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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING ______ B. WING ______	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	**189 MONICA BLVD LYNCHBURG, VA 24502**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/11/19 through 6/13/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicaid/Medicare standard survey was conducted on 6/11/19 through 6/13/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. There were no complaints investigated during the survey. The census in this ninety certified bed facility was 76 at the time of the survey. The survey sample consisted of twenty current resident reviews and three closed record reviews.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		7/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Electronically Signed — 06/26/2019

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 561	Continued From page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to honor bedtime preferences for one of 23 residents, Resident #15. Resident #15 preferred to be assisted to bed at 9:00 p.m., per resident interview it was often after 10:00 p.m. or later before she was assisted to bed. Findings were: Resident #15 was originally admitted to the facility on 12/23/2014. Her diagnoses included but were not limited to: Cerebral palsy, osteoarthritis, bipolar disorder, and anxiety disorder. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/08/2019, assessed Resident #15 as cognitively intact with a summary score of "15". On 06/11/2019 at approximately 11:15 a.m., Resident #15 was observed sitting in an electric	F 561	Resident #15's care plan, care guide and All about Me form updated to include bedtime preference. The grievance of resident #15 on 6/12/19 was completed and logged. All residents have the potential to be affected. 100% audit of All about Me assessments were completed to ensure bedtime preferences are listed. 100% care plans were audited to ensure resident preference is reflected. All about Me assessments will be reviewed in AM clinical meeting by Activities Director after admission so preferences can be updated. 100% nursing staff and Activities staff will be educated by DON/ADON on updating the All about Me assessments with bedtime preference and where this information can be located. Social Services to conduct weekly interviews of 4 alert and oriented residents	

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F 561	Continued From page 2 wheelchair in her room, working on a computer. Resident #15 was interviewed about life at the facility. She stated that her biggest problem was bedtime. She was asked to explain. Resident #15 stated, "I have cerebral palsy...I can't put any weight on my legs...they transfer me and get me up with the hoyer lift. I have asked over and over to please be put to bed at 9:00 p.m. at night. They [the CNAs-certified nursing assistants] start on the other end of the hall every night...I am all the way at the other end so I am always last...it takes two people and the hoyer lift to move me...I understand that I can't go to bed right at 9:00 every night, but it's always later than that...most of the time it is after 10:00 at night and it has been as late as 11:30." Resident #15 was asked if she had discussed that with the unit manager or any of the facility staff. She stated, "I have a list I keep on my computer...I emailed it to [Name of Former Administrator] whenever I added something...He knew they weren't putting me to bed on time." Resident #15 was asked if the former administrator had spoken with her about her bedtime concerns. She stated, "Oh yes, he came in and patted me on the shoulder and said, '[Resident's name] we are working on it'...but nothing ever changed." Resident #15 was asked if she had spoken with any other staff members or had the problem been discussed in her care plan meetings. She stated, "Yes, I've told them, and we discuss it every time I have a care plan meeting." The clinical record was reviewed on 06/12/2019 at approximately 9:30 a.m. The care plan contained the following: "Focus: Resident has made personal preferences known... Goal: Personal preferences will be met as able on a regular basis in the	F 561	a week x 3 months to ensure staff compliance with bedtime preference being within 20-30 minutes of preferred time. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	

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F 561	Continued From page 3	F 561		

specific areas addressed thru the next review." Interventions included but were not limited to: "Establish a preferred bedtime if desired."

During an end of the day meeting on 06/12/2019 at approximately 4:30 p.m., with the DON (director of nursing), the administrator, the corporate nurse consultant and the Social Servies Director, the above information was discussed. The Social Services Director stated that he had not been in Resident #15's care plan meetings but that minutes were kept. Those minutes were requested.

On 06/13/2019 at approximately 8:30 a.m., the Social Services Director presented the care plan meeting minutes for January 2019 and April 2019. He stated, "I don't see anything on there about her bedtime being a problem...I wasn't in the meetings and the social worker that was in the April meeting is no longer here." He was asked where it would be documented if Resident #15 voiced concerns over her bedtime. He stated, "There would be a grievance form completed.... [name of Social Services Coordinator] was in her (Resident #15) January care plan meeting...she's still here." Any grievance forms completed for Resident #15 were requested.

At approximately 8:40 a.m., the social services coordinator who had been in Resdient #15's January care plan meeting, was interviewed regarding bedtime preferences for Resident #15. She stated, "It wasn't discussed in the care plan meetings...she has told me in the hallway in passing that she was getting put to bed too late...I told the unit manager [no longer employed at the facility]...then when we got in her care plan meetings and I asked how things were going she

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F 561	Continued From page 4 said everything was good." The Social Services Coordinator was asked if she had specifically followed up with Resident #15 regarding her bedtime preferences not being honored. She stated, "No, I turned that over to nursing." Concern Forms [previously referred to as grievance forms in this writing] for Resident #15 were presented. On 11/20/2018 a concern form was completed that contained the following information: "Documentation of Concern: [Name of Resident #15] said she did not get put to bed till 10:45 last night and no one got her up till 11:55 today. She was crying really upset..." The DON (director of nursing) was interviewed at approximately 9:00 a.m., regarding Resident #15. She stated, "I talked to her last night about her bedtimes...one of the CNAs talked to her too...we offered her 8:30 and the staff to start on her end of the hallway...she was locked in to the 9:00 time...I am going to be following up with her to see if things are better." The DON was asked if the CNAs had a Kardex. She stated, "Yes, we have gone back to paper on that." The Kardex was requested and presented. The Kardex contained the following: "Specific Need for Resident ...Request to be in bed @ 2100 [9:00 p.m.]." The DON was asked if that time had been recently added. She stated, "No, as far as I know it has been on there." No further information was obtained prior to the exit conference on 06/13/2019.	F 561		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607		7/3/19

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F 607	Continued From page 5 implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility also failed fully implement their Virginia Resident Abuse Policy by failing to conduct a criminal records background check for one of 25 employee records reviewed. The findings include: During review of 25 personnel files, the file of one employee, the Assistant Admissions Coordinator, was found not to have a criminal records background check conducted by the Virginia State Police. The employee was a transfer from a sister facility located in another state, where a criminal background check for that locality had been conducted. At approximately 10:00 a.m. on 6/13/19, the Human Relations (HR) Director was interviewed regarding the lack of a criminal records background check for the employee. The HR Director acknowledged that the employee was a transfer from a sister facility in another state, and that a criminal background check for that state had been conducted. "I've only been in this position for about two months," the HR Director	F 607	A Virginia criminal background was completed on 6/13/19 on the employee that had transferred in from Ohio. 100% audit of all active employee files were completed on 6/21/19 to ensure they all had Virginia criminal background checks completed. There were no new findings of any employees not having one. HR Director was educated by RDCS on 6/14/19 that all employees were to have a Virginia criminal background check completed upon hire even if the employee is transferred in from another state as a Saber employee. An audit of all new hire employee files will be conducted monthly by HR to ensure that Virginia criminal background checks are present in the employee file. Audit results will be reviewed at the monthly QA committee meeting. Date of completion 7/3/19	

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F 607	Continued From page 6 said. The HR Director went on to say that he didn't know a criminal records background check for Virginia had to be done. Review of the facility's Virginia Resident Abuse Policy, effective May 2008, and revised on July 28, 2017, noted the following: "1) It is the policy of the facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. a. The facility will do the following prior to hiring a new employee: iv. Conduct a criminal background check in accordance with State law and Facility policy...." The findings were discussed during a meeting at 11:00 a.m. on 6/13/19 that included the Administrator, Director of Nursing, and the survey team.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		7/3/19

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F 656	Continued From page 7 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility staff failed to review and revise a comprehensive care plan for one of 23 residents, Resident #17. Resident #17's care plan had not been reviewed and revised to reflect the use of a Broda chair. Findings were: Resident #17 was admitted to the facility on 04/29/2017. Her diagnoses included but were not	F 656	Resident #17's care plan has been updated to reflect the broda chair. All residents have the potential to be affected. MDS completed 100% audit on 6/19/19 of all care plans to ensure accurate care planning of specialty chairs. MDS staff were educated by DON on 6/19/19 on accurately care planning specialty chairs. MDS will conduct weekly audits x 3	

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F 656	Continued From page 8 limited to: Chronic Pain. muscular dystrophy, osteoporosis, hypothyroidism and atherosclerotic heart disease. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/15/2019, assessed Resident #17 as being severely impaired in her cognitive status, with a summary score of "05". On 06/11/2019 during initial tour, Resident #17 was observed sitting in a Broda chair in the activity area of the unit. On 06/12/2019, at approximately 10:00 a.m., the clinical record was reviewed, there were no physician orders for the use of a Broda chair, nor was it on the care plan. The care plan included the following: "Focus: Resident at risk for falls...Interventions included but were not limited to: "6/29/17 Therapy to evaluate WC [wheelchair] positioning-lowered back of w/c [wheelchair], antitippers." The corporate nurse consultant was in the conference room on 06/12/2019 at approximately 10:30 a.m., and was asked if an order was needed for a Broda chair. She stated, "No, as long as therapy has evaluated her we don't need an order." She was asked if the Broda chair should be on the care plan. She stated, "Yes." The Rehab Manager was interviewed on 06/12/2019 at approximately 2:00 p.m., regarding Resident #17. She stated, "She [Resident #17] was evaluated back in October and the Broda chair was added...she has padding on both of her sides to assist with positioning...we had to talk her and her daughter into the change in chairs to	F 656	months of all new admissions to ensure they have accurate care planning specific to specialty chairs. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	

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F 656	Continued From page 9 help with positioning and to protect her skin." During an end of the day meeting on 06/12/2019 the above information was discussed. The DON was asked if Resident #17's care plan should have been updated to include her Broda chair. She stated, "Yes." No further information was obtained prior to the exit conference on 06/13/2019.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to apply a physician ordered positioning device for one of 23 residents in the survey sample. Resident #20, with contracted fingers on her right hand, did not	F 688	Resident #20's physician orders are accurate and are being followed to include palm guard, refusals are being documented. All residents have the potential to be	7/3/19

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F 688	Continued From page 10 have a physician ordered palm guard/splint in place as ordered by the physician. The findings include: Resident #20 was admitted to the facility on 2/13/13 with diagnoses that included cerebrovascular disease with hemiplegia and hemiparesis, contractures of the hand and ankle, osteoarthritis, depression, dysphagia and insomnia. The minimum data set (MDS) dates 4/25/19 assessed Resident #20 as cognitively intact. Section G0400 of this MDS listed the resident had limited functional range of motion of her upper extremity (shoulder, elbow, hand or wrist) on one side. On 6/11/18 at 11:38 a.m., Resident #20 was observed in bed. The third, fourth and fifth fingers of the resident's right hand were contracted, with the fingertips resting against the resident's palm. There was no positioning device or palm protector in place. Resident #20's clinical record documented a physician's order dated 5/6/19 for, "Palm protector to (R) [right] hand at all times except for hygiene or as resident allows every shift." Resident #20's plan of care (5/3/19) listed the resident had right hand contractures and required assistance with applying a palm protector with goal to "improve ROM [range of motion] through splint/brace application." Interventions to improve range of motion included application of splint/braces as ordered by the physician. On 6/12/19 at 1:33 p.m., the certified nurses' aide (CNA #1) caring for Resident #20 was	F 688	affected. All physician orders for palm guards have been reviewed for accuracy and are being followed. All palm guard orders are placed on the TAR for nurse to ensure in place. 100% licensed nurses will be educated by DON/ADON on carrying out physician orders to ensure transcription to TAR and refusal documentation. Physician orders will be reviewed daily Monday thru Friday in risk by DON/ADON/UM to ensure applicable transcription to TAR. 10 TARs / week for 3 months will be checked by DON/ADON/UM to ensure complete documentation of administration and/or refusals. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	

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F 688	Continued From page 11 interviewed about the ordered palm protector. CNA #1 stated the resident used to have a hand brace but she had not seen it lately. CNA #1 stated she did not know where the brace was located and stated it was possibly sent to the laundry. CNA #1 stated therapy usually took care of applying braces and splints. On 6/12/19 at 1:40 p.m., accompanied the registered nurse (RN #2) caring for Resident #20, the resident was observed in bed without the palm guard in place. RN #2 was interviewed at this time about the splint/brace. RN #2 looked about the room and found the palm protector in the drawer of the resident's bedside table. RN #2 stated the resident should have the palm protector in place due to her contracted fingers on the right hand. RN #2 stated the routine CNA for Resident #20 knew to apply the palm protector. RN #2 stated CNA #1 did not routinely care for Resident #20 but should have known about the brace. On 6/13/19 at 10:03 a.m., accompanied by RN #3, the Resident #20's right hand/palm were observed. The skin between the right thumb and index finger was red. The skin on the outer edge of the palm was red/pink with no open areas observed in the palm. These findings were reviewed with the administrator and director of nursing during a meeting on 6/12/19 at 4:30 p.m.	F 688		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate	F 700		7/3/19

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F 700	Continued From page 12 alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to complete a thorough safety assessment for one of 23 residents prior to the use of bed rails. Resident #20 had bed rails in use without prior attempts at appropriate alternatives or a medical need/diagnosis listed for use of the rails. The findings include: Resident #20 was admitted to the facility on 2/13/13 with diagnoses that included cerebrovascular disease with hemiplegia and hemiparesis, contractures of the hand and ankle, osteoarthritis, depression, dysphagia and insomnia. The minimum data set (MDS) dates	F 700	Resident #20's bedrail assessment has been re-done and the grab bars were deemed appropriately needed. This was discussed with family and consented. All residents have the potential to be affected. 100% bedrail assessments were reviewed for accuracy and appropriate documentation of need. This will be completed by 6/28/19. 100% licensed nurses will be educated by DON/ADON on how to appropriately fill out a bedrail assessment to ensure the need for bedrails to remain in place. This will be completed by 6/28/19. ADON will complete weekly audits of 5 bedrail assessments that nursing has	

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F 700	Continued From page 13 4/25/19 assessed Resident #20 as cognitively intact and totally dependent upon two people for bed mobility. Section G0400 of this MDS listed the resident had limited functional range of motion of her upper extremity (shoulder, elbow, hand or wrist) on one side. On 6/11/18 at 11:38 a.m., Resident #20 was observed in bed. Grab rails were in the raised position on each side of her bed. A purple, foam covering was applied to both rails. The resident was bruised on the back of her left wrist area and hand. On 6/12/19 at 9:15 a.m., Resident #20 was observed in bed again with the grab rails in the up position on each side of the bed. Resident#20's clinical record documented no medical condition or diagnoses associated with use of the bed rails. The most recent bed rail assessment for Resident #20 was dated 5/16/19. The section indicating the medical need for side rail use was marked, "Not applicable." The form documented no attempted alternatives or any alternatives considered and not deemed appropriate. The form documented "No potential risks" for Resident #20's use of bed rails. A nursing note dated 5/28/19 documented the resident was combative when a nurse attempted to give her medications and hit her left forearm/hand against the bed rail resulting in bruising. The note dated 5/28/19 documented, "...extremely irritated when approaching to give medications....she attempted to swing and knock the milk shake and medications out of the nurses hand...she is screaming, swinging blindly not making contact with staff. She hit the side rail several times blindly..." A skin assessment dated 5/30/19 documented the resident was assessed	F 700	completed to ensure accuracy and appropriateness and the need is established. The weekly audits will be completed x 3 months. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	

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F 700 Continued From page 14 F 700

with purple/red colored bruising on the back of the left forearm and hand.

On 6/12/19 at 1:52 p.m., the registered nurse (RN #2) caring of Resident #20 was interviewed about the bed rail. RN #2 stated Resident #20 was unable to move about and transfer independently but held the grab rails when assisted by staff during care. RN #2 stated the resident was diagnosed with a urinary tract infection and had recently been combative. RN #2 stated the resident hit her left arm/hand against the grab rail on 5/28/19 when swinging at her.

On 6/13/19 at 8:30 a.m., the director of nursing (DON) was interviewed about Resident #20's incomplete bed rail assessment. The DON had no response about the lack of a medical reason or condition listed for use of the rails. The DON was not aware of any attempted alternatives to the bed rails. When asked about the resident recently hitting her arm against the rail, the DON stated they added foam padding to the rails to protect the resident. The DON stated the resident had recently been combative. The DON stated they added the protective foam, thinking that would protect the resident until she improved. The DON stated they had not reassessed Resident #20 for bed rail use since her change in condition. The DON stated nurses were responsible for completing bed rail assessments.

The facility's policy titled Bed Rails Policy (revised 4/2/2018) documented, "The facility will attempt to use appropriate alternatives prior to installing a side or bed rail...If a bed or side rail is used, the facility will...Assess the potential risks associated with the use of bed rails including the risk of entrapment, prior to bed rail installation..."

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F 700	Continued From page 15 This finding was reviewed with the administrator and director of nursing during a meeting on 6/13/19 at 10:50 a.m.	F 700		
F 761 SS=D	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 properly label medications/biologicals in one of 2 medication room refrigerators: skilled unit med	F 761	The opened, updated PPD vials were disposed of on 6/12/19. All residents have the potential to be affected.	7/3/19

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F 761	Continued From page 16 room. Two vials of PPD (tuberculin skin test) solution were opened and undated. Findings include: On 6/11/19 at 3:40 p.m. the medication room refrigerator was inspected with LPN (licensed practical nurse) # 1. Located in the refrigerator were two 50 test vials of open PPD solution. LPN # 1 was asked if she knew when the vials had been opened, and she stated "I will be right back." She returned a few moments later with RN (registered nurse) # 1, who was the unit manager. RN # 1 picked up the vials and stated "These will need to be destroyed." RN # 1 stated she did not know how long the vials had been opened, but they should have been dated when opened. The label and storage policy was requested from RN # 1 at that time. The policy "5.3 Storage and Expiration of Medications, Biologicals, Syringes, and Needles" was reviewed. Article 5. documented "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." The attached information "Medication Storage and Expiration Quick Reference" directed "...tuberculin test....discard 30 days after opening...." On 6/12/19 at 4:30 p.m. during an end of the day meeting with facility staff, the administrator, DON (director of nursing), and corporate nurse consultant were informed of the above findings.	F 761	Both medication refrigerators were checked on 6/14/19 and all opened vials of PPD were dated per policy. 100% licensed nurses will be educated by DON/ADON on labeling PPD vials when opened per policy, this will be completed by 6/28/19. ADON/UM will check refrigerators 3x week x 4 weeks, then weekly x 2 months, to ensure all opened PPD vials are dated. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	

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F 761	Continued From page 17 No further information was provided prior to the exit conference.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to store food in a sanitary manner on one of two unit refrigerators. Fifteen-day-old leftover food for a current resident was stored in the nourishment refrigerator on the long-term care unit. The findings include: On 6/11/19 at 11:00 a.m., accompanied by the dietary manager, the nourishment refrigerator on the long-term care unit was inspected. Stored in	F 812	The food in the pantry refrigerator on LTC side was thrown away on 6/11/19. No residents were affected. Both pantry refrigerators were checked on 6/12/19 and all brought in food was in date per facility policy. HSKG/MAINT Director educated all housekeeping staff on 6/14/19 on checking the pantry refrigerators for out of date foods per facility policy. HSKG/MAINT Director will check the pantry refrigerators 3 x week x 3 months	7/3/19

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F 812	Continued From page 18 the refrigerator was a plastic container of food dated 5/27/19 with a current resident's name marked on the top. The dietary manager identified this as food brought in by a family for a current resident. The container contained partially eaten beef mixed with vegetables. On 6/11/19 at 11:10 a.m., the dietary manager was interviewed about the leftovers in the long-term care refrigerator. The dietary manager stated this food should have been discarded as leftovers were kept for a maximum of seven days. The dietary manager stated the refrigerators were reviewed daily for out of date food with expired food items discarded. The dietary manager stated she did not recall seeing this 5/27/19 dated food item in the refrigerator yesterday (6/10/19) and was not sure when it was placed in the refrigerator. The facility's policy titled Food Brought in From Outside the Facility (revised 2/25/19) documented, "Staff outside of the dietary department will store, and handle food in accordance with professional standards for food safety when residents or their friends or family bring food into the facility." Procedures listed for food storage included, "The container will be labeled with name of food item and Resident name, dated, and placed in an appropriate non-dietary refrigerator...Food dated by facility staff will be discarded within seven days from the date mark..." This finding was reviewed with the administrator and director of nursing during a meeting on 6/12/19 at 4:30 p.m.	F 812	to ensure no expired foods per facility policy. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	
F 883	Influenza and Pneumococcal Immunizations	F 883		7/3/19

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F 883 SS=D	Continued From page 19 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 20 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, the facility staff failed to accurately assess and document the pneumococcal vaccine for one of 5 records reviewed: Resident # 61. Resident # 61's vaccine status was not readily available for review, and was not documented in the correct format of month/day/year for vaccine receipt. Findings include: Resident # 61 was admitted to the facility 5/23/19 with diagnoses to include, but not limited to: diabetes, congestive heart failure, and peripheral vascular disease. The most recent MDS (minimum data set) was a 14 day Medicare assessment dated 6/6/19. Resident # 61 was coded as cognitively intact with a total summary score of 15 out of 15. On 6/13/19 at 9:00 a.m. the clinical record was	F 883	Resident #61 and family confirmed on 6/14/19 the type and date received of PNA vaccine the resident had received prior to admission and this was documented in the record. All admissions for the past 30 days were reviewed to ensure we had the correct information of PNA vaccine in the records. Completed on 6/18/19. Admissions was educated by DON on 6/14/19 when collecting information on the vaccinations upon admission we need to have clear information regarding the type of PNA vaccine and an exact date of receipt. This information is to be given to the DON/ADON and if clarification is needed the DON/ADON will be responsible to obtain further information. The DON/ADON will conduct weekly audits x 3months of all new admissions to ensure they have the applicable	

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F 883	Continued From page 21 reviewed for vaccine status of influenza and pneumococcal vaccines. There was no documentation of the resident's vaccine status located in the immunization section of the record. On 6/13//19 at 9:15 a.m. the DON (director of nursing) was asked for assistance in locating the information. She stated "Let me see what I can find; I guess it hasn't been scanned in yet. Did you look at the hospital discharge records?" The DON was informed that in other resident record reviews the immunization information was recorded in the immunization section of the record. At approximately 10:30 a.m. the DON and the admissions director presented a portion of the admission documentation "Vaccine Consent." There was a date of "9/18" documented on the form for receipt of influenza and pneumococcal vaccine. The admission director was asked what that date was; whether a month/day, or month/year? The DON stated "That's the month/year; the resident couldn't remember the exact day..." The DON and admissions director were then asked if an attempt had been made to obtain the correct date for the vaccines, and also to determine which pneumococcal vaccine had been given to assess whether the resident was eligible for the other pneumococcal vaccine. The DON stated she had not seen that form prior to that day (6/13/19), and the admission director stated no attempt had been made to see what vaccines had been given. The admissions director further stated "She [name of resident] thinks she got it at the doctor's office..." The DON acknowledged the vaccines were not correctly documented on the form, and that she or her designee was responsible for obtaining the	F 883	information needed on prior pneumonia vaccines documented in the clinical record. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	

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F 883	Continued From page 22 vaccine information. On 6/13/19 during a meeting with facility staff beginning at 10:50 a.m. the administrator, DON, and corporate nurse consultant were informed of the above findings. No further information was provided prior to the exit conference.	F 883		
F 909 SS=F	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility staff failed to implement an inspection protocol for bed frames, mattresses and bed rails to identify areas of possible entrapment. Current reviews included no specific inspections for potential entrapment risks associated with bed frames, mattresses and/or bed rails. The findings include: On 6/13/19 at 8:50 a.m., the facility's maintenance director was interviewed about safety inspections for beds, mattresses and bed rails related to potential entrapment risks. The maintenance director stated they inspected beds	F 909	No residents affected. 100% assessments of beds completed for entrapment issues per policy on 6/24/19. Maintenance Director and NHA were both educated by RDCS on 6/14/19 on the side rail and entrapment policy. Maintenance Director/NHA will conduct a monthly audit of 10 beds x 3 months to ensure the bed dimensions have no entrapment issues. Audit results will be reviewed monthly at the QA committee meeting. Date of completion 7/3/19	7/3/19

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F 909	Continued From page 23 every three months to see if rails were loose and if foot/headboards were damaged. The maintenance director stated the inspections were "visual" and he documented no measurements or specifics of the inspections. The maintenance director stated he checked mattresses but did not document the inspections. The maintenance director stated, "I don't have record of measurements." The maintenance director stated he was going to start measurements and keep records by bed number starting in June 2019. The maintenance director stated the previous administrator gave him the company policy that included FDA guidelines about entrapment risks but he had not implemented the program yet. The maintenance director stated he did not have records identifying individual beds or mattresses. The maintenance director stated he did not have any records regarding reviews of any specialty mattresses in use. The maintenance director stated he performed a visual check of beds/rails and mattresses as had been done in the past and was getting ready to start the inspections for entrapment risks in June 2019. The maintenance director presented a bed audit sheet dated 2019. Entries for January and April documented sections for bed, rails and head/footboards and listed "All pass" in each column. One headboard was listed as replaced in January and a broken rail and footboard were replaced in April. There was no indication of what criteria was included in the inspections and no reference to any specific measurements or inspections regarding entrapment risks. The facility beds were not identified and there was no evidence of any review/inspections regarding mattresses in use.	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING ______ B. WING ______	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 909	Continued From page 24 On 6/13/19 at 9:30 a.m., the maintenance director stated he was not previously aware of the company policy about bed/mattress inspections. The maintenance director stated, "I found out about it [policy] at the last minute." The maintenance director stated all the beds in the facility were numbered but he had no documented checks with measurements related to entrapment risks. The facility's policy titled Bed Identification and Safety Inspection Policy (effective 4/2/18) documented, "It is the policy of the facility to ensure that resident beds promote optimal safety, comfort and function for the resident." Procedures for bed/safety inspections included, "...identify each bed with a number that is on a sticker adhered to the bed...Beds, rails and mattress will be inspected for safe operation and any potential other adverse events. The inspection criteria will be based on the 'Bed and Rail Safety Inspection Checklist' and 'Bed System Dimensional and Assessment Guide' inspecting the seven areas in the bed system where there is a potential for entrapment...If any area is identified to be a risk for entrapment, the bed/mattress configuration will be removed immediately...When installing or adjusting bedrails, foot/headboard, mattresses, maintenance and nursing communicate and work together to ensure the manufacture instructions are followed and the bed's dimensions are appropriate for the resident...Inspections will be completed annually and as needed when bed/mattress configuration changes. The inspection checklists will be kept in a separate binder or tab kept current by environmental services/maintenance..." The policy included a checklist indicating specific inspections required	F 909		

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

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F 909	Continued From page 25 and referenced FDA guidelines regarding maximum dimensional gap measurements in the seven bed system entrapment zones (within rail; under rail/between rail supports; between rail and mattress; under rail/at ends of rail; between split bed rails; between end of rail and side edge of head/footboard; between head/footboard and mattress). These findings were reviewed with the administrator and director of nursing during a meeting on 6/13/19 at 10:50 a.m.	F 909		