealed a physician's order dated 4/19/19 for side rails (bed rails) to help with turning and repositioning. Further review of Resident #140's clinical record failed to reveal an initial assessment for the risk of entrapment, documentation that risks and benefits were reviewed with Resident #140 (or the resident's representative) or documentation of informed consent. On 6/12/19 at 7:56 a.m., Resident #140 was observed in bed. Bilateral quarter rails were observed on the bed. On 6/13/19 at 10:31 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked to explain the facility process for bed rails. LPN #6 stated nurses first recommend the residents to therapy and therapy staff has to evaluate the resident. LPN #6 stated after therapy staff says yes they do want bed rails for a resident, nurses let the resident and representative know, ensures a physician's order is obtained and calls maintenance staff to install the bed rails. When asked if the risks and benefits of bed rails is explained to the	F 700		

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F 700	Continued From page 172	F 700		

resident/representative, LPN #6 stated, "Usually they discuss in therapy and we come behind and explain." When asked if she could provide evidence that risks and benefits are explained to the resident/representative, LPN #6 stated, "I have never really documented." When asked if facility staff obtains informed consent, LPN #6 stated, "No."

On 6/13/19 at 1:57 p.m., an interview was conducted with OSM (other staff member) #13 (physical therapist). OSM #13 was asked the process for bed rail assessments. OSM #13 stated if a resident is newly admitted, they are evaluated by therapy staff and the therapy staff will complete a bed rail assessment screening if the resident presents as being inappropriate for alternative devices such as a trapeze bar and safety bed pull up. When asked what she assesses, OSM #13 stated either physical therapy or occupational therapy usually assesses shoulder range of motion upper extremity strength, lower extremity range of motion, lower extremity strength and wounds. When asked if she completes an assessment for risk of entrapment, OSM #13 stated, "I can't say. Usually the folks have to be able to use the rails so they have some level of orientation so they can follow a command or they use the rails themselves." OSM #13 acknowledged she does not complete a formal assessment for risk of entrapment but stated if someone is so demented that she feels they, cannot use the rail then they are not given a rail.

On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of

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F 700	Continued From page 173 the above concern. No further information was presented prior to exit.	F 700		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, resident representative interview, staff interview, facility document review and clinical record review, it	F 725	F725 1. Facility is staffed sufficiently. 2. Each residents has the potential of being affected. 3. Staffing Coordinator and DON (Director of Nursing) will be re-educated by the Administrator/ Designee to sustain sufficient staffing. 4. Audits will be conducted by DON/Designee to ensure sufficient staff sustained weekly for four weeks then monthly for three months. Compliance Date: 7/14/19	7/14/19

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F 725	Continued From page 174	F 725		

was determined that the facility staff failed to maintain sufficient nursing staff to care for a resident's needs for one of 71 residents in the survey sample, Resident #29.

On 5/26/19 during the day shift, the facility staff failed to assist Resident #29 out of bed due to insufficient CNA (certified nursing assistant) staffing.

The findings include:

Resident #29 was admitted to the facility on 10/19/09. Resident #29's diagnoses included but were not limited to stroke, major depressive disorder and chronic pain. Resident #29's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/22/19 coded the resident as being cognitively intact. Section G coded Resident #29 as requiring extensive assistance of one staff with bed mobility.

On 6/11/19 at 2:05 p.m., an interview was conducted with Resident #29 and his representative. During the interview, Resident #29's representative voiced concern that Resident #29 was not assisted out of bed until after 3:00 p.m. on 5/26/19 because there were only two CNAs (certified nursing assistants) staffed on the unit. When asked how he felt about not being assisted out of bed until after 3:00 p.m., Resident #29 stated it did not make him feel very good.

Review of Resident #29's ADL documentation revealed the resident was not assisted with transfers during the day shift on 5/26/19.

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Review of the facility staffing schedule for 5/26/19 and the 5/26/19 facility census revealed five CNAs were scheduled for Resident #29's unit on 5/26/19 but two CNAs called in and no other CNA was transferred to the unit so three CNAs cared for 56 residents.

On 6/13/19 at 3:38 p.m., an interview was conducted with CNA #4 (the CNA who cared for Resident #29 during the day shift on 5/26/19). CNA #4 stated she believed there were three CNAs on Resident #29's unit during the day shift on 5/26/19 and there was a whole lot of residents to be cared for so she did not assist Resident #29 out of bed. When asked why, CNA #4 stated she had so many residents to care for. CNA #4 stated people kept asking her to go to the bathroom and there were so many meal trays to deliver. CNA #4 further stated she could not grab another CNA to help transfer Resident #29 so she cleaned him up but did not assist him with getting out of bed.

On 6/13/19 at 4:00 p.m., an interview was conducted with OSM (other staff member) #16 (the staffing coordinator). OSM #16 was asked how many CNAs should be staffed during the day shift on the C wing (Resident #29's unit). OSM #16 stated, "About six." OSM #16 was asked how she ensures the wings are adequately staffed with CNAs. OSM #16 stated the facility has sign-up sheets for staff to sign up for extra shifts if there are not enough staff scheduled. OSM #16 further stated she asks staff to pick up extra shifts via phone or email. OSM #16 stated for instance, she may have six CNAs scheduled but then she has to pull from another wing that has more CNAs if a CNA calls in. The day shift staffing schedule for 5/26/19 was reviewed with

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 725	Continued From page 176 OSM #16. OSM #16 verified that five CNAs were scheduled but two CNAs called in and the other two units were only staffed with four CNAs each due to call-ins. OSM #16 was asked what should have been done on 5/26/19 to ensure sufficient CNA coverage. OSM #16 stated the CNAs and nurses have to call the director of nursing if they call in, then normally CNAs are pulled from other units but on 5/26/19, there were not enough CNAs to pull from other units. OSM #16 stated normally if she cannot pull CNAs from another unit then she calls CNAs to see if they will come in to work. On 6/13/19 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 6/14/19 at 1:10 p.m., ASM #2 stated the facility did not have a policy regarding staffing. No further information was presented prior to exit.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755	F755 1. Resident #158 has expired. Resident #96 Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol are available and administered per physician's order. Resident #76 Tramadol is available and administered per physician's order.	7/14/19

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F 755	Continued From page 177 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide pharmacy services for three of 71 residents in the survey sample, Residents # 158, #96 and #76. 1. The facility staff failed to provide the medication Apixaban for administration to Resident #158 as ordered by the physician. 2. The facility staff failed to provide the medications Potassium Chloride Solution, Keppra, Carvedilol, and Tramadol for administration to Resident #96 as ordered by the physician. 3. The facility staff failed to provide medication	F 755	2. An audit of residents on Apixaban, Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol will be conducted to ensure medications are available and administered per physician's order. 3. Licensed nursing staff will be re-educated by DON/Designee on ensuring Apixaban, Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol are available and administered per physician's order. 4. Audits of residents who have Apixaban, Carvedilol, Keppra Solution, Potassium Chloride Solution and Tramadol orders will be conducted by DON/Designee to ensure medications are available and administered per physician's orders weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 7/14/19	

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F 755	Continued From page 178 Tramadol for administration to Resident #76 as ordered by the physician. The findings include: 1. The facility staff failed to provide the medication Apixaban for administration to Resident #158 as ordered by the physician. Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1) high blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician order dated 4/18/19, documented, Apixaban (Apixaban is used help prevent strokes	F 755		

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F 755	Continued From page 179	F 755		

or blood clots in people who have atrial fibrillation) (4), 5 MG (milligrams); give 5 mg by mouth two times a day related to atrial fibrillation."

The June 2019 MAR (medication administration record) documented the above physician order. On 6/5/19 a "7" was documented in the box for administration. The code for a "7" is "Other/See Nurse Notes."

The nurse's note dated, 6/5/19, documented the above order for Apixaban. After the medication, order "Awaiting meds (medications) form pharmacy" was documented.

The comprehensive care plan dated, 1/25/19 documented in part, "Focus: Impaired Cardiovascular status related to: hypertension (high blood pressure), A-fib (atrial fibrillation)." The "Interventions" documented, "Medications as ordered by physician and observe use and effectiveness."

The contents of the STAT (Immediate-emergency drug box) was requested. The list of the contents of the STAT box failed to evidence the medication was available.

An interview was conducted with LPN #4 on 6/13/19 at 9:27 a.m., regarding the process staff folliows if a medication is not available on the medication cart for administration. LPN #4 stated, "I put it in the nurse's note that the meds (medications) are awaiting pharmacy and then follow up with the pharmacy." When asked if they have a backup, stat box, LPN #4 stated, "Yes, it's usually used for antibiotics."

An interview was conducted with LPN #1, the unit

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F 755	Continued From page 180 manager, on 6/13/19 at 9:36 a.m., regarding the process staff follows when medication ordered is not available in the medication cart. LPN #1 stated, "First you check the stat box. If it's not, there you call the pharmacy. You call the MD (medical doctor) to let him know the medication is not available. Then you sign it out that you don't have the medication. The above notes documenting "awaiting pharmacy" were reviewed with LPN #1. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html. 2. The facility staff failed to provide the medications Potassium Chloride Solution, Keppra, Carvedilol, and Tramadol for administration to Resident #96 as ordered by the	F 755		

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F 755	Continued From page 181 physician. Resident #96 was admitted to the facility on 1/30/13 with a recent readmission on 4/26/19, with diagnoses that included but were not limited to: anoxic brain damage (occurs when there is not enough oxygen getting to the brain. The brain needs a constant supply of oxygen and nutrients to function.) (1), depression, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/17/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. The current physician orders documented the following medication orders: - 4/26/19 - Carvedilol Tablet 6.25 MG (milligrams); give 6.25 mg via Peg-tube (feeding tube) two times a day related to hypertension (high blood pressure)." (Used to treat heart failure and high blood pressure) (3) - 5/3/19 - Keppra Solution (used to treat seizures) (4) 100 MG/ML (milligrams per milliliter) Give 5 ml via Peg-tube every 12 hours related to other convulsions (seizures) 100mg/ml = give 5 ml equal 500 mg."	F 755		

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F 755	Continued From page 182 - 5/3/19 - Potassium Chloride Solution (For the prevention of hypokalemia [low potassium] in patients who would be at particular risk if hypokalemia were to develop, e.g., digitalized patients or patients with significant cardiac arrhythmias.) (5) 20 MEQ/15 ML (millequivalent/milliliters) (10 %) give 15 ml via Peg-tube one time a day related to heart failure. - 4/27/19 - Tramadol HCL (hydrochloride) (used to treat moderate to moderately severe pain) (6) Tablet; Give 50 mg via Peg-tube two times a day related to other chronic pain. The May 2019 MAR documented the above physician orders. Further review of the MAR revealed the following medications were not administered on the following dates: "Carvedilol - 5/22/19 - morning dose; 5/23/19 - morning dose; 5/24/19 - morning dose. "Keppra - 5/22/19 - morning dose; 5/24/19 - morning dose. "Potassium Chloride - 5/22/19 - morning dose; 5/23/19 - morning dose; 5/24/19 - morning dose. "Tramadol - 4/27/19 - morning dose; 4/28/19 - morning dose; 4/28/19 - evening dose; 4/29/19 - morning dose; 4/29/19 - evening dose. The nursing notes documented the following on the following dates: "Carvedilol - 5/22/19 at 8:05 a.m. - "Awaiting pharmacy." "Carvedilol - 5/23/19 at 8:03 a.m. - "Awaiting pharm (pharmacy)." "Carvedilol - 5/24/19 at 8:06 a.m. - "Awaiting pharmacy." "Keppra - 5/22/19 at 8:06 a.m. - "Awaiting pharmacy."	F 755		

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F 755	Continued From page 183 "Keppra - 5/24/19 at 8:07 a.m. - "Awaiting pharmacy." "Potassium Chloride - 5/22/19 at 8:07 a.m. - "Awaiting pharmacy." "Potassium Chloride - 5/23/19 at 8:11 a.m. - "Awaiting pharmacy." "Potassium Chloride - 5/24/19 at 8:08 a.m. - "Awaiting pharmacy." "Tramadol - 4/27/19 at 9:37 a.m. - "Awaiting arrival from pharmacy." "Tramadol - 4/28/19 at 9:38 a.m. - "Awaiting arrival from pharmacy." "Tramadol - 4/28/19 at 9:00 p.m. - "Waiting for delivery." "Tramadol - 4/29/19 at 12:29 p.m. - "Pharmacy." "Tramadol - 4/29/19 at 5:26 p.m. - "On order." "Tramadol - 5/22/19 at 8:05 a.m. - Awaiting pharmacy." The comprehensive care plan dated, 1/14/17 and revised on 2/20/19, documented in part, "Focus: At risk for complications related to blood thinning medications use for: atrial fibrillation." The "Interventions" documented in part, "Monitor medication regime for medications which increase effects." The comprehensive care plan dated, 1/4/17 and revised on 2/20/19, documented in part, "Needs Pain management and monitor related to: generalized pain." The "Interventions" documented in part, "Give Pain Medications as ordered." The comprehensive care plan dated, 2/7/19 and revised on 2/20/19, documented in part, "At risk for injuries r/t (related to) seizures." The comprehensive care plan dated, 5/1/17, and	F 755		

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revised on 2/20/19, documented in part, "Focus: Impaired Cardiovascular status related to heart failure, AFIB (atrial fibrillation)." The "Interventions" documented in part, "Medications as ordered by physician and observe use and effectiveness."

The contents of the STAT (Immediate - emergency drug box) was requested. The list of the contents of the STAT box failed to evidence the medication was available.

An interview was conducted with LPN #4 on 6/13/19 at 9:27 a.m., regarding the process staff follows if a medication is not available on the medication cart for administration. LPN #4 stated, "I put it in the nurse's note that the meds (medications) are awaiting pharmacy and then follow up with the pharmacy." When asked if they have a backup, stat box, LPN #4 stated, "Yes, it's usually used for antibiotics."

An interview was conducted with LPN #1, the unit manager, on 6/13/19 at 9:36 a.m., regarding the process staff follows when medication ordered is not available in the medication cart. LPN #1 stated, "First you check the stat box. If it's not there you call the pharmacy. You call the MD (medical doctor) to let him know the medication is not available. Then you sign it out that you don't have the medication. The above notes documenting "awaiting pharmacy" were reviewed with LPN #1.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m.

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F 755	Continued From page 185 No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/001435.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697042.html. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a699059.html. (5) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=48f93dac-79f0-4df7-ab17-a9bcb3d28f90 (6) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html. 3. The facility staff failed to provide medication Tramadol for administration to Resident #76 as ordered by the physician. Resident #76 was admitted to the facility on 10/31/17 with diagnoses that included but were not limited to: depression, high blood pressure, anxiety disorder, and COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1).	F 755		

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F 755	Continued From page 186 The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/11/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The physician order dated, 4/26/19, documented, "Ultram (tramadol) (used to treat moderate to moderately severe pain) (2) 50 MG (milligrams) give 1 tablet by mouth three times a day related to acute pain due to trauma." The April 2019 MAR (medication administration record) documented the above physician order. Further review of the MAR revealed on 4/26/19, a "7" was documented in the box for administration. The code for a "7" is "Other/See Nurse Notes." This was documented for the 8:00 a.m. dose and the 1:00 p.m. dose. The nurse's note dated 4/26/19 at 10:49 a.m. documented the above medication order. The note further documented, "Awaiting arrival from pharmacy." The nurse's note dated, 4/26/19 at 12:44 p.m. documented, "awaiting from pharmacy." The comprehensive care plan dated, 4/10/19, failed to evidence documentation for the treatment of pain. The contents of the STAT (Immediate-emergency drug box) was requested. The list of the contents of the STAT box failed to evidence the medication was available.	F 755		

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F 755	Continued From page 187	F 755		

An interview was conducted with LPN #4 on 6/13/19 at 9:27 a.m., regarding the process staff follows if a medication is not available on the medication cart for administration. LPN #4 stated, "I put it in the nurse's note that the meds (medications) are awaiting pharmacy and then follow up with the pharmacy." When asked if they have a backup, stat box, LPN #4 stated, "Yes, it's usually used for antibiotics."

An interview was conducted with LPN #1, the unit manager, on 6/13/19 at 9:36 a.m., regarding the process staff follows when medication ordered is not available in the medication cart. LPN #1 stated, "First you check the stat box. If it's not there you call the pharmacy. You call the MD (medical doctor) to let him know the medication is not available. Then you sign it out that you don't have the medication. The above notes documenting "awaiting pharmacy" were reviewed with LPN #1.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m.

No further information was provided prior to exit.

References:

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) This information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a695011.html

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756	F756 1. Resident #158 has expired. 2. An audit of residents using PRN anti-anxiety medications will be conducted to ensure documented rational by the physician for the continued use of a PRN anti-anxiety medication. 3. Facility Pharmacist and Licensed staff will be re-educated by DON/Designee on ensuring documented rational by the physician for the continued use of a PRN anti-anxiety medication. 4. Audits of residents using PRN anti-anxiety medications will be conducted by DON/Designee to ensure documented rational by the physician for the continued use of a PRN anti-anxiety medication weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 7/14/19	7/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 06/14/2019

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F 756	Continued From page 189 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined the facility staff failed to report an irregularity to the physician during the MRR (Medication Regimen Review) for one of 71, sampled resident, Resident #158. The facility pharmacist at the last completed medication regimen review dated 6/7/19, failed to make a recommendation to the physician requesting a documented rational for the continued use of a PRN (as needed) anti-anxiety medication ordered on 4/29/19 for Resident #158. The findings include: Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1) high blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (3).	F 756		

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F 756	Continued From page 190 The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility and being on hospice care. The physician order dated, 4/29/19 at 2:40 p.m. documented, "Lorazepam Intensol [used to relieve anxiety. It works by slowing activity in the brain to allow for relaxation. Lorazepam is also used to treat irritable bowel syndrome, epilepsy, insomnia, and nausea and vomiting from cancer treatment and to control agitation caused by alcohol withdrawal. (4)] 2 mg/ml (milligram per milliliter) 0.5 ml for breakthrough seizures only every 5 minutes up to 3 doses." The clinical record revealed a "Pharmacy Review" dated, 6/7/19 at 3:30 p.m., that documented in part, "Recommendations/Irregularities: This patient reviewed with no recommendations or irregularities noted at this time." An interview was conducted with other staff member (OSM) # 12, the facility consultant pharmacist; on 6/13/19 at 10:51 a.m., OSM #12 was asked about the process followed when a resident has a PRN order for an anti-anxiety medication. OSM #12 stated, "Normally they are only ordered for 14 days." OSM #12 was asked what has to be in place if the medication is to continue beyond the 14 days. OSM #12 stated, "The doctor has to specify the reason for the	F 756		

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F 756	Continued From page 191	F 756		

continuation and document it in the clinical record for the rationale for its continuation." OSM #12 stated she would like to review her notes and clinical record and would get back with this surveyor.

On 6/3/19 at 12:10 p.m., OSM #12 returned the call. She stated that the documentation is not supportive of the reason for the specific length of therapy. Because of the resident's decline, I didn't make any recommendations."

The facility policy, "Mediation Monitoring/Medication Management" documented in part, "PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.

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F 756	Continued From page 192 (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758	F758 1. Resident #158 has expired. 2. An audit of residents using PRN anti-anxiety medications will be conducted to ensure a review is conducted for continued use every 14 days of a PRN anti-anxiety medication. 3. Licensed staff will be re-educated by DON/Designee on ensuring a review is conducted for continued use every 14 days of a PRN anti-anxiety medication. 4. Audits of residents using PRN anti-anxiety medications will be conducted by DON/Designee to ensure a review is conducted for continued use every 14 days of a PRN anti-anxiety medication weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 7/14/19	7/14/19

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F 758	Continued From page 193 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure PRN (as needed) psychotropic medications were reviewed for continued use every 14 days for one of 71 residents in the survey sample, Resident #158. Resident #158 had a physician order for a PRN anti-anxiety medication that was prescribed on 4/29/19; there was no documentation in the clinical record by the physician for the continued use of this medication. Forty-five days had elapsed since the initial order. The findings include: Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of	F 758		

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F 758	Continued From page 194 emphysema and chronic bronchitis) (1) high blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The physician order dated, 4/29/19 at 2:40 p.m. documented, "Lorazepam Intensol [used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. Lorazepam is also used to treat irritable bowel syndrome, epilepsy, insomnia, and nausea and vomiting from cancer treatment and to control agitation caused by alcohol withdrawal. (4)] 2 mg/ml (milligram per milliliter) 0.5 ml for breakthrough seizures only every 5 minutes up to 3 doses." Review of the clinical record failed to evidence documentation of a diagnosis for seizures. Review of the MAR (medication administration record) for April, May and June 2019 failed to evidence documentation that the medication had been administered.	F 758		

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F 758	Continued From page 195 The comprehensive care plan dated, 1/25/19, documented in part, "Focus: Potential for drug related complications associated with use of psychotropic medication related to: Anti-psychotic medication, Hx (history) of mood disorder with psychosis, Bipolar, depression, dementia." The "Interventions" documented in part, "Monitor for side effects and report to physician: Anti-psychotic mediations - sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. Provide medications as ordered by physician and evaluate for effectiveness." An interview was conducted with other staff member (OSM) # 12, the facility consultant pharmacist; on 6/13/19 at 10:51 a.m., OSM #12 was asked about the process followed when a resident has a PRN order for an anti-anxiety medication. OSM #12 stated, "Normally they are only ordered for 14 days." OSM #12 was asked what has to be in place if the medication is to continue beyond the 14 days. OSM #12 stated, "The doctor has to specify the reason for the continuation and document it in the clinical record for the rationale for its continuation." OSM #12 stated she would like to review her notes and clinical record and would get back with this surveyor. Review of the clinical record revealed documented the pharmacist, OSM #12, had done a pharmacy review on 6/7/19 and made no recommendations related to the use of Lorazepam. On 6/3/19 at 12:10 p.m., OSM #12 returned the	F 758		

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F 758	Continued From page 196	F 758		

call. She stated that the documentation is not supportive of the reason for the specific length of therapy. Because of the resident's decline, I didn't make any recommendations."

An interview was conducted with ASM (administrative staff member) # 4, the nurse practitioner, on 6/13/19 at 12:33 p.m. When asked about restrictions or guidelines for the use of a PRN anti-anxiety medication, ASM #4 stated, "There is a 14 day guideline. After the 14 days, it needs to be reevaluated and if it's being used frequently, maybe a standing order would be needed. But the patient definitely needs to be reassessed."

On 6/14/19 at 9:07 a.m. ASM #2, the director of nursing, presented the written order for the Lorazepam by hospice for seizures. She stated, "We are following the physician's order."

The facility policy, "Mediation Monitoring/Medication Management" documented in part, "PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/14/19 at 12:25 p.m.

No further information was provided prior to exit.

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F 758	Continued From page 197 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-§483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure two of 71 residents in the survey sample were free of significant medication errors, Resident #96 and Resident #158. 1. The facility staff failed to administer Digoxin to Resident #96 as prescribed on 5/22/19 and 5/24/19. 2. The facility staff failed to administer Digoxin to Resident #158 as prescribed on two occasions and Lasix on two occasions. The findings include:	F 760	F760 1. Resident #158 has expired; Resident #96 Digoxin is being administered per physician's orders 2. An audit of residents receiving Digoxin and Lasix will be conducted to ensure administered per physician's order. 3. Licensed nurse will be re-educated by DON/Designee on administering Digoxin and Lasix per physician's orders. 4. Audits will be conducted by DON/Designee on ensuring resident receiving Digoxin, and Lasix are administered per physician's orders weekly for four weeks then monthly for three months. Results of the	7/14/19

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F 760	Continued From page 198 1. The facility staff failed to administer Digoxin to Resident #96 as prescribed on 5/22/19 and 5/24/19. Resident #96 was admitted to the facility on 1/30/13 with a recent readmission on 4/26/19, with diagnoses that included but were not limited to: anoxic brain damage (occurs when there is not enough oxygen getting to the brain. The brain needs a constant supply of oxygen and nutrients to function.) (1), depression, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/17/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. The physician order dated, 4/27/19, documented, "Digoxin [used to treat heart failure and abnormal heart rhythms [arrhythmias]. It helps the heart work better and it helps control your heart rate. (3)], 125 MCG (micrograms); give 125 mcg via Peg (feeding) tube one time a day related to atrial fibrillation * Administer along with Digoxin 250 mcg to equal 375 mcg daily. Check Apical Pulse prior to administration. Hold for Pulse Rate less than 60 bpm (beats per minute), notify MD (medical doctor)."	F 760	audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 760	Continued From page 199 The physician order dated, 4/27/19, documented, "Digoxin 250 MCG; Give 250 mcg via Peg Tube one time a day related to atrial fibrillation.* Administer along with Digoxin 125 mcg to equal 375 mcg daily. Check Apical Pulse prior to administration. Hold for Pulse Rate less than 60 bpm, notify MD." The April and May 2019 MAR (mediation administration record) documented the above physician orders for Digoxin. Further review of the MAR revealed on the following dates, 5/22/19 at 8:05 a.m. and 5/24/19 at 8:07 a.m. a "7" was documented in the area for administration. A "7" coded is "other/see nurse's note." The nurse's note dated, 5/22/19 at 8:05 a.m. documented the above order for Digoxin 125 MCG. After the medication order the nurse documented, "Awaiting pharmacy." RN (registered nurse) # 1 documented this note. The nurse's noted dated, 5/42/19 at 8:07 a.m. documented the above order for Digoxin 125 MCG. After the medication order the nurse documented, "Awaiting pharmacy." RN (registered nurse) # 1 documented this note. The comprehensive care plan dated, 5/1/17, and revised on 2/20/19, documented in part, "Focus: Impaired Cardiovascular status related to heart failure, AFIB (atrial fibrillation)." The "Interventions" documented in part, "Medications as ordered by physician and observe use and effectiveness." The list of the medications in the stat box (Immediate- emergency medication box) was	F 760		

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F 760	Continued From page 200 requested. The Stat box list documented, "Lanoxin (Digoxin) 0.125 mg, four doses were available. Note: 125 mcg is equal to 0.125 mg (milligrams). An interview was conducted with RN #1 on 6/13/19 at 10:35 a.m. RN #1 was asked to review the above orders for Digoxin. When asked what staff do when a medication is not available in the medication cart, RN #1 stated, "I would normally check the stat box. If we have it on hand, I'd pull it from the box." When asked how many stat boxes are in the building, RN #1 stated, "I believe three." When asked if she was capable of converting mcg to mg, RN #1 just smiled. The stat box contents were reviewed with RN #1. When asked if the medication was available for use, RN #1 stated, "Yes, I should have done more research into that. I could have verified the dose with the pharmacy too." The facility policy, "Medication Administration: General Guidelines" documented in part, "If a dose of regularly scheduled medication is withheld, refused or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time or a started dose of antibiotic is needed), the space provided on the front of the MAR (medication administration record) for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive dose of a vital medication are withheld or refused, the physician is notified." One of the responsibilities of the nurse administering medications is to check to ensure	F 760		

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	495299	A. BUILDING _____ B. WING _____	C 06/14/2019

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F 760	Continued From page 201 the medications are available for administration at the times ordered ...verify the physician's order and check the drugs to be sure they are correct ... if medications are not given for any reason the physician must be notified ...Lippincott Handbook of Nursing Procedures Bethlehem Pa 2008 page 569-570. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/001435.htm. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682301.html. 2. The facility staff failed to administer Digoxin to Resident #158 as prescribed on two occasions and Lasix on two occasions. Resident #158 was admitted to the facility on 11/29/18 with a readmission on 1/10/19 with diagnoses that included but were not limited to: Stroke, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1) high blood pressure, atrial fibrillation (a condition	F 760		

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F 760	Continued From page 202	F 760		

characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (2), and Parkinson's Disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (3).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The physician order dated, 4/18/19, documented, "Digox Tablet 125 mcg (Digoxin) [used to treat heart failure and abnormal heart rhythms (arrhythmias). It helps the heart work better and it helps control your heart rate. (4)]; give 125 mcg by mouth one time a day related to atrial fibrillation."

The physician order dated, 4/16/19, documented, "Lasix [furosemide (generic) is used alone or in combination with other medications to treat high blood pressure. Furosemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. (5)], 40 MG (milligrams) orally one time a day for fluid retention."

The April and May 2019, MARs (medication

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F 760	Continued From page 203 administration record) documented the above physician orders for Digoxin and Lasix. On 4/29/19, and 5/3/19, the Digoxin was documented as not given and the following was documented, "7". The "7" indicated "Other/See Nurse Note." The nurse's note dated, 4/29/19 at 12:10 p.m. documented the above order. After the order "Awaiting from pharmacy" was documented." The nurse's note dated, 5/3/19 at 10:02 a.m. also documented the above order. After the order, "Awaiting from pharmacy" was documented. The May and June 2019, MARs documented the above physician order for Lasix. On 5/13/19, and 6/6/19, the Lasix was documented as not given and the following was documented, "7". The "7" indicated, "Other/See Nurse Note." The nurse's note dated, 5/13/19 at 9:44 a.m. documented the above order. After the order "Awaiting from pharmacy" The nurse's note dated, 6/6/19 at 10:04 a.m., documented the above order. After the order, "Awaiting from pharmacy" was documented. LPN (licensed practical nurse) # 4 wrote this note. The comprehensive care plan dated, 1/25/19 documented in part, "Focus: Impaired Cardiovascular status related to: hypertension (high blood pressure), A-fib (atrial fibrillation)." The "Interventions" documented, "Medications as ordered by physician and observe use and effectiveness." The list of the medications in the stat box was requested.	F 760		

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F 760	Continued From page 204 The Stat (Immediate emergency box of medications) box documented, "Lanoxin (Digoxin) 0.125 mg, four doses were available." Note: 125 mcg is equal to 0.125 mg (milligrams). Furosemide tab (tablet) 20 mg (milligrams) five doses were available. An interview was conducted with LPN #4 on 6/13/19 at 9:27 a.m., regarding the process staff follows when medication is not available for administration as prescribed. LPN #4 stated, "I put it in the nurse's note that the meds (medications) are awaiting pharmacy and then follow up with the pharmacy." When asked if they have a backup, stat box, LPN #4 stated, "Yes, it's usually used for antibiotics." The stat box contents were reviewed with LPN #4. When asked if the Digoxin and Lasix were available in the stat box, LPN #4 stated, "Yes, Ma'am. I should have checked there." An interview was conducted with LPN #1, the unit manager, on 6/13/19 at 9:36 a.m. When asked what happens when a medication is not available on the medication cart at the time of the scheduled dose, LPN #1 stated, "First you check the stat box. If it's not, there you call the pharmacy. You call the MD to let him know the medication is not available. Then you sign it out that you don't have the medication. The above notes that documented "awaiting pharmacy" were reviewed with LPN #1. LPN #1 stated, "I know the dig (digoxin) is in the stat box and I'm pretty sure Lasix is too." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above	F 760		

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F 760	Continued From page 205 concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682301.html. (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682858.html.	F 760		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility	F 804	F804 1. Meals are being served at temperatures palatable for food enjoyment. 2. Each resident has the potential to be affected. 3. Dietary Staff and Nursing staff will be re-educated by the Administrator/ Designee happening serving meals at temperatures palatable for food enjoyment.	7/14/19

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F 804	Continued From page 206 document review, it was determined that the facility staff failed to serve food at temperatures palatable for food enjoyment. The findings include: On 6/12/19 at 11:34 AM, the tray line service was observed and the following food temperatures were obtained by OSM #17 (Other Staff Member - a cook), using a facility thermometer: Chicken and Dumplings 204.8 degrees. Mashed potatoes 178.1 degrees. Peas 191.9 degrees. Corn 195.4 degrees. Rice 207.2 degrees. Pureed Chicken and Dumplings 183.8 degrees. Pureed Vegetables 195.1 degrees. Chicken Noodle Soup 196.1 degrees. Tomato Soup 204.3 degrees. On 6/12/19 at 12:45 PM, a test tray was requested to go on the last cart (for Unit B). On 6/12/19 at 1:00 PM, the test tray was prepared and put on the last cart. On 6/12/19 at 1:02 PM, the cart arrived to Unit B. On 6/1219 at 1:22 PM, all residents were served and OHM #2, the district dietary manager, obtained the food temperatures using a facility thermometer at this time. The temperatures were rechecked as follows: Chicken and Dumplings 130 degrees. This was a 74.8-degree drop in temperature. Mashed potatoes 132 degrees. This was a 46.1-degree drop in temperature.	F 804	4. Audits will be conducted by the Dietary Manager/Designee on ensuring resident receiving meals at temperatures palatable for food enjoyment weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 804	Continued From page 207 Peas 145 degrees. This was a 46.9-degree drop in temperature. Corn 128 degrees. This was a 67.4-degree drop in temperature. Rice 134 degrees. This was a 73.2-degree drop in temperature. Pureed Chicken and Dumplings 135 degrees. This was a 48.8-degree drop in temperature. Pureed Vegetables 127 degrees. This was a 68.1-degree drop in temperature. Chicken Noodle Soup 143 degrees. This was a 53.1-degree drop in temperature. Tomato Soup 143 degrees. This was a 61.3-degree drop in temperature. On 6/12/19 at 1:31 PM, after tasting all the food items with 2 surveyors and OSM #2. OSM #2 agreed the Chicken and Dumplings were not warm enough for palatability and enjoyment. A review of the facility policy, "Food: Quality and Palatability" documented, "Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature." On 6/14/19 at 5:04 PM the Administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842	F842 1. Resident #157 clinical record was reviewed to ensure a complete and accurate record, containing no other resident's information.	7/14/19

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F 842	Continued From page 208 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842	2. An audit was conducted to ensure clinical records complete and accurate record, containing no other resident's information. 3. Licensed Nursing and Medical Records staff will be by Administrator/Designee re-educated on ensuring clinical records are complete and accurate, containing no other resident's information. 4. Audits will be conducted by the Administrator to ensure clinical records are complete and accurate, containing no other resident's information weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/14/19	

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F 842	Continued From page 209 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to ensure a complete and accurate clinical record for one of 71 residents in the survey sample, Resident # 157. The facility staff failed to ensure another resident's information was not in the clinical record of Resident #157. The findings include: Resident # 157 was admitted to the facility on 8/17/17 with a recent readmission on 4/12/19, with diagnoses that included but were not limited to: dementia, depression fractured hip, and	F 842		

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F 842	Continued From page 210 anxiety disorder. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/3/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Upon review of the clinical record, a document dated, 5/6/19, from a "Vascular Surgery OP (out-patient) Visit" was located in the clinical record. This document belonged to another resident on the A wing. It was not related to Resident #157. An interview was conducted with LPN (licensed practical nurse) #1, the unit manager; on 6/12/19 at 9:21 a.m., LPN #1 was asked who files reports in the clinical record. LPN #1 stated, "Whoever cleans out the doctor's book files them." The above document was shown to LPN #1. She pulled it out of the chart and stated, "It hasn't even been reviewed by the doctor. I have no idea who did this." The facility policy, taken from the Lippincott Manual, documented in part, "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members.....Maintain the confidentiality of the medical record at all times." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above	F 842		

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F 842	Continued From page 211 concerns on 6/13/19 at 5:04 p.m. No further information was provided prior to exit.	F 842		