

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/27/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BIG STONE GAP			STREET ADDRESS, CITY, STATE, ZIP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
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E 000	Initial Comments	E 000			
F 000	An unannounced Emergency Preparedness survey was conducted 6/25/18 through 6/27/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	F 000			
F 578	Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578	F578 Corrective Action(s): Residents #118 has had their code status and DDNR form reviewed by the DON and the attending physician and the comprehensive care plan and the residents closet care plan have been updated to correctly reflect their DNR code status. An Incident and Accident form was completed for this incident.		
SS=D	<p>§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.</p> <p>§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.</p> <p>§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 inform and provide written information to all adult</p>				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dustie Graham* TITLE: Administrator (X6) DATE: 7/7/19

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	<p>Continued From page 1</p> <p>residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and clinical record review, the facility staff failed to complete a DDNR (durable do not resuscitate) order form for 1 of 39 Residents, Resident #118.</p> <p>The findings included:</p> <p>The facility staff failed to accurately complete the Residents DDNR. All the boxes on this form had been left unchecked. This form was part of the Resident clinical record and was located in the hard chart.</p> <p>The clinical record review revealed that Resident</p>	F 578	<p>Identification of Deficient Practice(s) & Corrective Action(s): All other residents may have been potentially affected. The Social Services Director and/or Admissions Director will review all resident's medical records to ensure the Code status and the DDNR are accurate and that the DDNR form is accurately filled out. Any negative findings with result in the Social Services Director and/or Admission Director to contact all responsible parties to verify each resident's code status and advance directives to insure that the proper code status has been explained and that written notification has been placed in the medical record, comprehensive care plan and the residents closet care plan..</p> <p>Systemic Change(s); The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director and Social Services director have been inserviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record.</p>		

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F 578	<p>Continued From page 2</p> <p>#118 had been admitted to the facility 09/07/18. Diagnoses included, but were not limited to, dementia, Alzheimer's, and seizures.</p> <p>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) 05/21/19 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points.</p> <p>The Residents clinical record included a physicians order dated 09/15/18 that indicated the Resident was a DNR (do not resuscitate).</p> <p>The clinical record also included a DDNR form from the Virginia Department of Health. This DDNR had been signed by the physician and the Resident and was also dated 09/15/18.</p> <p>This DDNR read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked.</p> <p>Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank.</p> <p>The administrative staff were notified of the incomplete DDNR during a meeting with the survey team on 06/26/19 at 2:44 p.m.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit</p>	F 578	<p>Monitoring: The Admission Director and Social Services Director are responsible for maintaining compliance. The Social Services Director and/or Admissions Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. Completion Date: 8/11/19</p>		

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F 578	Continued From page 3 conference.	F 578		
F 607 SS=D	<p>Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to implement their policy/procedure in regards to preadmission screening of admissions to determine if a potential Resident was a convicted sex offenders for 1 of 39 Residents, Resident #59.</p> <p>The findings included:</p> <p>The facility staff failed to follow their policy in regards to preadmission screening. The facility failed to check the sex offender website when Resident #59 was admitted to the facility and only checked the website when it was brought to their attention by the survey team.</p> <p>The clinical record review revealed that Resident #59 had been admitted to the facility 10/26/17.</p>	F 607	<p>F607 Corrective Action(s): Resident #59 has been screened through the sex offender website. A facility Incident and Accident form has been completed for this incident.</p> <p>Identification of Deficient Practices & Corrective Action(s): All other resident may have potentially been affected. The Admissions Department will audit 100% of all new admissions for the last 6 months to identify any residents admitted to the facility without a sex offender screening being completed. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident form will be completed for any/all negative findings.</p> <p>Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. Admissions department will be serviced on the policy & procedure regarding abuse prevention and pre-admission sex offender screening procedures by the Administrator. Any new admission admitted to the facility without meeting the requirements of the facility policy & procedure for pre-admission sex offender screening will receive disciplinary action.</p>	

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F 607	<p>Continued From page 4</p> <p>Diagnoses included but were not limited to, hypertension, depressive disorder, mild cognitive impairment, conduct disorder, diabetes, and chronic kidney disease.</p> <p>Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/26/19 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.</p> <p>The surveyor was able to interview this Resident and the Resident was alert and orientated to self during these conversations.</p> <p>On 06/25/19, the surveyor requested the facility policy on screening of Residents in regard to sex offenders. The facility provided the surveyor with a copy of a document titled "Preadmission Screening For Sex Offender" This document read in part, "...Any prospective resident who is expected to stay of (sic) longer than three (3) days shall have his named checked against the Virginia State Police Sex Offender Registry to determine whether he or she is a convicted sex offender...The director of Admission shall submit any prospective residents name to the Virginia State Police Sex Offender Registry...prior to admission to the facility..."</p> <p>The surveyor also requested from the facility documentation to indicate this procedure had been followed.</p> <p>On 06/25/19, the facility provided the surveyor with results of a search completed for this Resident on the sex offender registry. This search</p>	F 607	<p>Monitoring: The Admissions Director and the Administrator are responsible for maintaining compliance. The Admissions Department will conduct monthly audits of all new admissions each month to maintain compliance. Any/all negative findings will be corrected at the time of discovery and reported to the administrator for corrective action. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. Completion Date: 8/11/19</p>	

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F 607	<p>Continued From page 5</p> <p>was not completed until 06/25/19 at 12:40 p.m. after the surveyor had asked for the information. This search did not match any offender in the database. Indicating the Resident was not listed as a sex offender.</p> <p>The administrative team were notified of the above issue during a meeting with the survey team on 06/27/19 at 12:35 p.m.</p> <p>On 06/27/19 at approximately 1:16 p.m., the administrator verbalized to the surveyor that he did not know how this Resident was missed being screened and the person that should have completed the screening no longer worked at the facility.</p> <p>The administrator was able to provide documentation to indicate they had completed checks for other Residents in the facility.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference.</p>	F 607		
F 623 SS=E	<p>THIS IS A COMPLAINT DEFICIENCY.</p> <p>Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)</p> <p>§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State</p>	F 623	<p>F623</p> <p>Corrective Action(s):</p> <p>Resident #9 and their responsible party have been notified that the facility failed to provide written documentation of the reason for transfer/discharge to the hospital on 5/7/19.</p> <p>Resident #65 and their responsible party have been notified that the facility failed to provide written documentation of the reason for transfer/discharge to the hospital on 4/8/19, 5/6/19, 5/18/19, and 5/28/19.</p>	

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F 623	<p>Continued From page 6</p> <p>Long-Term Care Ombudsman.</p> <p>(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</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(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.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(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</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p>	F 623	<p>Resident #73 and their responsible party have been notified that the facility failed to provide written documentation of the reason for transfer/discharge to the hospital on 3/12//19.</p> <p>Resident #115 and their responsible party have been notified that the facility failed to provide written documentation of the reason for transfer/discharge to the hospital on 3/9/19, 3/16/19, and 5/16/19.</p> <p>Resident #151 and their responsible party have been notified that the facility failed to provide written documentation of the reason for transfer/discharge to the hospital on 5/29/19 and failed to notify the ombudsman of the 5/29/19 discharge from the facility.</p> <p>Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 30 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible party and the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding.</p>		

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F 623	<p>Continued From page 7</p> <p>(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;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(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</p> <p>(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.</p> <p>§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.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure</p>	F 623	<p>Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s), nursing administration and licensed staff on the discharge and transfer requirements that are to be given to the resident and resident's responsible party and that the state ombudsman will be notified of resident discharges/transfers.</p> <p>Monitoring: The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>	

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F 623	<p>Continued From page 8</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, staff interview, and facility document review, the facility staff failed to provide appropriate notice of transfer or discharge for 5 of 39 Residents in the survey sample, Resident # 9, Resident # 65, Resident # 73, Resident # 115, and Resident # 151.</p> <p>The findings included:</p> <ol style="list-style-type: none"> The facility staff failed to provide Resident # 9 and her representative with written documentation of reason for transfer. Resident # 9 was a 63-year-old-female who was originally admitted to the facility on 7/30/12, and had a readmission date of 5/10/19. Diagnoses included but were not limited to, respiratory failure, type 2 diabetes mellitus, bipolar disorder, and schizophrenia. <p>The clinical record for Resident # 9 was reviewed on 6/26/19 at 4:22 pm. The most recent MDS (minimum data set) assessment for Resident # 9 was a quarterly assessment with an ARD (assessment reference date) of 6/14/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 9 had a BIMS (brief interview for mental status) score of 5 out of 15, which indicated that Resident # 9's cognitive status was severely impaired.</p>	F 623			

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F 623	<p>Continued From page 9</p> <p>On 6/26/19 at 4:22 pm, the surveyor reviewed Resident # 9's clinical record and observed documentation that reflected that Resident # 9 was transferred and admitted to the hospital on 5/7/19. The surveyor reviewed Resident # 9's clinical record further and did not locate any documentation that reflected that Resident # 9, or Resident # 9's representative had been made aware of the reason for transfer and discharge in writing.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked administration to provide documentation that Resident # 9 and Resident # 9's representative had been made aware in writing of reason for transfer and discharge on 5/7/19.</p> <p>The facility policy on "Transfer or Discharge Documentation" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 4. When a resident is transferred or discharged despite his or her pending appeal, the following information will be documented in the medical record: b. That an appropriate notice was provided to the resident and/or legal representative." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 9 and Resident # 9's representative had been made aware in writing of the reason for transfer and discharge on 5/7/19.</p> <p>No further information was provided to the survey team prior to the exit conference on 6/27/19.</p>	F 623			

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F 623	<p>Continued From page 10</p> <p>2. The facility staff failed to provide Resident # 65 and her representative with written documentation of reason for transfer.</p> <p>Resident # 65 was a 39-year-old-female who was originally admitted to the facility on 9/20/15, and had a readmission date of 5/29/19. Diagnoses included but were not limited to, anemia, type 2 diabetes, major depressive disorder, anxiety, and insomnia.</p> <p>On 6/26/19 at 10:50 am, the surveyor reviewed Resident # 65's clinical record and observed documentation that reflected that Resident # 9 was transferred and admitted to the hospital on 4/8/19, 5/6/19, 5/18/19, and 5/28/19. The surveyor reviewed Resident # 65's clinical record further and did not locate any documentation that reflected that Resident # 65, or Resident # 65's representative had been made aware of the reason for transfers and discharges on the dates mentioned above in writing.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked administration to provide documentation that Resident # 65 and Resident # 65's representative had been made aware in writing of reason for transfer and discharge on 4/8/19, 5/6/19, 5/18/19, and 5/28/19.</p> <p>The facility policy on "Transfer or Discharge Documentation" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 4. When a resident is transferred or discharged despite his or her pending appeal, the following information will be documented in the medical</p>	F 623			

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F 623	<p>Continued From page 11 record:</p> <p>b. That an appropriate notice was provided to the resident and/or legal representative." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 65 and Resident # 65's representative had been made aware in writing of the reason for transfer and discharge on 4/8/19, 5/6/19, 5/18/19, and 5/28/19.</p> <p>No further information was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>3. The facility staff failed to provide Resident # 73 and her representative with written documentation of reason for transfer.</p> <p>Resident # 73 was a 45-year-old-female who was originally admitted to the facility on 5/11/01, and had a readmission date of 3/15/19. Diagnoses included but were not limited to, schizophrenia, attention and concentration deficit, anxiety, retention of urine.</p> <p>The clinical record for Resident # 73 was reviewed on 6/25/19 at 4:48 pm. The most recent MDS (minimum data set) assessment for Resident # 73 was a quarterly assessment with an ARD (assessment reference date) of 5/2/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 73's cognitive status was severely impaired.</p> <p>On 6/25/19 at 4:48 pm, the surveyor reviewed Resident # 73's clinical record and observed documentation that reflected that Resident # 73 was transferred and admitted to the hospital on</p>	F 623			

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F 623	<p>Continued From page 12</p> <p>3/12/19. The surveyor reviewed Resident # 73's clinical record further and did not locate any documentation that reflected that Resident # 73, or Resident # 73's representative had been made aware of the reason for transfer and discharge on 3/12/19 in writing.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked administration to provide documentation that Resident # 73 and Resident # 73's representative had been made aware in writing of reason for transfer and discharge on 3/12/19.</p> <p>The facility policy on "Transfer or Discharge Documentation" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 4. When a resident is transferred or discharged despite his or her pending appeal, the following information will be documented in the medical record: b. That an appropriate notice was provided to the resident and/or legal representative." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 73 and Resident # 73's representative had been made aware in writing of the reason for transfer and discharge on 3/12/19.</p> <p>No further information was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>4. The facility staff failed to provide Resident # 115 and her representative with written documentation of reason for transfer.</p>	F 623			

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F 623	Continued From page 13 Resident # 115 was a 52-year-old-female who was originally admitted to the facility on 1/6/19, and had a readmission date of 5/20/19. Diagnoses included but were not limited to, hypertension, end stage renal disease, anxiety, and anemia. The clinical record for Resident # 115 was reviewed on 6/26/19 at 9:08 am. The most recent MDS (minimum data set) assessment for Resident # 115 was a quarterly assessment with an ARD (assessment reference date) of 5/28/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's cognitive status was severely impaired. On 6/26/19 at 4:22 pm, the surveyor reviewed Resident # 115's clinical record and observed documentation that reflected that Resident # 115 was transferred and admitted to the hospital on 3/9/19, 3/16/19, and 5/16/19. The surveyor reviewed Resident # 115's clinical record further and did not locate any documentation that reflected that Resident # 115, or Resident # 115's representative had been made aware of the reason for transfer and discharge on 3/9/19, 3/16/19, and 5/16/19 in writing. On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked administration to provide documentation that Resident # 115 and Resident # 115's representative had been made aware in writing of reason for transfer and discharge on 3/9/19, 3/16/19, and 5/16/19. The facility policy on "Transfer or Discharge	F 623			

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F 623	<p>Continued From page 14</p> <p>Documentation" contained documentation that included but was not limited to, ... "Policy Interpretation and Implementation</p> <p>4. When a resident is transferred or discharged despite his or her pending appeal, the following information will be documented in the medical record:</p> <p>b. That an appropriate notice was provided to the resident and/or legal representative." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 115 and Resident # 115's representative had been made aware in writing of the reason for transfer and discharge on 3/9/19, 3/16/19, and 5/16/19.</p> <p>No further information was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>5. The facility staff failed to provide Resident # 151 and her representative with written documentation of reason for transfer, and failed to notify the ombudsman of Resident # 151's discharge on 5/29/19.</p> <p>Resident # 151 was a 62-year-old-female who was originally admitted to the facility on 3/20/19, and had a readmission date of 5/31/19. Diagnoses included but were not limited to, hypertension, type 2 diabetes mellitus, bipolar disorder, and anxiety.</p> <p>The clinical record for Resident # 151 was reviewed on 6/26/19 at 10:43 am. The most recent MDS (minimum data set) assessment for Resident # 151 was a quarterly assessment with an ARD (assessment reference date) of 6/7/19. Section C of the MDS assesses cognitive</p>	F 623			

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F 623	<p>Continued From page 15</p> <p>patterns. In Section C0500, the facility staff documented that Resident # 151 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 151 was cognitively intact.</p> <p>On 6/26/19 at 10:43 am, the surveyor reviewed Resident # 151's clinical record and observed documentation that reflected that Resident # 151 was transferred and admitted to the hospital on 5/29/19. The surveyor reviewed Resident # 151's clinical record further and did not locate any documentation that reflected that Resident # 151, or Resident # 151's representative had been made aware of the reason for transfer and discharge on 5/29/19 in writing.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked the administrative to provide documentation that Resident # 151 and Resident # 151's representative had been made aware in writing of reason for transfer and discharge on 5/29/19, and to provide information that the ombudsman had been notified of Resident # 151's discharge from the facility on 5/29/19.</p> <p>The facility policy on "Transfer or Discharge Documentation" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 4. When a resident is transferred or discharged despite his or her pending appeal, the following information will be documented in the medical record: b. That an appropriate notice was provided to the resident and/or legal representative." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker</p>	F 623			

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F 623	Continued From page 16 informed the surveyor that the facility did not have documentation that Resident # 151 and Resident # 151's representative had been made aware in writing of the reason for transfer and discharge on 5/29/19. On 6/27/19 at 11:43 am, the director of nursing informed the surveyor that the facility did not notify the ombudsman of Resident # 151's discharge from the facility on 5/29/19. No further information was provided to the survey team prior to the exit conference on 6/27/19.	F 623			
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625	F625 Corrective Action(s): Residents #9, #65, #73, #115, #151, and #153 and their RP's have been notified that the facility failed to review and offer notice of bed-hold when Residents #9, #65, #73, #115, #151, and #153 were discharged to the hospital. An Incident and Accident form has been completed for each resident identified in the review. Identification of Deficient Practice(s) and Corrective Action(s): All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties.		

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F 625	<p>Continued From page 17</p> <p>the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>6. For Resident #153, the facility failed to offer a bed hold when they were transferred and admitted to an acute care hospital.</p> <p>The clinical record review revealed that Resident #153 had been originally admitted to the facility 11/03/14 and had been readmitted on 06/23/19. Diagnoses included, but were not limited to, heart failure, muscle weakness, chronic obstructive pulmonary disease, dysphagia, hypertension, dementia, and chronic pain syndrome.</p> <p>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/06/19 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points.</p> <p>The clinical record included information to indicate the Resident had been transferred and admitted to an acute care hospital on 06/19/19. The clinical record did not include any information to indicate a bed hold had been offered to the Resident or the Residents family/authorized representative.</p> <p>On 06/27/19 at 9:25 a.m., the nurse consultant verbalized to the surveyor that they did not have any information to indicate that a bed hold had been offered when the Resident was admitted to</p>	F 625	<p>Systemic Change(s): The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed staff have been inserviced by the administrator and/or Social Services director on the bed-hold requirement and the proper use and notification of the Bed-Hold policy.</p> <p>Monitoring: The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.</p> <p>Completion Date: 8/11/19</p>		

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F 625	<p>Continued From page 18 the hospital.</p> <p>The administrative team were notified of the concern regarding a bed hold and this Resident on 06/27/19 at 12:35 p.m.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference.</p> <p>Based on clinical record review, staff interview, and facility document review, the facility staff failed to provide notice of bed hold 6 of 39 Residents in the survey sample, Resident # 9, Resident # 65, Resident # 73, Resident # 115, Resident # 151, and Resident # 153.</p> <p>The findings included</p> <ol style="list-style-type: none"> 1. The facility staff failed to provide Resident # 9 with notice of bed hold upon transfer. <p>Resident # 9 was a 63-year-old-female who was originally admitted to the facility on 7/30/12, and had a readmission date of 5/10/19. Diagnoses included but were not limited to, respiratory failure, type 2 diabetes mellitus, bipolar disorder, and schizophrenia.</p> <p>The clinical record for Resident # 9 was reviewed on 6/26/19 at 4:22 pm. The most recent MDS (minimum data set) assessment for Resident # 9 was a quarterly assessment with an ARD (assessment reference date) of 6/14/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 9 had a BIMS (brief interview for mental status) score of 5 out of 15, which</p>	F 625			

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F 625	<p>Continued From page 19</p> <p>indicated that Resident # 9's cognitive status was severely impaired.</p> <p>On 6/26/19 at 4:22 pm, the surveyor reviewed Resident # 9's clinical record and observed documentation that reflected that Resident # 9 was transferred and admitted to the hospital on 5/7/19. The surveyor reviewed Resident # 9's clinical record further and did not locate any documentation that reflected that Resident # 9 had received notice of bed hold upon transfer on 5/7/19.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked the administrative to provide documentation that Resident # 9 was provided notification of bed hold upon transfer on 5/7/19.</p> <p>The facility policy on "Bed-Holds and Returns" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 3 Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. B. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer)." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have</p>	F 625			

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F 625	<p>Continued From page 20</p> <p>documentation that Resident # 9 had been issued a notice of bed hold upon transfer on 5/7/19.</p> <p>No further information was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>2. The facility staff failed to provide Resident # 65 with notice of bed hold upon transfer.</p> <p>Resident # 65 was a 39-year-old-female who was originally admitted to the facility on 9/20/15, and had a readmission date of 5/29/19.</p> <p>Diagnoses included but were not limited to, anemia, type 2 diabetes, major depressive disorder, anxiety, and insomnia.</p> <p>On 6/26/19 at 10:50 am, the surveyor reviewed Resident # 65's clinical record and observed documentation that reflected that Resident # 9 was transferred and admitted to the hospital on 4/8/19, 5/6/19, 5/18/19, and 5/28/19. The surveyor reviewed Resident # 65's clinical record further and did not locate any documentation that reflected that Resident # 65, had been issued a notice of bed hold upon transfer on 4/8/19, 5/6/19, 5/18/19, and 5/28/19.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked the administrative to provide documentation that Resident # 65 had been issued a notice of bed hold upon transfer on 4/8/19, 5/6/19, 5/18/19, and 5/28/19.</p> <p>The facility policy on "Bed-Holds and Returns" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation</p>	F 625		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2019
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BIG STONE GAP	STREET ADDRESS, CITY, STATE, ZIP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219
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F 625	<p>Continued From page 21</p> <p>3 Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail:</p> <p>e. The rights and limitations of the resident regarding bed-holds;</p> <p>f. B. The reserve bed payment policy as indicated by the state plan (Medicaid residents);</p> <p>g. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and</p> <p>h. The details of the transfer (per the Notice of Transfer). " ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 65 had been issued a notice of bed hold upon transfer on 4/8/19, 5/6/19, 5/18/19, and 5/28/19. The facility social worker stated, "We did it once and it drained her account and she told us to never do it again, but we don't have that documented." No further information was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>3. The facility staff failed to provide Resident # 73 and her representative with notice of bed hold upon transfer.</p> <p>Resident # 73 was a 45-year-old-female who was originally admitted to the facility on 5/11/01, and had a readmission date of 3/15/19. Diagnoses included but were not limited to, schizophrenia, attention and concentration deficit, anxiety, retention of urine.</p> <p>The clinical record for Resident # 73 was reviewed on 6/25/19 at 4:48 pm. The most recent MDS (minimum data set) assessment for</p>	F 625		
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F 625	<p>Continued From page 22</p> <p>Resident # 73 was a quarterly assessment with an ARD (assessment reference date) of 5/2/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 73's cognitive status was severely impaired.</p> <p>On 6/25/19 at 4:48 pm, the surveyor reviewed Resident # 73's clinical record and observed documentation that reflected that Resident # 73 was transferred and admitted to the hospital on 3/12/19. The surveyor reviewed Resident # 73's clinical record further and did not locate any documentation that reflected that Resident # 73, had been issued a notice of bed hold upon transfer on 3/12/19.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked the administrative to provide documentation that Resident # 73 had been issued a notice of bed hold upon transfer on 3/12/19.</p> <p>The facility policy on "Bed-Holds and Returns" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 3 Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail:</p> <ol style="list-style-type: none"> a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and 	F 625		
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F 625	<p>Continued From page 23</p> <p>d. The details of the transfer (per the Notice of Transfer)." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 73 had been issued a notice of bed hold upon transfer on 3/12/19.</p> <p>No further information was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>4. The facility staff failed to provide Resident # 115 with notice of bed hold upon transfer.</p> <p>Resident # 115 was a 52-year-old-female who was originally admitted to the facility on 1/6/19, and had a readmission date of 5/20/19. Diagnoses included but were not limited to, hypertension, end stage renal disease, anxiety, and anemia.</p> <p>The clinical record for Resident # 115 was reviewed on 6/26/19 at 9:08 am. The most recent MDS (minimum data set) assessment for Resident # 115 was a quarterly assessment with an ARD (assessment reference date) of 5/28/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's cognitive status was severely impaired.</p> <p>On 6/26/19 at 4:22 pm, the surveyor reviewed Resident # 115's clinical record and observed documentation that reflected that Resident # 115 was transferred and admitted to the hospital on 3/9/19, 3/16/19, and 5/16/19. The surveyor reviewed Resident # 115's clinical record further and did not locate any documentation that</p>	F 625			

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F 625	<p>Continued From page 24</p> <p>reflected that Resident # 115, had been issued a notice of bed hold upon transfer on 3/9/19, 3/16/19, and 5/16/19.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked the administrative to provide documentation that Resident # had been issued a notice of bed hold upon transfer on 3/9/19, 3/16/19, and 5/16/19.</p> <p>The facility policy on "Bed-Holds and Returns" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 3 Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. B. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer)." ...</p> <p>On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 115 had been issued a notice of bed hold upon transfer on 3/9/19, 3/16/19, and 5/16/19.</p> <p>No further information was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>5. The facility staff failed to provide Resident #</p>	F 625			

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F 625	<p>Continued From page 25</p> <p>151 had been issued a notice of bed hold upon transfer.</p> <p>Resident # 151 was a 62-year-old-female who was originally admitted to the facility on 3/20/19, and had a readmission date of 5/31/19. Diagnoses included but were not limited to, hypertension, type 2 diabetes mellitus, bipolar disorder, and anxiety.</p> <p>The clinical record for Resident # 151 was reviewed on 6/26/19 at 10:43 am. The most recent MDS (minimum data set) assessment for Resident # 151 was a quarterly assessment with an ARD (assessment reference date) of 6/7/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 151 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 151 was cognitively intact.</p> <p>On 6/26/19 at 10:43 am, the surveyor reviewed Resident # 151's clinical record and observed documentation that reflected that Resident # 151 was transferred and admitted to the hospital on 5/29/19. The surveyor reviewed Resident # 151's clinical record further and did not locate any documentation that reflected that Resident # 151, had been issued a notice of bed hold upon transfer on 5/29/19.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked the administrative to provide documentation that Resident # 151 had been issued a notice of bed hold upon transfer from the facility on 5/29/19.</p>	F 625			

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F 625	Continued From page 26 The facility policy on "Bed-Holds and Returns" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 3 Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. B. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer)." ... On 6/27/19 at 11:23 pm, the facility social worker informed the surveyor that the facility did not have documentation that Resident # 151 had been issued a notice of bed hold upon transfer on 5/29/19. No further information was provided to the survey team prior to the exit conference on 6/27/19.	F 625			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment for 1 of 39 Residents, Resident #169.	F 641	F641 Corrective Action(s): Resident #169 has had a modification completed for their discharge assessment to accurately code the residents discharge location. A facility Incident & Accident form was completed for this incident.		

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F 641	<p>Continued From page 27</p> <p>The findings included:</p> <p>For Resident #169, the MDS coordinator coded the Resident as being discharged to an acute hospital when in fact they had been discharged home.</p> <p>The record review revealed that Resident #169 had been admitted to the facility 08/08/17. Diagnoses included, but were not limited to, bipolar disorder, cellulitis, diabetes, anxiety disorder, and depressive disorder.</p> <p>Section C (cognitive patterns) of the Residents discharge MDS assessment with an ARD (assessment reference date) of 03/29/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section A (identification information) had been coded to indicate the Resident was discharged to an acute care hospital.</p> <p>The clinical record included a nursing progress note dated 03/29/19 that indicated the Resident had went LOA (leave of absence) with their mother. A second note revealed that the "Family returned to pick up res (resident) belongings and meds."</p> <p>On 06/27/19 at 11:15 a.m., after reviewing the Residents clinical record MDS coordinator #1 verbalized to the surveyor that the Residents discharge MDS should have been coded as a community discharge.</p> <p>The administrative team were made aware of the inaccurate MDS assessment during a meeting with the survey team on 06/27/19 at 12:35 p.m.</p>	F 641	<p>Identification of Deficient Practice(s) and Corrective Action(s): All other residents may have potentially been affected. A 100% audit of the last 90 days of MDS discharge assessments will be completed by the RCC and/or designee to ensure that the correct discharge location has been coded correctly on the MDS discharge assessments. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the MDS discharge assessment.</p> <p>Systemic Change(s): The Resident Interdisciplinary Care Team has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections of the MDS. All MDS discharge assessments will now be reviewed weekly by the RCC and/or DON to ensure the accuracy and integrity of resident data.</p> <p>Monitoring: The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>		

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F 641	Continued From page 28	F 641			
F 657 SS=D	<p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to— (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review, and over the course of a</p>	F 657	<p>F657 Corrective Action(s): Resident #368's comprehensive care plan has been reviewed and revised to reflect nonpharmacological interventions and approaches for managing and decreasing combative behaviors. A Risk Management Incident & Accident Form was completed for this incident.</p> <p>Identification of Deficient Practices & Corrective Action(s): Any/all residents with combative behaviors may have potentially been affected. A 100% review of all care plans for residents with combative behavior will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified.</p>		

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F 657	<p>Continued From page 29</p> <p>complaint investigation, the facility staff failed to review and revise the comprehensive plan of care for 1 of 39 Residents in the survey sample, Resident # 368.</p> <p>The findings included</p> <p>The facility staff failed to review and revise the comprehensive plan of care to address non-pharmacological interventions utilized to decrease combative behaviors for Resident # 368.</p> <p>Resident # 368 was a 77-year-old-male who was originally admitted to the facility on 2/22/19, with a readmission date of 3/21/19. Diagnoses included but were not limited to, urinary tract infection, dementia, altered mental status, and type 2 diabetes mellitus.</p> <p>The clinical record for Resident # 368 was reviewed on 6/25/19 at 4:02 pm. The most recent MDS (minimum data set) assessment for Resident # 368 was an admission assessment with an ARD (assessment reference date) of 3/1/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 368 had a BIMS score of 5 out of 15, which indicated that Resident # 368's cognitive status was severely impaired. Section E of the MDS assesses behaviors. In Section E0200, the facility staff documented that Resident # 368 displayed physical and verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others on 1 to 3 days during the look back period for the 3/1/19 ARD. In Section E0600, the facility staff documented that Resident #368's identified symptoms put others</p>	F 657	<p>Systemic Changes: The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition.</p> <p>Monitoring: The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>	

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F 657	<p>Continued From page 30 at significant risk for physical injury.</p> <p>The plan of care for Resident #368 had been reviewed and revised on 3/5/19. The facility staff documented a problem area for Resident # 368 as, "Psychotropic Drug Use/Behavior: Resident # 368 is alert with confusion. He is easily agitated has a history of verbal and physical aggression, cursing, hitting staff, and other residents, throw objects, rummaging, yelling and kicking DX: (diagnosis) dementia, AMS (altered mental status) symbolic dysfunctions." Upon review of the interventions documented for Resident # 368, the surveyor did not observe any Resident centered non-pharmacological interventions utilized to attempt to decrease Resident # 368's combative behaviors.</p> <p>On 6/26/19 at 1:48 pm, the surveyor spoke with MDS coordinator # 1 and MDS coordinator # 2. The surveyor asked MDS coordinator # 1 and MDS coordinator # 2 who updated the plans of care for the Residents in the facility. Both MDS coordinators stated that they were responsible for updating Resident care plans. The surveyor asked MDS coordinator # 1 and MDS coordinator # 2 to show documentation on Resident # 368's comprehensive plan of care that highlighted Resident centered non-pharmacological interventions utilized to decrease Resident # 368's combative behaviors. MDS # 1, MDS # 2, and the surveyor reviewed the comprehensive plan of care for Resident # 368. MDS coordinator # 1 and MDS coordinator # 2 agreed that there were no Resident centered non-pharmacological interventions to decrease combative behaviors documented on Resident # 368's comprehensive plan of care.</p>	F 657			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BIG STONE GAP			STREET ADDRESS, CITY, STATE, ZIP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219	
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F 657	Continued From page 31 The facility policy on "Dementia-Clinical Protocol" contained documentation that included but was not limited to, ..."Monitoring and Follow-Up 2. The IDT (interdisciplinary team) will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, ect." ... The facility policy on "Care Plans, Comprehensive Person-Centered" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 11. Care plan interventions are chosen only after careful data gathering proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and resident's condition change." ... On 6/27/19 at 11:43 am, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/27/19.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)	F 660	F660 Corrective Action(s): Resident #368 has been discharged from the facility. A facility Incident and Accident form has been completed for this incident	

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F 660	Continued From page 32 §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and: (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other	F 660	Identification of Deficient Practices/Corrective Action(s): All other residents discharged from the facility may have been affected. The Social Services Director/designee will conduct a 100% audit of all residents who have been discharged in the past 90 days. Residents identified at risk will have a facility Incident and Accident form completed for each incident Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s) on the requirements for discharge planning, to include notification to Adult Protective Services of potentially unsafe discharges. Additionally, the DON/designee has inserviced all licensed staff on the requirement that the status of all residents being discharged and instructions for their care be conveyed to receiving families/caregivers Monitoring: The Social Services Director will be responsible for maintaining compliance. The Social worker/designee will conduct chart audits weekly of all residents who have been discharged from the facility for complete discharge planning and care information. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19	

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F 660	<p>Continued From page 33</p> <p>appropriate entities made for this purpose.</p> <p>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, Resident representative interview, facility document review, and during the course of a complaint investigation, the facility staff failed to</p>	F 660		

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F 660	<p>Continued From page 34</p> <p>implement an effective discharge planning process for 1 of 39 residents in the survey sample, Resident # 368.</p> <p>The findings included:</p> <p>The facility staff failed to provide Resident # 368 and Resident # 368's representative with the status of the Resident upon discharge, and post-discharge planning instructions. The facility staff also failed to notify adult protective services of an unsafe discharge situation for Resident # 368.</p> <p>Resident # 368 was a 77-year-old-male who was originally admitted to the facility on 2/22/19, with a readmission date of 3/21/19. Diagnoses included but were not limited to, urinary tract infection, dementia, altered mental status, and type 2 diabetes mellitus.</p> <p>The clinical record for Resident # 368 was reviewed on 6/25/19 at 4:02 pm. The most recent MDS (minimum data set) assessment for Resident # 368 was an admission assessment with an ARD (assessment reference date) of 3/1/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 368 had a BIMS score of 5 out of 15, which indicated that Resident # 368's cognitive status was severely impaired.</p> <p>The plan of care for Resident #368 had been reviewed and revised on 3/5/19. The facility staff documented a problem area for Resident # 368 as, "LTC (long term care) is anticipated due to patient's current health care needs." Interventions included but were not limited to, "Continued care</p>	F 660			

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F 660	<p>Continued From page 35 by facility staff per PCP (primary care physician) and physician orders."</p> <p>On 6/25/19 at 5:47 pm, the surveyor informed the administrator of the complaint investigation and asked the administrator if he recalled when Resident # 368 was a resident in the facility. The administrator stated that he did remember Resident # 368, and that Resident # 368 had been involved in multiple Resident to Resident incidents. The surveyor asked the administrator if he had knowledge that the director of nursing called Resident # 368's daughter and had informed her that she would either have to come pick up Resident # 368, or the facility would have Resident # 368 arrested. The administrator stated that he was aware of the conversation held between the director of nursing and Resident # 368's daughter. The administrator stated the reason that the director of nursing made the phone call instead of him was that the director of nursing had a better relationship with Resident # 368's family. The administrator stated, "We were running out of options." "He was a danger to other Residents." The administrator stated that the facility contacted Resident # 368's daughter and that Resident # 368's daughter said that she would come pick him up.</p> <p>On 6/26/19 at 9:44 am, the surveyor conducted a phone interview with Resident # 368's daughter. The surveyor asked Resident # 368's daughter if she had been contacted by the director of nursing and told that she needed to come and pick up Resident # 368 or the facility would have him arrested. Resident # 368's daughter stated, "Yes." The surveyor asked Resident # 368's daughter if she was aware of what prompted the director of nursing to call her and tell her that she needed to</p>	F 660			

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F 660	Continued From page 36 pick up Resident # 368 or the facility would have him arrested. Resident # 368's daughter stated that facility staff had informed her that Resident # 368 had gotten into several incidents with other Residents while in the facility. Resident # 368's daughter then stated, "My dad got hit also when he was there." "My dad is hard of hearing and he doesn't talk loud and my dad was trying to get closer to hear what the other man had to say and he kicked dad in the mouth and busted dad's mouth." Resident # 368's daughter informed the surveyor that she and her sister attended a care plan meeting for Resident # 368 to discuss his behaviors. Resident # 368's daughter stated that she and her sister had requested that Resident # 368 be sent out for an evaluation and was told that Resident # 368 could not be sent out for an evaluation, but was eventually sent out. Resident # 368's daughter stated that Resident # 368 had "Terrible dementia," and had lived by himself until February of this year. The surveyor asked Resident # 368's daughter if she felt that she could safely care for Resident # 368 at home. Resident # 368's daughter stated, "No that's the reason he is in a nursing home." "If I could care for him at home I would have." The surveyor asked Resident # 368's daughter if the facility had given her instructions on how to care for Resident # 368 at home. Resident # 368's daughter stated, "No." The surveyor asked Resident # 368's daughter if she had knowledge that the facility staff contacted adult protective services when Resident # 368 was discharged home with her. Resident # 368's daughter stated, "Not that I am aware of." The surveyor asked Resident # 368's daughter what happened when Resident # 368 went home with her. Resident # 368's daughter stated that it was extremely difficult. Resident # 368's daughter stated that Resident # 368 stayed	F 660			

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F 660	<p>Continued From page 37</p> <p>up all night and had "Turned all the stove eyes on." Resident # 368's daughter stated that she did not know what to do and she called to the facility and spoke to the director of nursing who told her to take Resident # 368 to (Facility's name withheld).</p> <p>On 6/26/19 at 10:03 am, the surveyor reviewed the progress notes for Resident # 368. The surveyor observed a nursing note that had been documented on 3/22/19 at 2:44 pm. The nursing note stated, "1417 (2:17 pm) Resident alert no complaints voiced and no distressed observed or noted, resident being discharged to home with daughter at this time."</p> <p>The surveyor reviewed the facility "Nursing and Rehab Interdisciplinary Discharge Summary. Upon review of the nursing and rehab interdisciplinary discharge summary, the surveyor observed that social services, nursing services, activities, and rehab services documented information on 3/26/19, which was 4 days after Resident # 368 had been discharged. The surveyor reviewed the interdisciplinary discharge summary form further and did not observe any documentation or signatures that reflected that Resident # 368's daughter had been provided information regarding Resident # 368's status and care post discharge. The surveyor also reviewed Resident # 368's clinical record further and did not locate any documentation that Resident # 368's daughter had been informed of Resident # 368's status and was provided with post discharge care instructions.</p> <p>The surveyor also reviewed the facility "Discharge Summary" for Resident # 368. The surveyor observed that a registered nurse signed the discharge summary on 3/26/19 and the physician signed the discharge summary on 3/28/19. The</p>	F 660			

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F 660	<p>Continued From page 38</p> <p>surveyor reviewed the discharge summary for Resident # 368 further and did not locate any signatures or documentation that supported that Resident # 368 or his family received information on status and post-discharge instructions.</p> <p>On 6/26/19 at 1:30 pm, the surveyor interviewed the facility director of nursing. The surveyor asked the director of nursing if she had called Resident # 368's daughter and told her that she needed to pick Resident # 368 up or the facility would call the police and have him arrested. The director of nursing stated that she did call Resident # 368's daughter that she needed to come pick up Resident # 368's daughter that she needed to pick him up or the facility would have him arrested because of the behaviors Resident # 368 displayed. The director of nursing stated that she had called Resident # 368's daughter late at night and she asked if we could keep Resident # 368 until the morning. The director of nursing stated, "We did and she came and picked him up the next morning." The surveyor asked the director of nursing if the facility had a discharge meeting with Resident # 368 and his daughter to discuss current Resident status and care post discharge. The director of nursing stated, "She just came in and picked him up." "There wasn't really a formal meeting." The surveyor asked the director of nursing if the facility notified adult protective services when Resident # 368 was discharged from the facility. The director of nursing stated that she was not aware if adult protective services had been notified, but the facility social worker was the person responsible for notifying adult protective services. The surveyor asked the director of nursing if she felt that the facility ensured that Resident # 368 had a safe and appropriate discharge process. The</p>	F 660			

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F 660	Continued From page 39 director of nursing stated, "I see what you mean." "We could have done some things differently." On 6/26/19 at 2:05 pm, the surveyor interviewed the facility social worker. The surveyor asked the facility social worker if she had been involved in the discharge process with Resident # 368. The facility social worker reviewed her notes and stated, "I don't see discharge planning." The facility social worker stated, "I wasn't involved in his discharge." The surveyor asked the facility social worker if she was the person responsible for notifying adult protective services when she felt that a Resident was discharging from the facility to an unsafe situation. The facility social worker stated, "Yes." The surveyor asked the facility social worker if she notified adult protective services when Resident # 368 was discharged on 3/22/19. The facility social worker reviewed her notes and stated that there was nothing documented in her notes and that she did not notify adult protective services. The surveyor asked the facility social worker why she did not notify adult protective services. The facility social worker stated, "I didn't feel that it was an unsafe discharge." The surveyor spoke with the surveyor and reviewed that Resident # 368 was placed in the facility for long-term care due to his needs are unable to be met in the home setting. The surveyor and social worker discussed the Resident-to-Resident altercations as well as the excessive wandering mostly during the night that Resident # 368 displayed while a Resident in the facility. The surveyor asked the social worker if she still felt that the way Resident # 368 was discharged was safe. The facility social worker stated that she felt that it was a safe discharge because Resident # 368's daughters felt that they could handle Resident # 368.	F 660			

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F 660	Continued From page 40 The facility policy on "Discharge Summary and Plan" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 1. When the facility anticipated a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, ect.), a discharge summary and post discharge plan will be developed which will assist the resident to adjust to his or her living environment. 2. The discharge summary will include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge in accordance with established regulations governing release of resident information and as permitted by the resident. 5. The post discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will include: a. Where the individual plans to reside; b. Arrangements that have been made for follow-up care and services; c. A description of the resident's stated discharge goals; d. The degree of caregiver/support person availability, capacity and capability to perform required care; e. How the IDT (interdisciplinary team) will support the resident or representative in the transition to post-discharge care; f. What factors may make the resident vulnerable to preventable readmission; and g. How those factors will be addressed. 12. A member if the IDT will review the final post-discharge plan with the resident and family at least twenty four (24) hours before the	F 660			

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F 660	Continued From page 41 discharge takes place. 13. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary."... On 6/27/19 at 11:43 am, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/27/19.	F 660		
F 684 SS=D	This is a complaint deficiency. 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 and clinical record review the facility staff failed to follow physician's orders for 1 of 39 Residents, Resident #61. The findings included: For Resident #61 the facility staff failed to	F 684	F684 Corrective Action(s): Resident #61's attending physician was notified that the facility staff failed to administer the scheduled pain medication Norco as ordered by the physician. A facility Medication Error form was completed for this incident. Identification of Deficient Practices/Corrective Action(s): All other residents receiving scheduled pain medication may have potentially been affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician order scheduled pain medications and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 684	<p>Continued From page 42</p> <p>administer the scheduled pain medication Norco as prescribed by the physician.</p> <p>According to Davis Drug Guide, Norco is an opioid pain medication used to treat moderate to severe pain.</p> <p>Resident #61 was admitted to the facility on 03/26/18 and readmitted on 05/23/19. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, aphasia, cerebrovascular accident, hemiplegia, depression, psychotic disorder and chronic obstructive pulmonary disease.</p> <p>The most recent MDS (minimum data set) with an ARD of 05/30/19 coded the Resident as having both long and short-term memory loss with severely impaired cognitive skills for daily decision making. This is a 5-day MDS.</p> <p>Resident #61's comprehensive care plan was reviewed and contained a care plan for "Is at risk for alteration of comfort r/t (related to) dx: (diagnosis) of chronic pain". Approaches for this care plan include "pain meds as ordered".</p> <p>Resident #61's clinical record was reviewed on 06/26/19. It contained a signed physician's order summary for May 2019, which read in part "NORCO 7.5-325 TABLET give 1 tablet PO (by mouth) Q (every) 8hrs SCHEDULED DX: PAIN". The Resident's eMAR (electronic medication administration record) for May 2019 was reviewed. It contained as entry, which read in part "NORCO 7.5-325 TABLET give 1 tablet PO (by mouth) Q (every) 8hrs SCHEDULED DX: PAIN". This entry was initialed with "N" on 05/14/19 at 10:00 PM. The administration notes for this entry</p>	F 684	<p>Systemic Change(s): The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24-Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications and treatments. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders as ordered by the physician. Licensed staff will also be inserviced on the proper reasons for holding scheduled pain medication.</p> <p>Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly MAR and chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>	

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BIG STONE GAP			STREET ADDRESS, CITY, STATE, ZIP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219	
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F 684	Continued From page 43 read in part "11:33 PM, 5/14/19 (Scheduled: 10:00PM, 51419; Norco 7.5-325 Tablet) Norco 7.5-325 Tablet give 1 tablet PO Q...scheduled for 05/14/12019 10:00PM.sleeping). Surveyor spoke with the DON (director of nursing) on 0627/19 at approximately 1055 regarding Resident #61. Surveyor asked the DON what "N" on the eMAR indicated, and she stated that it meant the medication was not administered. Surveyor also asked the DON if a Resident sleeping is a valid reason for not administering a scheduled medication, and she stated that it is not. The concern of not following the physician's orders was discussed with the administrative team during a meeting on 06/27/19 at approximately 1230.	F 684		
F 690 SS=D	No further information provided prior to exit. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690	F690 Corrective Action(s): Resident #73's catheter drainage bag is now anchored per policy and procedure to ensure the catheter collection bag and collection tubing is off the floor to prevent infection and injury. The resident's care plan has been revised to reflect accurate Suprapubic catheter care to include proper placement of the drainage bag and tubing.	

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F 690	<p>Continued From page 44</p> <p>resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, clinical record review, staff interview, and facility document review, the facility staff failed to provide care to prevent urinary tract infections for 1 of 39 Residents in the survey sample, Resident # 73.</p> <p>The findings included:</p> <p>The facility staff failed to ensure that Resident # 73's Foley catheter was secured, and failed to ensure that Resident # 73's urinary drainage bag was not touching the floor.</p> <p>Resident # 73 was a 45-year-old-female who was originally admitted to the facility on 5/11/01, and had a readmission date of 3/15/19. Diagnoses included but were not limited to, schizophrenia,</p>	F 690	<p>Identification of Deficient Practice(s) and Corrective Action(s): All other residents with a Foley catheter may have been potentially affected. The DON, ADON and or Unit Manager will conduct a 100% review of all residents with a Foley catheter to identify residents at risk. Residents identified will be corrected at time of discovery and disciplinary action with be taken as warranted. A Facility Incident & Accident Form will be completed for each negative finding.</p> <p>Systemic Change(s): The facility Policy and Procedure for Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON on the policy and procedures for proper Foley Catheter care to include the proper anchoring of catheter tubing and proper placement of the drainage bag to prevent infection and injury.</p> <p>Monitoring: The Director of Nursing is responsible for maintaining compliance. The DON and/or Unit Manager will make daily random audits of all Foley/Suprapubic Catheter's to ensure compliance with anchoring of tubing and proper placement of drainage bags to monitor compliance. All negative findings will be corrected at time of discovery. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>		

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F 690	<p>Continued From page 45</p> <p>attention and concentration deficit, anxiety, retention of urine.</p> <p>The clinical record for Resident # 73 was reviewed on 6/25/19 at 4:48 pm. The most recent MDS (minimum data set) assessment for Resident # 73 was a quarterly assessment with an ARD (assessment reference date) of 5/2/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 73's cognitive status was severely impaired. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 73 had an indwelling catheter.</p> <p>The current plan of care for Resident # 73 was reviewed and revised on 5/4/19. The facility staff documented a problem area for Resident # 73 as, "Bowel & Bladder: Resident # 73 is incontinent bowel & currently requires the use of a Foley catheter r/t (related to) stage 2 & 4 pressure area to her buttocks, decrease in mobility & functional status r/t schizophrenia, seizures, MR (mental retardation)/see sct (section) notes for size and description." Interventions included but were not limited to, "Cath care Q (every) shift and prn (as needed) change cath as ordered using sterile technique/anchor foley using leg strap/maintain drainage bag below level of bladder."</p> <p>Resident # 73 had orders that included but was not limited to, "Change f/c (Foley catheter) size 20/30 prn dx (diagnosis) obstructive uropathy," which was initiated by the physician on 3/15/19.</p> <p>On 6/25/19 at 3:28 pm, the surveyor observed Resident # 73 lying in bed. The surveyor observed that Resident # 73's Foley catheter was</p>	F 690		

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F 690	Continued From page 46 not secured and that the urinary drainage bag was touching the floor. On 6/25/19 at 3:38 pm, the surveyor and LPN # 1 (licensed practical nurse) entered Resident # 73's room and observed Resident # 73 lying in bed. The surveyor and LPN # 1 observed that Resident # 73's Foley catheter was not secured and that Resident # 73's urinary drainage bag was touching the floor. The facility policy on "Emptying a Urinary Drainage Bag" contained documentation that included but was not limited to, ..." General Guidelines 9. Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage." ... On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/27/19.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F 693	F693 Corrective Action(s): Residents #73's attending physician has been notified that Resident 73's Gastrostomy Tube became disconnected from the tube feeding and resident #73 did not receive the Tube Feeding per physician order. A facility Incident & Accident form has been completed for this incident.	

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F 693	<p>Continued From page 47</p> <p>condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, clinical record review, staff interview, and facility document review, the facility staff failed to provide appropriate gastrostomy care for 2 of 39 Residents in the survey sample, Resident # 73 and Resident # 115.</p> <p>The findings included:</p> <p>1. The facility staff failed to ensure that Resident # 73 was receiving gastrostomy feedings as ordered.</p> <p>Resident # 73 was a 45-year-old-female who was originally admitted to the facility on 5/11/01, and had a readmission date of 3/15/19. Diagnoses included but were not limited to, schizophrenia, attention and concentration deficit, anxiety, retention of urine.</p> <p>The clinical record for Resident # 73 was reviewed on 6/25/19 at 4:48 pm. The most recent MDS (minimum data set) assessment for Resident # 73 was a quarterly assessment with an ARD (assessment reference date) of 5/2/19. Section C of the MDS assesses cognitive</p>	F 693	<p>Resident #115's enteral feeding set that had an uncovered transition connector was discarded and replaced. A facility Incident and accident form was completed for this incident.</p> <p>Identification of Deficient Practice(s) & Corrective Action(s): All other tube-feeding residents may have been potentially affected. A 100% review of all tube-feeding residents was performed to identify those at risk. Any negative findings will be corrected at the time of discovery and a facility Incident & Accident form will be completed for any/all negative findings.</p> <p>Systemic Change(s): The facility Policy and Procedure was reviewed and no changes are warranted at this time. All licensed staff will be inserviced by the DON and/or the Regional Nurse Consultant on the facility policy and procedure for administration, changing and flushing of gastrostomy tube-feedings, as well as proper documentation for tube-feedings. The Charge nurses will make rounds on each unit daily to monitor compliance.</p>		

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F 693	<p>Continued From page 48</p> <p>patterns. In Section C1000, the facility staff documented that Resident # 73's cognitive status was severely impaired. Section K of the MDS assesses swallowing and nutritional status. In Section K0510, the facility staff documented that Resident # 73 had a feeding tube.</p> <p>The current plan of care for Resident # 73 was reviewed and revised on 5/4/19. The facility staff documented a problem area for Resident # 73 as, "Feeding tube: Resident # 73 requires a feeding tube r/t (related to) dysphagia her CBW (current body weight) is 136#, IBW (ideal body weight) is 140# with a range of (126-154#), chewing & swallowing problems, edentulous, has increase in edema at times in her lower extremities." Interventions included but were not limited to, "Meds as ordered/ feeding as ordered/monitor for & report s/s (signs and symptoms) of intolerance to feedings ie (for example) vomiting, diarrhea, abdominal distension/HOB (head of bed) up at all times during feedings/verify tube placement before hanging feeding or giving meds."</p> <p>Resident # 73 had orders that included but was not limited to, "Nutren 2.0 @ (at) 75 ml/hr (milliliters per hour) via peg tube," which was initiated by the physician on 3/15/19.</p> <p>On 6/25/19 at 3:34 pm, the surveyor observed Resident # 73 lying in bed in her room. The surveyor observed that Resident # 73's feeding was not connected to Resident # 73's gastrostomy tube, and that the feeding had drained on Resident # 73 and in Resident # 73's bed. The surveyor also observed an abdominal binder that was in place around Resident # 73's upper chest. The abdominal binder did not cover Resident # 73's gastrostomy tube.</p>	F 693	<p>Monitoring: The Director of Nursing is responsible for compliance. The DON and or designee will perform 2 random tube feeding audits weekly to monitor for compliance. All negative findings identified during the audit will be corrected at time of discovery and appropriate disciplinary action taken. Detailed findings of these reviews will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>		

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F 693	<p>Continued From page 49</p> <p>On 6/25/19 at 3:38 pm, the surveyor and LPN # 1 (licensed practical nurse) entered Resident # 73's room and observed Resident # 73 lying in bed. The surveyor and LPN # 1 observed that Resident # 73's feeding was not connected to her gastrostomy tube and that Resident # 73's feeding had drained on Resident # 73 and in Resident # 73's bed. LPN # 1 stated, "She wiggles around a lot that's why we put the abdominal binder on her to try to keep things in place." "We will get her cleaned up now."</p> <p>The facility policy on "Enteral Feedings-Safety Precautions" contained documentation that included but was not limited to, ..."Preventing skin breakdown 1. Keep skin around exit site clean, dry and lubricated (as necessary) 2. Assess for leaking around the gastrostomy or jejunostomy frequently during the first 48 hours after tube insertion, and then with each feeding or medication administration." ...</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference on 6/27/19.</p> <p>2 The facility staff failed to ensure that the transitional connector on Resident # 115's enteral feeding set was covered while not in use.</p> <p>Resident # 115 was a 52-year-old-female who was originally admitted to the facility on 1/6/19, and had a readmission date of 5/20/19. Diagnoses included but were not limited to,</p>	F 693			

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F 693	<p>Continued From page 50</p> <p>hypertension, end stage renal disease, anxiety, and anemia.</p> <p>The clinical record for Resident # 115 was reviewed on 6/26/19 at 9:08 am. The most recent MDS (minimum data set) assessment for Resident # 115 was a quarterly assessment with an ARD (assessment reference date) of 5/28/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's cognitive status was severely impaired. Section K of the MDS assesses swallowing and nutritional status. In Section K0510, the facility staff documented that Resident # 115 had a feeding tube.</p> <p>The current plan of care for Resident # 115 was reviewed and revised on 5/30/19. The facility staff documented a problem area for Resident # 115 as, "Nutrition/Feeding Tube/Dehydration: Resident # 115's CBW (current body weight) is 110# with IBW (ideal body weight) 120# she req. (requires) the use of a feeding tube d/t (due to) dysphagia, hx (history of) trach, hx resp (respiratory) failure, anemia, GERD (gastroesophageal reflux disease)/she has her own teeth/rec'd (received) IV (intravenous) meds with prev (previous) hospital adm (admission)/ rec's po (by mouth) diet & is fed per family member/ rec's (receives) ST (speech therapy)." Interventions included but were not limited to, "Feedings per MD (medical doctor) order/ oral care Q (every) shift & PRN (as needed)/verify tube placement before hanging feedings or med administration/monitor I&O (intake and output)/ST as ordered."</p> <p>Resident # 115 had orders that included but was not limited to, "Novasource renal 50 cc/hr (cubic</p>	F 693		

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F 693	Continued From page 51 centimeters per hour) via g-tube via cont (continuous) feeding pump," which was initiated by the physician on 6/20/19. On 6/25/19 at 3:50 pm, the surveyor observed that Resident # 115 was not in her room. The surveyor observed the feeding pump in Resident # 115's room with the enteral feeding set hanging on the pole. The surveyor observed that the transition connector that attaches the feeding to Resident # 115's peg tube was uncovered and was touching the feeding pump. The facility policy on "Enteral Tube Feeding via Continuous Pump" contained documentation that included but was not limited to, ..."General Guidelines 1. Use aseptic technique when preparing or administering enteral feedings." ... On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. The surveyor asked the director of nursing in the presence of the survey team if she expected the transition connector to be covered when enteral feedings were not being administered. The director of nursing stated, "Yes." No further information regarding this issue was provided to the survey team prior to the exit conference on 6/27/19.	F 693			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695	F695 Corrective Action(s) Resident #73's attending physician has been notified that the facility failed to ensure oxygen was administered at all times as ordered by the physician and the facility failed to properly store their Nebulizer mask and tubing. A Facility Incident & Accident form was completed for this incident.		

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F 695	<p>Continued From page 52</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, clinical record review, and staff interview, the facility staff failed to properly maintain respiratory care equipment, and failed to provide respiratory care services for 1 of 39 Residents in the survey sample, Resident # 73.</p> <p>The findings included:</p> <p>The facility staff failed to ensure that Resident # 73 was receiving oxygen as ordered and failed to ensure that Resident #73's nebulizer connections were covered and that nebulizer tubing was off the floor.</p> <p>Resident # 73 was a 45-year-old-female who was originally admitted to the facility on 5/11/01, and had a readmission date of 3/15/19. Diagnoses included but were not limited to, schizophrenia, attention and concentration deficit, anxiety, retention of urine.</p> <p>The clinical record for Resident # 73 was reviewed on 6/25/19 at 4:48 pm. The most recent MDS (minimum data set) assessment for Resident # 73 was a quarterly assessment with an ARD (assessment reference date) of 5/2/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 73's cognitive status was severely impaired. Section O of the MDS assesses special treatments, procedures, and programs. In Section O0100, the facility staff</p>	F 695	<p>Identification of Deficient Practice & Corrective Action(s): All other resident receiving physician ordered oxygen and nebulizer treatments may have potentially been affected. A 100% review of all residents with physician ordered oxygen and nebulizer treatments was conducted to identify any/all residents at risk. Any negative findings were corrected at time of discovery and new oxygen and nebulizer equipment was obtained and dated and stored correctly as needed. A facility Incident & Accident form will be completed for each negative finding.</p> <p>Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing staff will be inserviced by the DON on the proper procedure for administering oxygen per physician order as well as proper cleaning, changing and storing of Oxygen equipment to include cleaning concentrators and storage of nasal cannulas and nebulizer tubing and masks when not in use.</p> <p>Monitoring: The DON and/or Unit Manager is responsible for maintaining compliance. The DON or Unit Manager will make rounds three times a week to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>	

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F 695	<p>Continued From page 53</p> <p>documented that Resident # 73 had received oxygen therapy within the last 14 days during the look back period of the 5/2/19 ARD.</p> <p>The current plan of care for Resident # 73 was reviewed and revised on 5/4/19. The facility staff documented a problem area for Resident # 73 as, "Respiratory: Resident # 73 has impaired respiratory status r/t (related to) tracheostomy s/t (secondary to) respiratory failure has a hx of pseudomosis of the sputum, resolved as of CP (care plan) date." Interventions included but were not limited to, "Suction as ordered & prm (as needed) trach care Q (every) shift & PRN (as needed) using strict sterile technique O2 (oxygen) as ordered/assess for s/s of increase circulation or O2 impairment ie (for example) cyanosis, low SPO2 (peripheral capillary oxygen saturation), labored breathing, Ect (excetra)."</p> <p>Resident # 73 had orders that included but were not limited to, "O2 @ (at) 3lpm (3 liters per minute) via trach mask Q shift," which was initiated by the physician on 3/15/19, and "Iprat-albut 0.5-3(2.5) mg/3 ML (milligrams per 3 milliliters) take 3 ML via inhalation Q 6 hours dx: wheezing/pneumonia," which was initiated by the physician on 3/19/19.</p> <p>On 6/25/19 at 3:23 pm, the surveyor observed Resident # 73 lying in bed. The surveyor observed that Resident # 73 had a tracheostomy and that a trach mash was around Resident # 73's neck, however the mask was observed by the surveyor in place on Resident # 73's mid chest. Upon further observation, the surveyor observed that the tubing that connected the oxygen from the oxygen concentrator to the connector on the trach mask was not attached</p>	F 695			

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F 695	<p>Continued From page 54</p> <p>and Resident # 73 was not receiving oxygen. The surveyor also observed nebulizer administration equipment on Resident # 73's nightstand that was uncovered and nebulizer tubing was observed lying on the floor.</p> <p>On 6/25/19 at 3:40 pm, LPN # 1 (licensed practical nurse) and the surveyor observed Resident # 73 in bed in her room. The surveyor and LPN # 1 observed that Resident # 73 was not receiving oxygen and that nebulizer supplies were uncovered on Resident # 73's nightstand, and observed nebulizer tubing lying on the floor. The surveyor observed LPN # 1 reconnect the oxygen to Resident # 73. The surveyor asked LPN # 1 if the nebulizer supplies should be uncovered and if the nebulizer tubing should be lying on the floor. LPN # 1 stated, "No, I will take care of it."</p> <p>On 6/26/19 at 10:24 am, the surveyor observed nebulizer supplies on Resident # 73's nightstand that was uncovered. The surveyor also observed that the trach collar was located on Resident # 73's right upper chest and was not covering the tracheostomy.</p> <p>The facility policy on "Departmental (Respiratory Therapy)-Prevention of Infection" contained documentation that included but was not limited to, ..."Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name between uses." ...</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above.</p> <p>No further information regarding this issue was</p>	F 695			

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F 695	Continued From page 55 provided to the survey team prior to the exit conference on 6/27/19.	F 695			
F 698 SS=D	<p>Dialysis CFR(s): 483.25(l)</p> <p>§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, Resident Representative interview, and facility document review, the facility staff failed to ensure that 1 of 39 Residents in the survey sample received dialysis services in accordance with professional standards of practice, Resident # 115.</p> <p>The findings included:</p> <p>The facility staff failed to ensure that Resident # 115 had an order for dialysis, and failed to ensure that the facility staff was monitoring the dialysis site.</p> <p>Resident # 115 was a 52-year-old-female who was originally admitted to the facility on 1/6/19, and had a readmission date of 5/20/19. Diagnoses included but were not limited to, hypertension, end stage renal disease, anxiety, and anemia.</p> <p>The clinical record for Resident # 115 was reviewed on 6/26/19 at 9:08 am. The most recent MDS (minimum data set) assessment for Resident # 115 was a quarterly assessment with</p>	F 698	<p>F698</p> <p>Corrective Action(s): Resident #115's attending physician was notified that the facility failed to ensure resident #115 had an order for dialysis services and the facility staff failed to ensure an order to assess the dialysis site was present in the medical record. Resident #115's Dialysis orders have been obtained as well as an order to monitor dialysis site every shift. A facility Incident & Accident Form was completed for this incident</p> <p>Identification of Deficient Practices/Corrective Action(s): All other residents on dialysis may have potentially beenaffected. The DON, and/or Unit Managers will conduct a 100% audit of all residents on dialysis to identify residents at risk. Residents identified at risk will be corrected at time of discovery. A facility Incident & Accident Form will be completed for each negative finding.</p> <p>Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON will inservice all licensed staff on the policy and procedure for obtaining dialysis orders for treatment and for proper monitoring and assessing resident dialysis sites every shift.</p>		

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F 698	<p>Continued From page 56</p> <p>an ARD (assessment reference date) of 5/28/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 115's cognitive status was severely impaired. Section O of the MDS assesses special treatments, procedures, and programs. In Section O0100, the facility staff documented that Resident # 115 had received dialysis within the last 14 days during the look back period for the 5/28/19 ARD.</p> <p>The current plan of care for Resident # 115 was reviewed and revised on 5/30/19. The facility staff documented a problem area for Resident # 115 as, "Bowel/Bladder: Resident # 115 is freq (frequently) inc (incontinent) urine & inc bowel r/t (related to) muscle weakness/ESRD (end stage renal disease), chronic kidney disease, lack of coordination, GERD (gastroesophageal reflux disease), epilepsy/She req dialysis & rec's (received) before adm (admission) to facility." Interventions included but were not limited to, "Meds/labs as ordered inform MD (medical doctor) of any changes, monitor for s/s (signs and symptoms) of UTI (urinary tract infections), impaction or constipation."</p> <p>On 6/26/19 at 8:19 am, the surveyor was in Resident # 115's room conducting an interview with her Resident representative. The surveyor asked Resident # 115's representative if Resident # 115 went to dialysis. Resident # 115's representative stated, "Yes she goes on Tuesdays, Thursdays, and Saturdays."</p> <p>On 6/26/19 at 8:33 am, the surveyor reviewed the current physician's orders for Resident # 115. Upon review of Resident # 115's current physician's orders, the surveyor did not locate</p>	F 698	<p>Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly coinciding with the Care Plan calendar in order to maintain compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>		

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F 698	Continued From page 57 orders for dialysis or orders to assess the dialysis site. The facility policy on "Hemodialysis Access Care" contained documentation that included but was not limited to, ..."Documentation The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter 2. Condition of dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis." ... On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/27/19.	F 698		
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	F 758	F 758 Corrective Action(s): Resident 65's attending physician was notified that facility staff failed to monitor resident #65 for side effects and effectiveness of the physician ordered Remeron, Rozerem, and Sertraline. Resident 65's physician has reviewed resident 65's medication regime and no adjustments to the medication regime are required. A facility Incident & Accident form was completed for this incident.	

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F 758	Continued From page 58 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 §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 clinical record review, staff interview,	F 758	Resident 368's attending physician was notified that facility staff failed to assess and attempt non-pharmacological interventions prior to initiating antipsychotic medications. A facility Incident & Accident form was completed for this incident Identification of Deficient Practice(s) and Corrective Action(s): All other residents receiving psychotropic medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic medication to identify residents without appropriate psychotropic medication monitoring. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring for behaviors, side effects and effectiveness of psychotropic medications.		

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F 758	<p>Continued From page 59</p> <p>facility document review, and over the course of a complaint investigation, the facility staff failed to ensure that 2 of 39 Residents in the survey sample were free of unnecessary psychotropic medications, Resident # 65 and Resident # 368.</p> <p>The findings included:</p> <p>1. The facility staff failed to monitor Resident # 65 for side effects and effectiveness associated with the use of Rozerm, Remeron, and Sertraline.</p> <p>Resident # 65 was a 39-year-old-female who was originally admitted to the facility on 9/20/15, and had a readmission date of 5/29/19. Diagnoses included but were not limited to, anemia, type 2 diabetes, major depressive disorder, anxiety, and insomnia.</p> <p>The clinical record for Resident # 65 was reviewed on 6/26/19 at 10:52 am. The most recent MDS (minimum data set) assessment for Resident # 65 was a quarterly assessment with an ARD (assessment reference date) of 5/1/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 65 had a BIMS score (brief interview for mental status) of 15 out of 15, which indicated that Resident # 65 was cognitively intact.</p> <p>The current plan of care was reviewed and revised on 5/28/19. The facility staff documented a problem area for Resident # 65 as, "Psychotropic: Resident # 65 has a dx (diagnosis) of depression, anxiety, suicidal attempt & adjustment d/o (disorder) with severe depression & receives psychotropic meds daily, has a hx (history) of suicide attempt x 2, hx pacing in her</p>	F 758	<p>Monitoring:</p> <p>The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will complete weekly physician orders and MAR audits on all residents receiving psychotropic medications to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.</p> <p>Completion Date: 8/11/19</p>		

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F 758	<p>Continued From page 60</p> <p>w/c (wheelchair), refuses a meal at times, & disruptive & a hx of rummaging/will ref meds at X's (times) Rec's (receives) abt (antibiotics) d/t (due to) UTI (urinary tract infection)."</p> <p>Interventions included but were not limited to, "Meds as ordered/pharmacist will review med regimen monthly to establish an appropriate dose reduction, elimination plan/assess for medical conditions ie (for example) infection hypo/hyperglycemia, ect that may be causing increased confusion or behavioral disturbances."</p> <p>Resident # 65 had orders that included but was not limited to, "Remeron 15 mg (milligram) tablet 1 po (by mouth) Q HS (at bedtime) dx depression," "Rozerem 8 mg tablet 1 po Q HS dx insomnia," and "Sertraline HCL 100 mg tablet 1 po Q (every) day dx depression." All orders listed above were initiated by the physician on 5/29/19.</p> <p>On 6/26/19 at 10:55 am, the surveyor reviewed the June 2019 medication administration record for Resident # 65. The surveyor did not observe any documentation on Resident # 65's June 2019 medication administration record that reflected that the facility staff had monitored Resident # 65 for side effects and effectiveness associated with the use of Remeron, Rozerem, and Sertraline. The surveyor reviewed the clinical record further for Resident # 65 and did not locate documentation that indicated that Resident # 65 had been monitored for side effects and effectiveness associated with the use of Remeron, Rozerem, and Sertraline.</p> <p>On 6/26/19 at 4:55 pm, the administrative team was made aware of the findings as stated above.</p> <p>No further information regarding this issue was</p>	F 758			

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F 758	<p>Continued From page 61 provided to the survey team prior to the exit conference on 6/27/19.</p> <p>2. The facility staff failed to assess Resident # 368 for underlying conditions associated with aggressive and combative behaviors prior to initiating antipsychotic medications.</p> <p>Resident # 368 was a 77-year-old-male who was originally admitted to the facility on 2/22/19, with a readmission date of 3/21/19. Diagnoses included but were not limited to, urinary tract infection, dementia, altered mental status, and type 2 diabetes mellitus.</p> <p>The clinical record for Resident # 368 was reviewed on 6/25/19 at 4:02 pm. The most recent MDS (minimum data set) assessment for Resident # 368 was an admission assessment with an ARD (assessment reference date) of 3/1/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 368 had a BIMS score of 5 out of 15, which indicated that Resident # 368's cognitive status was severely impaired. Section E of the MDS assesses behaviors. In Section E0200, the facility staff documented that Resident # 368 displayed physical and verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others on 1 to 3 days during the look back period for the 3/1/19 ARD. In Section E0600, the facility staff documented that Resident #368's identified symptoms put others at significant risk for physical injury.</p> <p>The plan of care for Resident #368 had been reviewed and revised on 3/5/19. The facility staff documented a problem area for Resident # 368</p>	F 758			

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F 758	<p>Continued From page 62</p> <p>as, "Psychotropic Drug Use/Behavior: Resident # 368 is alert with confusion. He is easily agitated has a history of verbal and physical aggression, cursing, hitting staff, and other residents, throw objects, rummaging, yelling and kicking DX: (diagnosis) dementia, AMS (altered mental status) symbolic dysfunctions." Upon review of the interventions documented for Resident # 368, the surveyor did not observe any Resident centered non-pharmacological interventions utilized to attempt to decrease Resident # 368's combative behaviors.</p> <p>The surveyor reviewed the admission orders for Resident # 368 and did not observe any antipsychotic medications ordered for Resident # 368 upon his initial admission to the facility on 2/22/19.</p> <p>The surveyor observed a nursing note documented in Resident # 368's clinical record that had been documented on 2/24/19 at 12:19 am. The nursing note stated, "Resident resting in bed at present, up earlier wandering hallways stated he needed to go to court. Explained to resident that it was the middle of the night and there was no court this late at night. Resident voiced understanding and went back to room. Remains on abt (antibiotic) therapy d/t (due to) pneumonia, no adverse reactions noted. Will monitor."</p> <p>The surveyor observed a nursing note documented in Resident # 368's clinical record that was documented on 2/24/19 at 3:04 am. The nursing note stated, "Resident up wandering in and out of other resident's rooms, upon redirection resident noted to get verbally aggressive with staff, resident very hard to redirect, snacks given and accepted but</p>	F 758			

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F 758	<p>Continued From page 63 continues to wander hallways will monitor."</p> <p>A nursing note was documented on 2/24/19 at 10:16 am. The nursing note stated, "Pt (patient) is exit seeking behavior/ goes from one unit door, to the next door. States "I want to get on that road out there do you see it?" Pt can become combative at times and at times is hard to redirect also wandering into other patient's rooms Will cont (continue) to redirect."</p> <p>A nursing note documented on 2/24/19 at 3:13 pm stated, "Right after family members arrived & gave pt his cane, he walked straight to Resident # 49 (unsampled) and tried to strike him with his cane. Resident # 49 then became upset & got up but by the time Resident # 49 got to the door Resident # 368's family member had gotten him out of Resident # 49's room. Pt could have been upset from earlier incident 1045 when he went to the back doors to look outside and Resident # 49 came out yelling at him. Family states they don't feel that it is safe to leave him here (Employee's name withheld) notified and pt changed rooms." The surveyor observed a physician's telephone order sheet that was written on 2/25/19 that contained an order for Abilify 2.5 mg (milligram) po (by mouth) daily.</p> <p>A physician's telephone order sheet was written on 2/25/19 that contained an order for Haldol 0.5 mg (milligram) give 1 dose po (by mouth) now if unable give IM-now dx (diagnosis) aggressive behavior.</p> <p>A nursing note was documented on 2/26/19 at 1:26 am. The nursing note was documented as, "2130 (9:30 pm) Pt up walking in facility screaming and cursing that he wants to smoke he</p>	F 758			

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F 758	<p>Continued From page 64</p> <p>is throwing objects anything that he can find off the nurse station, linen carts, nurses cart, he has hit a fer pt, several staff. The staff has offered to take him out to smoke to redirect him. It just made him more upset when we offered him a cig. I offered him his tobacco he hit me multiple times with it. 2200 (10:00 pm) I call (Physician's name withheld) received an order for a one time dose of Haldol This dose does not seem to help the pt he has cont to hit staff and take his fist to the painting on the wall. Tried to bust the windows out of the doors and trying to leave the facility. I called the family RP (responsible party) She stated that he was hitting her yesterday and I could try talking to him about working in the coal mines or on the farm. The pt cont to hit staff and throw objects at staff and other pt. I called (Physician's name withheld) 2400 (12:00 am) received n/o (new order) for haldol. 0100 (1:00 am) pt is calmer sitting in his room watching tv at this time will cont to monitor cb (call bell) in reach."</p> <p>The surveyor observed a physician's telephone order sheet that was written on 2/26/19. The surveyor observed that the nurse signed the telephone order at 1700 (5:00 pm). An order was written for Haldol 1 mg IM (intramuscular) QHS (every night at bedtime) PRN (as needed) for aggressive behavior. The surveyor observed that this prn antipsychotic order did not have a stop date.</p> <p>The surveyor observed another physician's telephone order that was written on 2/26/19. The surveyor observed that the nurse signed the telephone order at 2400 (12:00 am). An order was written for Haldol 1 mg IM now-dx aggressive behavior.</p> <p>The surveyor observed a physician's telephone</p>	F 758			

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F 758	<p>Continued From page 65</p> <p>order that was written on 3/1/19. The nurse signed the telephone order at 0947 (9:47 am). An order was written to increase Abilify to 5 mg po daily and Haldol 1 mg IM Q 8 hours PRN for aggressive behavior. The surveyor observed that the pm antipsychotic order did not have a stop date.</p> <p>The surveyor observed a physician's telephone order that was written on 3/4/19. The nurse signed the telephone order at 0625 (6:25 am). An order was written for Haldol 2 mg IM PRN for one dose d/t (due to) excessive agitation.</p> <p>A nursing note was documented on 3/4/19 at 6:55 am. The nursing note stated, "For 0610 (6:10 am) res going up and down hallway cursing at staff went into other res room that res started cursing at staff going into other res rooms yelling and cursing at other res to get out of the rooms unable to redirect. Res went into another res room told him to get out and grabbed at res ankles but staff was with res and got res away from another res before anything could happen res back out in hallway cursing hitting and kicking at staff res attempted to hit this nurse with bottle tc (telephone call) to (Physician's name withheld) with orders receive to give res 1 time order of Haldol 2 mg shot given per staff.</p> <p>An administration note was documented on 3/10/19 at 12:48 am. The administration note stated, "Haldol 5 mg/ml (milliliter) ampul Give 2 mg IM x 1 do ... given at this time d/t increased agitation trying to hit staff, spitting at staff, going into other residents rooms trying to get them out of bed, shaking rails on porch area. Shot given IM in left deltoid after explaining the procedure."</p> <p>A nursing note documented on 3/10/19 at 6:40</p>	F 758			

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F 758	<p>Continued From page 66</p> <p>am, stated, "2430 (12:30 am) On call md (medical doctor) notified of resident becoming increasingly agitated trying to hit staff, spitting at staff, going into other residents rooms trying to get them out of the bed. Shaking the rails on the porch area unable to redirect. New order from (Physician's name withheld) Haldol 2 mg in now x 1 dose notify if not relief."</p> <p>A nursing note was documented on 3/10/19 at 1:00 pm that stated, "Resident became extremely agitated earlier and punched his roommate in the face and left leg, threw water pitcher, tried to void on roommate and walked out into hallway into other residents room trying to grab and hit them. Family MD, DON (director of nursing) notified and (Facility name withheld) crisis worker along with LPN (licensed practical nurse and resident sent out at 1250 (12:50 pm) hours for psych eval at hospital."</p> <p>A nursing note was documented on 3/10/19 at 3:35 pm stated, "Hospital called to give report on pt coming back dx severe UTI (urinary tract infection) stated they gave him 1 gm (gram) Rocephin and Keflex."</p> <p>A nursing note documented on 3/10/19 at 4:49 pm, stated "New order rcvd (received) from hospital, Cephalexin (Keflex) 500 mg capsule take 1 capsule by mouth 4 times a day x 10 days qty 40 dx uti."</p> <p>The facility policy on "Antipsychotic Medication Use" contained documentation that included but was not limited to, ..."9. For acute psychiatric situations, antipsychotics medications use shall meet the following criteria:</p>	F 758			

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F 758	<p>Continued From page 67</p> <p>a. The acute treatment period is limited to 7 days or less; and A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days, to identify and address any contributing and underlying causes of acute psychiatric condition and verify the continued need for antipsychotic medication.</p> <p>10. For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are:</p> <p>a. Not due to a medical condition or problem (e.g., headache or joint pain, fluid or electrolyte imbalance, pneumonia, hypoxia, unrecognized hearing or visual impairment) that can be expected to improve or resolve as the underlying condition is treated</p> <p>d. Not due to environmental stressors (e.g., alteration in the resident's customary location or daily routine, unfamiliar care provider, hunger or thirst, excessive noise for the individual, inadequate or inappropriate staff response, physical barriers) that can be addressed to improve the psychotic symptoms or maintain safety; and</p> <p>e. Not due to psychological stressors (e.g., loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g., the mistaken belief that this is not where je/she lives or inability to find his or her clothes or glasses) that can be expected to improve or resolve as the situation is addressed." ...</p> <p>On 6/27/19 at 11:43 am, the administrative team was made aware of the findings as stated above. The administrator voiced understanding.</p> <p>No further information regarding this issue was presented to the survey team prior to the exit</p>	F 758			

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F 758	Continued From page 68 conference on 6/27/19.	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, clinical record review and in the course of a complaint survey the facility staff failed to ensure 2 of 39 Residents were free of significant medication errors, Resident #19 and Resident #117. The findings included: 1. For Resident #19 the facility staff administered another Resident's medications to Resident #19 in error. Resident #19 was admitted to the facility on 08/31/09. Diagnoses included but not limited to hypertension, peripheral vascular disease, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, cerebrovascular accident, hemiplegia, respiratory failure, and dementia. The most recent yearly MDS (minimum data set) with an ARD (assessment reference date) of 04/02/19 assigned the Resident a BIMS (brief interview for mental status) of 05 out of 15 in Section C, cognitive patterns. Surveyor spoke with the DON (director of nursing) on 06/26/19 at approximately 1530 regarding Resident #19. DON stated that	F 760	F760 Corrective Action(s): Resident #19's attending physician has been notified that the facility administered the incorrect medication to resident #19. The nursing staff received inservice training from the DON on the 5 rights of medication administration. A facility Medication error form was completed for each incident. Resident #117's attending physician has been notified that the facility staff held Levemir insulin without a physician order. A facility Medication error form was completed for each incident Identification of Deficient Practice(s) and Corrective Action(s): All other residents receiving physician ordered medications may have potentially been affected. A 100% medication order review has been completed to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action and inservice training will be administered as warranted. An Incident and Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed Nursing staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of sliding scale insulin per physician order.		

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F 760	<p>Continued From page 69</p> <p>Resident had received another Resident's medication on 05/02/19 for the evening medications. DON provided the surveyor with a written statement, which read in part "On 05-2-19 at approximately 7:30, I received a phone call at home from ...(name omitted), LPN (licensed practical nurse). ...(name omitted) was upset and stated she had given ...(Resident #19) the wrong medication. Stated that another Resident had fallen in the floor and she was assisting with that. Also stated when she came out of Resident's room, there were several patients lined up in hallway wanting their medication. ...(name omitted) stated she pulled another Resident's meds and Resident ...(Resident #19) came to her and was yelling she wanted her meds and she accidentally gave ...(Resident #19) the wrong medication. I advised her to check allergies and contact MD as soon as possible (now)." The DON stated that she did re-education on medication administration with all nurses in the facility, and provided the surveyor with a copy of an inservice form dated 05/06/19.</p> <p>Surveyor was unable to speak with the LPN who accidentally administered the wrong medications.</p> <p>Resident #19's clinical record was reviewed on 06/26/19. It contained nurse's progress notes, which read in part "5/2/2019 11:25 PM 1900 Called ...(MD name omitted) new orders neuro checks started as ordered will cont to monitor", "5/3/2019 2:30 AM Resident in bed at present very legargic (sic) and not easily aroused VSS (vital signs stable) Neuro Checks done per order.02 in use.Will continue to monitor", "5/3/2019 6:24 AM Notified ...(MD name omitted) this AM concerning Resident being legargic (sic) throughout the night. New order received to Draw</p>	F 760	<p>Monitoring: The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will perform 2 random weekly Medication Pass audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>	

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F 760	Continued From page 70 Stat BMP (basic metabolic panel) NPO (nothing by mouth) until further noticed and May start INT (intermittent needle therapy) if needed pending lab", "5/3/2019 6:34 AM Notified (RP) [responsible party] ... (name omitted) made aware this am", "5/3/2019 12:46 PM @ 0900 ...(MD name omitted) in to see Resident new orders change neb tx (treatment) q (every 4 hrs x 48 hrs, when able assist Resident to drink fluids try get in 1000cc via 6pm, notify ...(MD name omitted) unable to start fluids by 2pm. Daughter ...(name omitted) aware of new orders and spoke with ... (MD name omitted)", "5/3/2019 4:39PM @ 1400 Received new orders per ...(MD name omitted) for 250cc NS (normal saline) IV bolus call Md for further orders", "5/3/2019 6:06 PM patient drowsy at this time unable to go pace pace notified by ... (MD name omitted) she is lethargic md visited vitals taken as previous recorded 172/92 initial this am 830am 1170/78 she is still drowsy but able to respond unable to adm meds this am due to drowsiness and to hold at this time per order in a couple hrs attempt to give water takes small sips only and continue to try every hr and small sips taken at this time able to arouse Resident she is getting irritated when ask to respond by calling her name leave me alone she responds patient back to sleep no meds given this am per order". "5/3/2019 6:11 PM around 200PM order received for meds as ordered and were given at this time swallowing without problems now and responding to questions asked by this nurse", "5/3/2019 10:16 PM Vitals obtained per MD order, every 2 hours until 2200, when vitals are to be obtained at 2200 and every 4 hours after 2200. Resident has became more alert, able to take po medics (crushed in applesauce). Resident's blood pressure has been elevated with pulse, respiration rate, oxygen saturation% and	F 760			

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F 760	<p>Continued From page 71</p> <p>temperature within normal limits. MD aware of vitals. Resident is stable at this time. Resident has been verbal. Slight confusion as to time of day. Will continue to monitor" and "5/4/2019 3:43 PM Resident now requesting to be dressed and gotten up in w/c (wheelchair). Request granted, staff dressed Resident and assisted her into w/c. More like her old self at this time. Will continue to monitor. CB (call bell) in reach".</p> <p>The concern of administering the wrong medications was discussed with the administrative team during a meeting on 06/27/19 at approximately 1230.</p> <p>No further information was provided prior to exit.</p> <p>THIS IS A COMPLAINT DEFICIENCY</p> <p>2. For Resident #117 the facility staff held the long-acting insulin, Levemir, without a physician's order.</p> <p>Resident #117 was admitted to the facility on 03/31/17. Diagnoses included but not limited to congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, psychotic disorder and chronic obstructive pulmonary disease.</p> <p>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/28/19 assigned the Resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, cognitive patterns.</p> <p>Resident #117's clinical record was reviewed on 06/26/19. It contained a signed physician's order</p>	F 760		

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F 760	<p>Continued From page 72</p> <p>summary for the month of May 2019, which read in part "Levemir 100 units/ml vial give 55 units Q (every) 12 hours". Resident #117's eMAR (electronic medication administration record) for the month of June 2019 was reviewed. It contained an entry, which read in part "Levemir 100 units/ml vial give 55 units Q (every) 12 hours". This entry was initialed with "N" on 06/09/19 and 06/10/19 at 9:00PM. The administration record notes contained entries for these dates, which read in part "9:27PM, 6/09/19 (Scheduled: 9:00PM, 6/09/19; Levemir 100 unit/ml vial) Levemir 100 unit/ml vial sq (subcutaneously) give 55 uni...scheduled for 06.09/2019 9:00 was not administered-Other.special requirement not met." and " 9:35PM, 6/10/19 (Scheduled: 09:00PM, 6/10/19; Levemir 100 unit/ml vial) Levemir 100 units/ml vial sq given 55 uni... scheduled for 06/10/2019 9:00PM was not administered-Other.special requirement not met".</p> <p>Surveyor spoke with the DON (director of nursing) on 06/27/19 at approximately 1055 regarding Resident #117. Surveyor asked DON what "N" on the eMAR stood for, and DON responded that it meant the medication was not administered. Surveyor then asked the DON of Resident #117's insulin should have been held, and the DON stated that it should have been administered as ordered.</p> <p>The concern of holding the Resident's insulin without a physician's order was discussed with the administrative team during a meeting on 06/27/19 at approximately 1230.</p> <p>No further information was provided prior to exit.</p>	F 760		

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F 761 F 761 SS=D	Continued From page 73 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to store medications appropriately for 1 of 39 Residents (Resident #27), on 1 of 4 medication carts, and in 1 of 2 medication rooms. The findings included: 1. For Resident #27, the facility staff failed to	F 761 F 761	F761 Corrective Action(s): The 3 unopened vials of ipratropium bromide/albuterol were removed from Resident #27's over-bed table. A facility incident & accident report was completed for this incident. The South back side medication cart found to have loose pills, expired & undated mineral oil, and open Budesonide Inhalation suspension has been removed and the medication cart was thoroughly cleaned. A Facility Incident & Accident form was completed for this incident. Identification of Deficient Practices & Corrective Action(s): All unit Medication Carts and resident rooms may have been potentially affected. The DON and/or designee will conduct a 100% review of all licensed nurses during medication passes to identify any medication carts that are left unlocked unattended during medication passes. A 100% review of all resident rooms will be completed to identify any resident rooms with medications or biologicals left in the resident rooms unattended. Any/all negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each incident identified.		

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F 761	<p>Continued From page 74</p> <p>securely store the resident's medication. The resident had three unopened vials of ipratropium bromide/albuterol on his over the bed table.</p> <p>The clinical record review revealed that Resident #27 had been admitted to the facility 10/06/14. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertensive heart disease, diabetes, glaucoma, and peripheral vascular disease.</p> <p>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/04/19 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points.</p> <p>The resident's comprehensive care plan included the focus areas cognitive loss, alteration in vision, hard of hearing, and alteration in respiratory status.</p> <p>During initial tour of the facility on 06/25/19 at approximately 11:30 a.m., the surveyors observed 3 unopened vials of ipratropium bromide/albuterol on the Residents over the bed table. The surveyor observed 3 unopened vials of the same medication on 06/25/19 at 3:11 p.m. and again on 06/26/19 at 7:47 a.m. The Residents roommate was observed to be in this room during these observations.</p> <p>On 06/26/19 at 8:35 a.m., LPN (licensed practical nurse) #1 was asked about the medication and stated the resident could cut his nebulizer machine off and on but she did not leave the medication in his room.</p>	F 761	<p>Systemic Change(s): Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON and/or regional nurse consultant on the facility policy and procedure for storing medications and biological to include not leaving medications on the medication carts or in resident rooms unattended. The Pharmacy consultant will check each medication carts and medication room for improper storage of medications monthly during scheduled visits.</p> <p>Monitoring: The DON is responsible for maintaining compliance. The DON or Unit Manager will perform 3 random weekly audits of medication carts, medication rooms, and resident rooms to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and appropriate disciplinary action taken as warranted. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>		

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F 761	<p>Continued From page 75</p> <p>LPN #1 verbalized to the surveyor that she had removed the medication from the Residents room.</p> <p>The facility policy/procedure titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" read in part, "...Facility should ensure that all medications and biologicals...are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors..."</p> <p>The clinical record did not include any information to indicate this Resident had been assessed for self-administration of medications.</p> <p>The administrative staff were notified of the unsecured medications during a meeting with the survey team on 06/26/19 at 2:44 p.m.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference.</p> <p>2. The facility staff failed to ensure that medications were stored and labeled appropriately, and failed to discard expired medications.</p> <p>On 6/27/19 at 9:04 am, the surveyor inspected the south back medication cart with LPN # 2 (licensed practical nurse). Upon inspection of the medication cart, the surveyor observed 8 loose pills, and open 16-ounce bottle of mineral oil that did not have the date opened documented on the bottle. The surveyor also observed an expiration date of 4/2019 printed on the bottle of mineral oil. The surveyor also observed a package of Budesonide Inhalation Suspension 0.25 mg (milligram)/ 2 ml (milliliter) that had been opened</p>	F 761			

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F 761	<p>Continued From page 76</p> <p>and was not dated. The surveyor counted the narcotic medication on the medication cart with LPN # 2. While counting the medication, the surveyor observed documentation on the controlled substance log for Resident # S1 (not sampled), that reflected that 39 1 mg Clonazepam were in the medication bottle. While counting the medication with LPN # 2, the surveyor observed 38 blue tablets, and 1 yellow tablet. LPN # 2 stated to the surveyor, "She brought these in from home this way, and we just counted it." The surveyor asked LPN # 2 if there was any documentation that supported what she had reported to the surveyor regarding the clonazepam discrepancy. LPN # 2 stated that she would check and get back with the surveyor.</p> <p>On 6/27/19 at 10:04 am, the surveyor inspected the medication room on the skilled hall along with the unit manager LPN # 3. Upon inspection of the refrigerator in the medication room, the surveyor observed a Novolog flexpen that had date opened as 5/29/18. Instructions on the Novolog Flexpen stated, "Discard 28 days after use."</p> <p>Documentation on the package of Budesonide Inhalation Suspension contained documentation that included but was not limited to, "Once the foil envelope is opened, use the vials within 2 weeks."</p> <p>The facility policy on "Storage and Expiration of Medications, Biologicals, Syringes and Needles contained documentation that included but was not limited to, ..."2. Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding.</p>	F 761		

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F 761	Continued From page 77 4. Facility should ensure that medication and biologicals: 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility should record the date opened on the medication container when the medication has a shortened expiration date once opened." ... On 6/27/19 at 11:43 am, the administrative team was made aware of the findings as stated above. The surveyor asked the director of nursing if she could locate any documentation regarding the discrepancy noted with the clonazepam on the south back medication cart. On 6/27/19 at 12:07 pm, the director of nursing informed the surveyor that there was no documentation regarding the discrepancy with the clonazepam on the south back medication cart. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/27/19.	F 761			
F 836 SS=F	License/Comply w/ Fed/State/Local Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in	F 836	F836 Corrective Action(s) The facility administrator and the admission department have registered with the Virginia State Police Sex Offender registry and are set to receive automatic notifications of registration of any sex offenders in the contiguous zip codes. A Facility Incident & Accident form was completed for this incident.		

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F 836	<p>Continued From page 78</p> <p>compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.</p> <p>§483.70(c) Relationship to Other HHS Regulations.</p> <p>In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, clinical record review, facility document review, the Code of Virginia, and during the course of a complaint investigation, the facility staff failed to comply with state laws in regards to registering with the Virginia State Police Sex Offender registry to receive automatic notifications of registration/re-registration of any sex offender with the same or a contiguous zip code and failed to determine prior to admission if a potential Resident was a registered sex offender for 1 of 39 Residents, Resident # 59.</p>	F 836	<p>Identification of Deficient Practice & Corrective Action(s): All other residents may have potentially been affected. The Admissions Department will review 100% of the last 90 days of admission to identify residents that were not prescreened on the Virginia State Police Sex offender registry prior to admission. Any negative findings will be corrected at time of discovery and a risk management form was completed.</p> <p>Systemic Change(s): The administrator will inservice the admissions and social services departments on the policy and procedure for reviewing the Virginia State Sex Offender registry prior to potential new admissions being admitted to check if they are a registered sex offender.</p> <p>Monitoring: The Admissions Director and Administrator are responsible for maintaining compliance. The Admissions director will audit all new admissions weekly to ensure that the Virginia State Police Registry was checked prior to placement in the facility. Aggregate findings of these audits will be forwarded to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>		

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F 836	Continued From page 79 The findings included: The facility staff failed to register with the Virginia State Police Sex Offender registry to receive automatic notifications of registration/re-registration of any sex offender with the same or a contiguous zip code and failed to determine prior to admission if a potential Resident was a registered sex offender. Per the Code of Virginia-12 VAC 5-371-150. (Resident Rights) The nursing facility shall develop and implement policies and procedures that ensure Resident's rights as defined in §§ 32.1-138 and 32.1-138.1 of the Code of Virginia. The nursing facility shall certify, in writing, that it is in compliance with the provisions of §§ 32.1-138 and 32.1-138.1 of the Code of Virginia, relative to resident rights, as a condition of license issuance or renewal. The nursing facility shall register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the facility is located pursuant to § 9.1-914 of the Code of Virginia. Prior to admission, each nursing facility shall determine if a potential resident is a registered sex offender when the potential resident is anticipated to have a length of stay: Greater than three days; or in fact stays longer than three days. Statutory Authority §§ 32.1-12 and 32.1-162.12 of the Code of Virginia. The facility policy/procedure titled "Preadmission Screening for Sex Offender" with an effective date of 07/01/2007 read in part, "Any prospective resident who is expected to stay of (sic) longer than three (3) days shall have his named checked	F 836			

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F 836	<p>Continued From page 80</p> <p>against the Virginia State Police Sex Offender Registry to determine whether he or she is a convicted sex offender...The director of Admission shall submit any prospective residents name to the Virginia State Police Sex Offender Registry...prior to admission to the facility..."</p> <p>The clinical record review revealed that Resident #59 had been admitted to the facility 10/26/17. Diagnoses included but were not limited to, hypertension, depressive disorder, mild cognitive impairment, conduct disorder, diabetes, and chronic kidney disease.</p> <p>Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/26/19 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.</p> <p>On 06/25/19, the surveyor requested the facility to provide evidence that they had submitted Resident #59's name to the Virginia state police sex offender registry.</p> <p>On 06/25/19, the facility provided the surveyor with results of a search completed for this Resident. This search was not completed until 06/25/19 at 12:40 p.m. after the surveyor had asked for the information. This search did not match any offender in the database. Indicating the Resident was not listed as a sex offender.</p> <p>On 06/27/19 at approximately 12:50 p.m., the surveyor requested from the administrator proof that the facility had signed up to receive automatic notifications of</p>	F 836		
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F 836	Continued From page 81 registration/re-registration of any sex offender with the same or a contiguous zip code. On 06/27/19 at approximately 1:16 p.m., the administrator verbalized to the surveyor that he did not know how this Resident was missed being screened and the person that should have completed the screening no longer worked at the facility. The administrator also provided the surveyor with a copy of an email notification dated 06/27/19 at 12:59 p.m. indicating the facility had just registered for community notification with the Virginia state police sex offender and crimes against minors registry. The administrator verbalized to the survey team that he had been the administrator since 2015, he had not been receiving these notifications, and he had signed up today. No further information regarding this issue was provided to the survey team prior to the exit conference. THIS IS A COMPLAINT DEFICIENCY.	F 836		
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 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.	F 842	F842 Corrective Action(s): Resident #19's attending physician has been notified that the facility staff failed to document in the medical record when resident #19 had received the incorrect medication. A facility incident and accident form has been completed for this incident.	

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F 842	<p>Continued From page 82</p> <p>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§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-</p> <p>(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.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(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</p>	F 842	<p>Identification of Deficient Practices & Corrective Action(s): All other residents may have potentially been affected. A 100% review of all residents medical records will be conducted by the DON, ADON and/or Unit Managers to identify residents at risk for inappropriate documentation and physician notification of medication errors. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Accident form will be completed for each negative finding.</p> <p>Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This inservice will include the standards for proper notification and documentation of physician ordered weight changes.</p> <p>Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>		

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F 842	<p>Continued From page 83 legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (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. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 1 of 33 Residents, Resident #19.</p> <p>The findings included:</p> <p>For Resident #19 the facility staff failed to document in the clinical record that the resident received medications not prescribed to her and what those medications were. Resident #19 was admitted to the facility on 08/31/09. Diagnoses included but not limited to hypertension, peripheral vascular disease, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, cerebrovascular accident, hemiplegia, respiratory failure, and dementia.</p> <p>The most recent yearly MDS (minimum data set) with an ARD (assessment reference date) of 04/02/19 assigned the Resident a BIMS (brief interview for mental status) of 05 out of 15 in Section C, cognitive patterns.</p>	F 842			

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F 842	Continued From page 84 Surveyor spoke with the DON (director of nursing) on 06/26/19 at approximately 1530 regarding Resident #19. DON stated that Resident had received another Resident's medication on 05/02/19 for the evening medications. DON provided the surveyor with a written statement, which read in part "On 05-2-19 at approximately 7:30, I received a phone call at home from ... (name omitted), LPN (licensed practical nurse). ... (name omitted) was upset and stated she had given.... (Resident #19) the wrong medication. Stated that another Resident had fallen in the floor and she was assisting with that. Also stated when she came out of Resident's room, there were several patients lined up in hallway wanting their medication. ... (name omitted) stated she pulled another Resident's meds and Resident ... (Resident #19) came to her and was yelling she wanted her meds and she accidentally gave ... (Resident #19) the wrong medication. I advised her to check allergies and contact MD as soon as possible (now)." The DON stated that she did re-education on medication administration with all nurses in the facility, and provided the surveyor with a copy of an inservice form dated 05/06/19. Surveyor was unable to speak with the LPN who accidentally administered the wrong medications. Resident #19's clinical record was reviewed on 06/26/19. The surveyor could not find information in the clinical record that the Resident had received the wrong medications or the names of the medications administered in error. No further information was provided prior to exit.	F 842		
F 868	QAA Committee	F 868	F868 Corrective Action(s) The Administrator has reviewed the QA Meeting and QA Committee requirements and regulations. The current Medical Director has been inserviced on the current QA requirements and regulations regarding having a minimum of quarterly QA meetings as well as the committee members required to attend.	

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F 868 SS=F	Continued From page 85 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, facility staff failed to ensure the quality assessment and assurance (QAA) committee met at least quarterly. The surveyor conducted the QAA review with the director of nursing on 6/27/19. There were QA sign in sheets 4/23/19, 1/28/19, 8/20/18. There was a 5 month interval between meetings. The administrator and director of nursing were notified of the concern during a summary meeting on 6/12/19.	F 868	Identification of Deficient Practices & Corrective Action(s): All residents and staff have the potential to be affected by the inconsistent meeting and attendance of the QA Committee. All QA committee members have been inserviced on the QA committee requirements and expectations of the QA committee. Systemic Change(s): The QA Committee will take a more visible role in the day-to-day operations of the facility. Any facility related or employee related issues will be addressed via a QA committee and QA Action Plan to resolve concerns. The regional V. P. of Operations and the regional nurse consultant will attend the QA Committee impromptu to monitor the process and provide oversight. They will monitor all aspects of resident care and services for continuous quality improvements. Monitoring: The administrator is responsible for maintaining compliance. The Regional Director of Operations and/or Corporate QA Nurse Consultant will visit the facility weekly/prn to provide management / operational oversight per corporate direction. Regional V. P. of Operations will reports of negative findings during facility on-site visits to the appropriate Resource Center department for assistance in making corrections. Completion Date: 8/11/19	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	F880 Corrective Action(s): LPN #2 involved in the Treatment Pass Observation for Resident's #153 has received one-on-one inservice training on	

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F 880	<p>Continued From page 86</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism</p>	F 880	<p>proper infection control practices to be followed during a dressing change. A Facility Incident & Accident form was completed for this incident.</p> <p>Identification of Deficient Practice(s) & Corrective Action(s): All other residents who receive a dressing change may have potentially been affected. The DON, ADON and/or Unit Manager will conduct an observation audit of all licensed nursing staff who regularly provide dressing changes to observe proper infection control practices and proper hand washing during the treatment pass administration procedures. Any negative findings will be addressed immediately, and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding.</p> <p>Systemic Change(s): The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed staff will be inserviced on the facility policy and procedure for proper infection control practices during medication and treatment procedures by the DON and/or Regional Nurse Consultant.</p> <p>Monitoring: The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will perform 2 random weekly Treatment Pass audits to monitor nursing staff for compliance. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 8/11/19</p>	

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F 880	<p>Continued From page 87</p> <p>involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow established infection control guidelines for 1 of 39 Residents, Resident #153.</p> <p>The findings included:</p> <p>The facility staff failed to complete any hand hygiene or change their gloves between cleaning a stage III pressure ulcer and applying a new dressing.</p>	F 880			

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F 880	<p>Continued From page 88</p> <p>The clinical record review revealed that Resident #153 had been originally admitted to the facility 11/03/14 and had been readmitted on 06/23/19. Diagnoses included, but were not limited to, stage III pressure ulcer, heart failure, muscle weakness, chronic obstructive pulmonary disease, dysphagia, hypertension, dementia, and chronic pain syndrome.</p> <p>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/06/19 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. Section M (skin conditions) had been coded to indicate the Resident had a stage III pressure ulcer.</p> <p>The Residents comprehensive care plan included the problem area stage III pressure ulcer to sacrum.</p> <p>The Residents clinical record included a physician orders dated 06/23/19 to clean the Residents stage III pressure ulcer with normal saline, pat dry lightly, pack with calcium alginate, cover with 4 X 4, cover with bordered foam, change daily and prn (as needed).</p> <p>On 06/26/19 at 11:53 a.m., the surveyor observed LPN (licensed practical nurse) #2 complete this treatment. LPN #3 assisted LPN #2. After gathering her supplies, disinfecting the Residents over the bed table, washing her hands, and applying gloves LPN #2 was observed to remove the Residents old dressing. LPN #2 then washed her hands, applied new gloves, and cleaned the open wound X 2 in a circular motion. After cleaning the wound, LPN #2 did not change her</p>	F 880			

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F 880	<p>Continued From page 89</p> <p>gloves or perform any hand hygiene. LPN #2 then placed the calcium alginate in the wound bed using a q tip, picked up a 4 x 4 with her gloved hands, folded the 4 x 4, and placed this over the open wound, picked up the bordered gauze with her gloved hand and covered the wound/dressing. LPN #2 then threw the old dressing and trash away and washed her hands.</p> <p>The surveyor interviewed the designated infection control nurse on 06/27/19 at 9:35 a.m., after reading the above scenario the infection control nurse verbalized to the surveyor that LPN #2 should have washed her hands between cleaning the wound and applying a new dressing.</p> <p>On 06/27/19 at 10:18 a.m., the surveyor interviewed LPN #2 when asked if she should have changed her gloves or washed her hands between cleaning the wound and applying a new dressing LPN #2 stated I guess my thinking was I didn't contaminate my hands when I cleaned the wound I just touched the outside of the gauze.</p> <p>The facility policy/procedure titled "Handwashing/Hand Hygiene" read in part, "...This facility considers hand hygiene the primary means to prevent the spread of infections...Use an alcohol-based hand rub...or, alternatively, soap...and water for the following situations...Before moving from a contaminated body site to a clean body site during resident care...After contact with blood or bodily fluids. After handling used dressing, contaminated equipment..."</p> <p>The facility policy/procedure titled "Wound Care" did not reference performing any hand hygiene between cleaning the dirty wound and applying a</p>	F 880			

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F 880	<p>Continued From page 90 new clean dressing.</p> <p>Per the CDC (Centers for Disease Control and Prevention) website accessed 07/01/19 https://www.cdc.gov/handhygiene/providers/index.html Perform hand hygiene before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, and after contact with blood, body fluids or contaminated surfaces.</p> <p>The administrative staff were notified of the issue regarding hand hygiene during treatment of a stage III pressure ulcer on this Resident on 06/26/19 at 2:44 p.m.</p> <p>No other information regarding this issue was provided to the survey team prior to the exit conference.</p>	F 880			