STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING _____ B. WING _____	C 06/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(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 6/18/19 through 6/20/19, and on 6/24/19. 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 Medicare/Medicaid standard survey was conducted 6/18/19 through 6/20/19. An extended survey was conducted on 6/21/19 and 6/24/19. One complaint was investigated. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity Level IV, Pattern, which constituted Substandard Quality of Care. Following submission and acceptance of a Plan of Removal, the Scope and Severity was lowered to Level II, Widespread in the area of Quality of Care. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 107 at the time of the survey. The survey sample consisted of 22 current Resident reviews and two (2) closed record reviews.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		7/22/19

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

Electronically Signed | 07/08/2019

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F 686	Continued From page 1 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to perform a pressure ulcer dressing change per physician's order for one of 24 residents, Resident #67. LPN (licensed practical nurse) #2 was observed providing incorrect treatments to two pressure ulcer sites on Resident #67's hips. Findings were: Resident #67 was admitted to the facility on 09/10/2014. Her diagnoses included but were not limited to: Osteoporosis, history of breast cancer, chronic obstructive pulmonary disease, schizoaffective disorder, atrial fibrillation, and diabetes mellitus. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/15/2019, assessed Resident #67 as moderately impaired in her cognitive status, with a summary score of "10". The clinical record was reviewed on 06/18/2019. Per the clinical record, Resident #67 had two unavoidable pressure ulcers. One was located on the right hip and was classified as a Stage II, the other was on the left	F 686	F 686 1. For Resident #67, the physician was contacted on 6/20/19 and orders were clarified for treatment to stage IV and stage II pressure ulcers. 2. Residents currently residing in the center with physician orders for treatment to pressure ulcers have the potential to be affected. A review was done by the director of clinical services (DCS)/designee to ensure physician orders for treatments to pressure ulcers is accurate and being performed by the licensed nurse per physician order. 3. In-servicing will be provided to licensed nurses by the DCS/designee to ensure pressure ulcer treatments are performed correctly per physician order. Random weekly observations will be completed by the Director of Clinical Services/designee for five (5) residents per week for three (3) months to ensure physician orders for pressure ulcer treatment are accurate and being performed by the licensed nurse per physician order. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance	

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F 686	Continued From page 2 hip and classified as a Stage IV. The physician orders were reviewed and the following orders for dressing changes were observed: "To Stage 2 wound R [right] hip, cleanse with DWC [wound cleanser], sure prep to periwound, medihoney to wound base, adhesive foam dressing to cover. Change daily every day shift for Pressure wound R hip. "To Stage 4 wound L [left] hip, cleanse with 1/4 strength Dakin's solution, pack with iodoform gauze, cover with alginate, adhesive foam dressing to cover. Change BID [twice a day] and as needed. Every shift for wound care." On 06/18/2019 at approximately 2:00 p.m.,, LPN (licensed practical nurse) #2 was interviewed regarding Resident #67's wounds. She stated, "I've already done the dressing change today...she was wet and it was off so I did them earlier." On 06/19/2019, at approximately 3:00 p.m. the dressing changes for Resident #67 were observed. Per LPN #2, Resident #69 preferred to have her dressing changes done in the bathroom, she did not like to lie back down. LPN #2 was assisted by CNA (certified nursing assistant) #1. Resident #67 was assisted to her feet, she held herself steady using the grab bar and the physical assistance of CNA #1. A bedside table was in the bathroom with all the supplies for the dressing change arranged on top. Resident #67's pants were lowered and the dressing was removed from her right hip. LPN #2 was asked what stage the pressure ulcer was. She stated, "It's a healing stage IV." She then cleaned the area with	F 686	Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 686	Continued From page 3	F 686		

H-Chlor (facility's choice for 1/4 strength Dakins), applied iodoform gauze to the area, covered it with alginate and a foam dressing. She then did the dressing change to the left hip. She was asked what stage that wound was. She stated, "It was a Stage II, but it looks healed. She cleaned the area with wound cleanser, applied medihoney and covered the area with a foam dressing.

The clinical record was again reviewed as the stages given to the wounds, as well as the dressing changes, were opposite of the orders observed on 06/18/2019. Review of the record showed that the orders had been revised on 06/19/2019, reversing the two wounds (orders for the right pressure ulcer were written for the left and the left orders were written for the right). The DON (director of nursing) was informed of the observations on 06/19/2019 at approximately 4:00 p.m. She stated, "Yes, I just talked to her...it looks like she did the dressing change yesterday and rewrote the orders, she got confused because the left hip looks so good, she thought it was the stage 2...she is going to contact the doctor and rewrite the orders."

On 06/20/19 at approximately 9:30 a.m., LPN #2 was interviewed regarding the dressing change observations on 0619/2019. She stated, "I feel so bad...I got my left and right mixed up when I rewrote the orders yesterday...the dressing I did on the right should have been for the left and the other way around." She was asked if the left hip dressing was done twice on 06/19/2019 as originally ordered. She stated, "No, they did the right one twice, because that's the way I rewrote it." She was asked if the orders had been corrected. She stated, "Not yet, I am going to do that as soon as I can."

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F 686	Continued From page 4 No further information was obtained prior to the exit conference on 06/24/2019.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide supervision for one of 24 residents in the survey sample, Resident #89. Resident #89 was observed seated in a wheelchair with her toes pointing downward and her feet not flat on the floor. Resident #89 was attempting to self propel in her wheelchair but was unable to do so using only her toes. Resident #89 was then pulling at the door of another resident's room and in the living room of the unit, leaning forward and getting cups out of the trash cans; she was observed putting the cups to her lips and spitting into them. The findings include: Resident #89 was admitted to the facility on 01/31/2018 with the following diagnoses, but not limited to: Alzheimer's Disease, weight loss, Chronic diastolic heart failure, anxiety, history of	F 689	F689 1. Resident #89 no longer resides in the facility. 2. Residents currently residing in the center have the potential to be affected. For residents currently residing in the center a review will be done by the director of clinical services/designee to ensure wheelchairs are individualized to meet specific resident needs and care plan is being followed for redirecting wandering residents. 3. In-servicing will be provided to nursing and therapy staff by the DCS/designee ensuring wheelchairs are individualized to meet specific resident needs and that care plan is being followed for redirecting wandering residents. Random weekly observations will be completed by the Director of Clinical Services/designee for five (5) residents per week for three (3)	7/22/19

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F 689	Continued From page 5 TIA (transient ischemic attacks), history of falls, and abnormal posture. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/29/2019, assessed Resident #89 as severely impaired in her cognitive status with a summary score of "03". On 06/19/2019 at approximately 8:40 a.m., Resident #89 was observed in the hallway. She was seated in her wheelchair, a self alarming seat belt in place, her feet were pointed downward and she was able to touch the floor using her toes. She was observed shuffling her feet to self propel forward but was not moving the chair. She reached out to a resident near her, put her hand on the brake of their wheelchair and pulled herself forward. She was then observed stopping at another residents room and entering the doorway. A trash can was sitting in front of the door. Resident #89 leaned forward in her chair, picked the trash can up and took out a used plastic cup. She put the cup to her mouth and attempted to spit into it. She then placed the cup back into the trash can and placed the trash can back at the door. Resident #89 sat inside the doorway of the other resident's room. Staff walked by and did not move her. At approximately 8:55 a.m., CNA (certified nursing assistant) #1 came down the hallway and removed Resident #89 from the other residents room and took her to the living room on the unit. An occupational therapist (Other Staff #3) was standing at the nurses station and was asked about Resident #89's position in her wheelchair. She stated that the resident had been on case load and had been fitted with the cushion that	F 689	months to ensure their wheelchair is individualized for mobility and care plan is being followed for redirecting wandering residents. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 689	Continued From page 6	F 689		

was in her wheelchair. She stated, "She has a contour cushion with a pelvic well and a wedge...it is designed to keep her from sliding out of the chair." OS #3 was asked if Resident #89 should have her foot flat on the floor. She stated, "Well, it might be the shoes she has on...those are her bedroom slippers, they aren't providing her much traction...if she had on shoes that had a rubber sole on them that were thicker I think her feet would touch....she can pull herself with the hand rails in the hall when she gets over to them."

At approximately 9:00 a.m. the DON (director of nursing) was on the unit and was interviewed regarding the position of Resident #89 in her wheelchair. She stated she would have therapy look at her. She agreed that Resident #89's feet were not touching the floor. While watching Resident #89, she self propelled herself to the trash can in the room. She leaned over and got a used plastic cup, put it to her lips and started to spit in it. The DON was asked if someone should be watching her and redirecting her. The DON stated, "Yes."

The care plan was reviewed and contained the following: Focus: "...at risk for falls r/t [related to] poor safety awareness..." Interventions included but were not limited to: "Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair..." Focus: "...has impaired or inappropriate behaviors..." Interventions included but were not limited to: "Redirect her when she wanders in inappropriate areas - ie [sic]: residents rooms..."

On 06/19/2019 at approximately 4:00 p.m. the DON came to the conference room and stated that therapy had re-evaluated Resident #89 and

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F 689	Continued From page 7	F 689		

had changed the cushion in her chair which would lower the seat so her feet could touch the floor.

The OT evaluation was obtained and contained the following information: "Positioning: Previous/Current Positioning Devices in Use: Pt was fitted with saddle cushion with slight wedge to decrease her from sliding forward and increasing her fall risk. However with the use of this seating system, pt is not fully able to place her feet fully on the floor, only her tip toes. OT warranted to adjust seating system to allow her to fully reach the floor with her feet and allow her to use her feet to propel her wheelchair if she chooses throughout the facility.....Assessment Summary: Pt presents with the need for adjustment to current seating system. Pt is fully unable to reach her feet flat on the floor and propel with her feet is [sic] she chooses. Pt can pull herself along using side rails and arms to propel wheelchair but is unable to use feet to move chair if she is not near the railings within the facility thus warranting skilled intervention to make necessary adjustments and allow her to place her feet on floor using all types of footwear. Trial with alternate seating systems to allow her to reach the floor while seated in wheelchair and propel herself within her environment as well as maintain an upright position without sacral sitting and sliding forward using her feet if she chooses to. With the change in seating system, this will allow pt to propel her wheelchair when she is not close to the handrail thus allowing her to maintain level of independence throughout her environment and improve her quality of life..."

No further information was obtained prior to the exit conference on 06/24/2019.

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F 700	Continued From page 8	F 700		
F 700 SS=K	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to attempt appropriate alternatives prior to the use of side/bed rails, failed to assess residents for risk of entrapment prior to use, failed to review the risks/benefits of side/bed rails with the resident and/or resident representative and failed to obtain informed consent prior to use, failed to have a system in place to ensure residents beds were appropriate for the resident's size and weight, and failed to have a system in place for assessment and	F 700	F700 1. Resident #1 side rails had been removed on 6/7/19. For residents #18, #89, #46, #80 and #97, the proper side rail assessment was completed by a licensed nurse on 6/20/19. It was determined that side rails were needed as an enabler for bed mobility for resident #18. For resident #18, the licensed nurse obtained proper consent from the responsible party, a physician order was	7/22/19

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F 700	Continued From page 9 ongoing monitoring/supervision of side/bed rails in use. One resident (Resident #1) in the survey sample was identified as having his legs entrapped in the side/bed rails. Five additional residents (Resident #46, #89, #18, #80, and #97) were identified at risk for falls, had bed alarms due to attempts to get out of bed, and had side/bed rails in use. These six residents did not have attempted alternatives prior to the use of side/bed rails, proper assessment, consent, or ongoing monitoring/supervision of the side/bed rails. The facility census was 107 at the time of the survey. Forty-eight (48) residents had side/bed rails in use without assessments. The facility had not implemented the policy and procedure developed by the company, nor had they implemented new assessments and consent forms developed by the company in response to the 2017 regulation, thus identifying a system wide failure. Immediate Jeopardy (IJ) and SQC (substandard quality of care) was identified in the area of Quality of Care on 06/20/2019 at 5:02 p.m. The plan of removal for the immediacy was accepted by the survey team on 06/20/2019 at 9:40 p.m. The IJ was abated on 06/24/2019 at 3:42 p.m. with the Scope and Severity lowered to Level II, Widespread. Findings were: 1. Resident #1 was admitted to the facility on 02/18/2018 with the following diagnoses, but not limited to: Diffuse TBI (traumatic brain injury) with loss of consciousness greater than 24 hours without return to pre-existing conscious level, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting right	F 700	obtained for side rails as an enabler to aid in bed mobility and care plan was updated to reflect on going monitoring/supervision of the side/bedrails. For residents #46, #80, #89 and #97, side/bedrails were removed on 6/20/19. Resident #46 and resident #97 is no longer reside in the facility. The facility Executive Director (E.D.) and Director of Clinical Services (DCS) were educated via telephone on 6/20/2019 at 5:30pm by the Regional Director of Clinical Services (RDCS) on the policy and federal regulations for side rails. The interdisciplinary team was educated on the same policy by the Regional Director of Business Development on 6/20/2019. 2. Residents currently residing in the center have the potential to be affected. Quality review of all residents currently with side rails in-house were evaluated by a licensed nurse as of 6/23/19 and alternative measures were put in place i.e. – trapeze bar, fall mats, bed bolsters, bed alarm, tab alarm, low bed. Physician orders were obtained and individual care plans were revised by 6/23/19. Maintenance completed measurements for side/bed rails to ensure there was no potential risk for entrapment as of 6/23/2019. 3. a) Facility staff were educated on F-700 and the policy regarding bed rails/side rails to include assessment schedule as well as risk by the director of clinical services. b) New admissions will be evaluated for the use side rails/bed rails. Risks and benefits will be discussed at the time of	

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F 700	Continued From page 10 dominant side, mixed receptive-expressive language disorder, cardiac arrhythmia, atherosclerotic heart disease, spinal stenosis, and hypertension. A quarterly MDS with an ARD of 06/07/2019 (completed after his entanglement in the side rails), assessed Resident #1 as severely impaired in his cognitive function with a score of "01". The previous MDS was a annual assessment with an ARD of 03/08/2019, and assessed Resident #1 as moderately impaired in his cognitive status with a score of "09". A review of the electronic clinical record was done on 06/18/2019 at approximately 3:00 p.m.. Observed in the nurse's note section was the following entry: "06/07/2019 03:11 [3;11 a.m.] Res [resident] personal alarm noted sounding @ [at] 0215 this morning, staff immediately attending to the sound and entered res room. Res noted on the right side of bed at the nightstand, res was on left hand side with arm behind body and head on the fall mat. Res noted [with] bilateral legs in railing of bed, Assessment was performed on res, limitedly due to positioning of res at the time, res stated no pain at all. Multiple staff were attending, staff assisted res back to bed, assessment was completed thoroughly at that time and one noted marking on the back of reddened area, laterally, less than a half inch long..." On 06/19/2019 at approximately 9:00 a.m., Resident #1 was observed sitting in his wheelchair next to his bed. A tab alarm was in place on his chair. He was wearing a self-releasing seatbelt. Resident #1 was able to remove the alarming seatbelt on request but he did not communicate verbally. There were no	F 700	assessment by the licensed nurse and consent for usage will be obtained. c) Residents with side rails/bed rails as an enabler will be assessed quarterly and with any change of condition to validate the ongoing need by a licensed nurse. d) Maintenance director will inspect side rails/bedrails quarterly and with any changes in bedding equipment to ensure no risk for entrapment. d) A quality review of residents with side rails will be completed by the ED or designee weekly X four (4) weeks then monthly x six (6) months to ensure that risk/benefits have been reviewed, measurements taken, and consent is signed. 4. The quality assurance committee will meet monthly to review the results of quality review and make changes as necessary.	

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side/bed rails on his bed. An alarm box for a bed alarm was observed on his bed.

The clinical record was reviewed on 06/19/2019 and included the following: SBAR (Situation; Background; Appearance; Review and Notify) forms were on the clinical record for the following falls: "12/11/2018: Resident found sitting next to bed facing wall, side rails still up on bed-no injuries noted...; 12/14/2018: Patient observed trying to roll himself out of bed...unable to reach in time to prevent patient from falling, pad alarm sounding...; 4/11/2019: Res found on floor on fall matt [sic] beside bed...; 05/14/2019: Res fell from bed @0155 [1:55 a.m.], landed on L [left] should which has had previous fx [fracture] with dislocation. Res screaming in pain, abrasion noted to L shoulder...sent to ER for eval; 06/07/2019: Staff assisted res when alarm was sounding res noted on floor @0215...1/2 inch reddened abrasion to L lateral side..."

On 06/20/2019 at approximately 8:20 a.m., the clinical record was reviewed for bed rail evaluations, consents, and the attempt of alternates prior to using the side/bed rails. A quarterly data collection tool dated 03/08/2019 included: "SIDE RAIL EVALUATION". The first area of yes/no questions were in regard to "RESIDENT STATUS...Is the resident non-ambulatory? YES; Is the resident comatose, semi-comatose, obtunded, or has fluctuation in levels of consciousness? NO; Does the resident have alteration in safety awareness due to cognitive decline? NO; Does the resident have a history of falls? YES: Has the resident demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed? YES; Does the resident have difficulty with

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balance or poor trunk control? YES; Does the resident have difficulty with postural hypertension? NO; Is the resident on any medications, which would require safety precautions? NO; Is the resident currently using the side rail for positioning or support? YES; Has the resident expressed a desire to have side rails raised while in bed for their own safety and/or comfort? YES; Has the resident requested that side rails not be released while sleeping? YES; Is the resident visually challenged? NO." The next area was "INTERVENTIONS." The following interventions were checked: "Periodic assisted toileting for resident at night; Verbal reminders to use the call light...RECOMMENDATIONS: Bilateral Quarter Rails...Side rails are indicated and serve as an enabler to promote independence...COMMENTS/RECOMMENDATIONS: Resident requires bilateral quarter side rails to provide bed mobility." There was no documentation in the clinical record regarding the attempt to use alternative measures prior to the use of side/bed rails, nor was there an informed consent for the use of the side/bed rails.

On 06/07/2019, after Resident #1's fall from the bed and entanglement in the side/bed rails, an additional side/bed rail evaluation was completed. Under the area "RESIDENT STATUS" the questions were answered the same as the March evaluation with the exception of the following: "Does the resident have alteration in safety awareness due to cognitive decline? YES; Has the resident requested that side rails not be released while sleeping? NO." Under "RECOMMENDATIONS" the following was checked: "Side rails do not appear to be indicated at this time.

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COMMENTS/RECOMMENDATIONS: Resident was using bilateral half rails to help position self when in bed however not indicated @ this time due to poor safety and cognition."

On 06/20/2019 at approximately 9:00 a.m.,, the DON (director of nursing) was interviewed regarding side/bed rails in the facility. She stated that there was a tool in her office when she came to the facility and she had given it to the maintenance director. She was asked for the investigation regarding Resident #1's fall from his bed on 06/07/2019.

A witness statement from 06/07/2019 was presented and contained the following: "Res alarm sounded and myself/CNA [certified nursing assistant] [Name] noted res on fall mat on (R) [right] side of bed in front of nightstand. Res appeared in a position of majority of upper body weighted on res (L) side and (L) arm behind body-res noted with bilat legs in railing. Res upper body was fully over railing, at hips body was noted partially on mattress and bilat legs at area of railing. (L) [left] was noted under railing/mat and (R) leg overhead railing to mattress. CNA [Names] and this nurse present at time of transfer due to positioning, bed was slowly moved over for assessment, res stated, 'no' r/t [related to] pain, ROM [range of motion] wnl [within normal limits]; transferred res to bed for further assessment. (L) lateral abrasion noted- [symbol for no] other noted injuries."

At approximately, 10:30 a.m., on 06/20/2019 the maintenance director came to the conference room. He stated, "I haven't measured the beds... [Name of former DON] developed this tool." He was holding a wooden rod with a flat round disc

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on the top an another on the bottom. He stated, "This measures the sides of the mattresses, the head board and the footboard. [Name of former DON] did measurements on all the beds last year before you came to survey...I don't know where those measurements are and I haven't measured them since...I can look at a bed and see if there are gaps without measuring it."

On 06/20/2019 at approximately 10:50 a.m. LPN [licensed practical nurse] #3 was called regarding her witness statement and was asked if she could explain what had happened. She stated, "Yes, I was working and there were two CNAs working with me. The CNAs were in other resident rooms. We heard the bed alarm sounding and all went to the room. [Resident name] whole upper body was resting on the fall mat that was on the side of the bed where the air conditioner is...His left leg knee was touching the fall mat, part of his calf on his left leg was under the side rail, his right leg was over the rail. All of his weight was on his upper body on his left side...It looked like if you were doing a cartwheel and your first leg went down and the other leg was trying to come over...that's where he stopped, in the middle of the cartwheel...he couldn't go over any further because he got caught." LPN #3 was asked where the side rails were located on the bed. She stated, "They were in the middle of the bed...his whole calf wasn't under the bed, just part of it..if all his pressure hadn't been on his upper body he would have been hurt...he's a frail man, very limited in communication...he just had a reddened area on his side when we assessed him."

On 06/20/2019 at approximately 11:50 a.m., a meeting was held with the DON, the administrator and the maintenance director. Questions were

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asked regarding the bed frames and mattresses. The maintenance director stated, "All mattresses are purchased from the same company that the bed frames come from...when we replace a mattress I call the company and tell them what I size I need and they send it...all our mattresses come from them, the concave mattresses, air mattresses...all of them...Some of our beds are from hospice and they bring in their beds and mattresses and install them. I can see if the mattress fits the bed, I don't need to measure it... [Name of former DON] measured all the beds a year ago...he made the tool I showed you...he and [name of another employee] went room to room and made sure the rails did not exceed the tool measurements." The DON stated, "We are looking for those measurements now." The DON was asked when the side/bed rails were removed from Resident #1's bed. She stated, "They were removed after the fall [06/07/2019]." She was asked if any alternatives had been attempted with Resident #1 prior to the use of his side/bed rails. She stated, "I can't answer that I wasn't here at the time." The administrative team was asked how it was ascertained if the beds were the right size based on a resident's size and weight. The DON stated, "We get the height and weight at admission." They were asked what the guidelines were regarding height and weight of the beds in use. The maintenance director stated, "All the mattresses are 80 inches long...the maximum weight on the bed frame is 500 pounds, I don't know what the mattress is." The DON was asked why bed alarms were used in the facility. She stated, "To alert staff when they are trying to get out of bed and they can try to get to them before they fall."

At approximately 12:30 p.m. the survey team

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conducted a walk through of the facility to determine what residents had side/bed rails either in use or available for use. It was determined that every bed in the facility except two had side/bed rails in place and available for use by the residents. Multiple beds had side/bed rails in the upright position at the time of the walk through. Five additional residents with side/bed rails up, bed alarms in place, and a history of falls, were identified at that time.

Review of the five residents identified indicated that no alternatives to side/bed rails had been attempted prior to their use, no measurements or assessments were present to prevent the risk of entrapment, there were no informed consents present for the use of side/bed rails, nor was there a system in place for ongoing monitoring and supervision of side/bed rails in use. The team supervisor and the State Agency were contacted with the concerns identified by the survey team. The office concurred and Immediate Jeopardy with subsequent Substandard Quality of Care identified.

At 5:00 p.m., on 06/20/2019 the administrator and the DON were called to the conference room. They were informed at 5:02 p.m., that the survey team with concurrence from the State Agency had identified immediate jeopardy with subsequent substandard quality of care. A system wide failure was identified due to the facility's failure to attempt appropriate alternatives prior to the installation of side/bed rails, had failed to assess residents for the risk of entrapment, had failed to review the risks of side/bed rails with residents or their representatives and obtain an informed consent for their usage. They had also failed to have a

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system in place to ensure that resident beds were appropriate for the resident's size and weight and failed to have a system in place for assessment and ongoing monitoring/supervision of side/bed rails in use. The administrative team was informed that one resident (Resident #1) had been identified as having his legs entrapped in his side/bed rails and five additional residents had been identified as having bed alarms due to the risk of falls and having side/bed rails in use without proper assessment and monitoring. The DON was asked to verify how many residents in the facility were using the side/bed rails on their beds. She verified that of the 107 residents residing in the facility, 48 had side/bed rails in use.

At approximately 7:00 p.m., the facility administrator presented a blank side/bed rail evaluation form. The revision date on the form was "04/18". This form had been revised to include the regulatory requirements set forth in the 2017 Federal Long Term Care regulations for bed/side rails.

Also presented with the side rail evaluation was an "INFORMED CONSENT FOR THE USE OF BED RAILS" form that was dated 05/18 and contained information regarding the benefits and potential risks/negative outcomes associated with bed rail usage. The back of the consent contained the following: Assessed medical needs addressed by the use of bed rails, the type of rails recommended for the resident, and the actual consent stating that the resident or representative had been informed of the medical need for the bed rails as well as the risks versus benefits of the rails. There were two choices for the person signing the form, "I DO voluntarily consent to the

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use of bed rails..." or "I DO NOT consent to the use of bed rails..." The bottom of the consent had a line for signatures, additional comments and the following "Physician order has been obtained, including medical symptom/condition."

In addition to the two forms detailed above, a policy and procedure for "Side Rail/Bed Rail" was presented. The effective date of the policy was 04/19/2018 and contained the following: "POLICY: The Center, will attempt alternative interventions, and document in the medical record, prior to the use of side rail/bed rail. Side Rail/Bed rail may include but not limited to: Side rails, bed rails, safety rails, grab bars and assist bars. Procedure: 1. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. 2. Review the risk and benefits with the resident and/or representative. 3. Obtain consent from the resident and/or resident representative. 4. Obtain physician order for side rail/bed rail. 5. Update the care plan and kardex. 6. Re-evaluate the use of side rail/bed rail, quarterly, with a change in condition or as needed. 7. Follow the manufacturers' recommendations and specifications for installing and maintaining side rails/bed rails."

After reviewing the documents above, the administrator was asked where the forms had come from. He stated, "They came from the corporate office." The revision dates on the two forms were pointed out to the administrator. He was asked if the revision dates/effective dates (April 2018 and May 2018) indicated the forms were implemented by the corporate office and should have been put into use at the facility at that time. He stated, "Yes." He was asked how

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the information was communicated to the facility. He stated, "An email was sent to either the administrator or the DON [director of nursing]". He was asked if he had received the email. He stated, "I don't recall ever seeing it." He was asked if the former DON had received it should it have been communicated to him. He stated, "Yes."

The plan of removal was accepted on 06/20/2019 at 9:40 p.m. and contained the following information:

"1. The corrective action for the alleged deficient practice will be accomplished by:
* The 5 identified residents were observed, the resident or RP was interviewed to identify who requested the bed rail to be installed, and assessed for the risk of entrapment from bed rails.
* The bed rails were removed for 4 residents identified on 6/20/19.
* Bed rails will be removed from beds of current residents with no assessment in place, an alternative measure will be put in place to assess the effectiveness prior to installing a side rail by 6/23/19.
* [Resident #18's Name] RP [responsible party] was educated on the risks/benefits of the side rails and verbalized understanding and signed consent on 6/20/19.
* Current staff working have been in serviced on the side rail/bed rail policy and F770 [typo should be 700] 6/20/19.
* Staff not working will be in serviced on the side rail/bed rail policy and F770 [typo] prior to working their next scheduled shift by 6/23/19. Any staff currently on leave will be educated upon return.
* For the 5 identified residents their bed was

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measured to ensure appropriate size and dimensions on 6/20/19
*The facility Executive Director and Director of Nursing have been educated via telephone on 6/20/2019 at 5:30 pm by the Regional Director of Clinical Services on the policy and federal regulations for side rails. The interdisciplinary team will be educated on the same policy by the Regional Director of Business Development on 6/20/2019 by 6:05 pm.

2. Residents with the potential to be affected by alleged deficient practice:
Quality review of all residents currently with side rails in-house will be evaluated by a licensed nurse by 6/23/19 and alternative measures will be put in place i.e. - bed bolsters, bed alarm, tab alarm, low bed. Physician orders to be obtained and care plan revised by 6/23/19. Residents identified as candidates for side rail usage, will have risk and benefits reviewed and consent signed per the policy. Maintenance to provide measurements for bed and side rail to ensure no potential risk for entrapment by 6/23/2019.

3. Systemic Changes:
I. Facility staff currently in the facility will be educated on policy regarding bed rails/side rails to include assessment schedule as well as risk on 6-20-2019. All other clinic staff will be educated prior to working their next shift. Staff not working will be in serviced on the side rail/bed rail policy and F770 [typo] prior to working their next scheduled shift by 6/23/19. Any staff currently on leave will be educated upon return.
II. Residents with side rails/bed rails will be assessed quarterly and with any change of condition.
III. Quality Review of residents with side rails

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weekly X 4 to ensure that risk and benefits, measurements, consent signed then monthly X 6 months
IV. The quarterly assurance committee will meet monthly to review the results of quality review and make changes as necessary."

On 06/21/2019 at approximately 9:00 a.m., the SBARs for Resident #1's falls out of bed were reviewed. After review, the DON was asked if Resident #1's side rails had been in the up position at the time of the falls, as only the fall out of bed on 12/11/2018 included information regarding the side rails. She stated, "I don't know, I wasn't here then. I have looked for witness statements and I can't find them for any of the falls out of bed except the one on 06/07/2019." She was asked when the bed rails were removed for Resident #1. She stated, "We removed them right after that fall."

A meeting was held with the DON, the corporate nurse consultant and the administrator on 06/21/2019 at approximately 11:30 a.m. While discussing side rails the corporate nurse consultant stated, "We know we need to put a process in place, it is broken."

On 06/24/2019 the survey team returned to the facility. The plan of removal was reviewed for evidence verifying the plan had been fully implemented and no residents in the facility were in jeopardy. Information reviewed included the bed/side rail evaluations for the 48 residents identified by the facility as having bed/side rails in use. Of those 48 residents, the facility determined by use of the bed/side rail evaluation, that bed/side rails were not indicated for 30 of those residents. The remaining 18 residents or their

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RPs (responsible party) refused the use of alternatives to bed/side rails. For those 18 residents, bed/side rail assessments were completed, consents were signed, physician orders were obtained and the care plans were updated. The facility bed/side rail policy was also updated to include the following: "Addendum: On going [sic] monitoring will include: 1) Side rail/bed rail will be monitored by licensed nurse per physician order; 2) Side rails will be lowered as indicated to provide care. toileting, hydration, meals and positioning; 3) Re-evaluate the use of side rail/bed rail, on admission, quarterly, and with any change of condition as needed by a licensed nurse. If the side rail/bed rail is no longer indicated the licensed nurse will notify maintenance for removal of the bed rail/side rail; 4) Maintenance will conduct routine maintenance of beds and side rail/bed rail to ensure they meet safety standards and are not in need of repair upon resident admission, readmission, significant change and quarterly." Education of staff regarding the changes to the use of bed/side rails was evidenced by in-service records and staff interviews.

The Immediate Jeopardy was abated at 06/24/2019 at 3:42 p.m. The Scope and Severity was lowered from a pattern of Immediacy to a Level II, widespread.

No further information was obtained prior to the exit conference.

2. Resident #46 was originally admitted to the facility on 02/16/2017 and was recently readmitted on 04/20/2019. Her diagnoses included but were not limited to: Unspecified dementia with behaviors, unspecified psychosis,

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Parkinson's Disease, scoliosis, and hypertension.

A significant change MDS (minimum data set) with an ARD (assessment reference date) of 05/04/2019, assessed Resident #46 as severely impaired in her cognitive status with a summary score of "00".

On 06/18/19 at approximately 12:00 p.m., Resident #46 was observed in bed, asleep, a tab alarm was in place, a fall mat was on the right side of her bed between her bed and the wall, a wedge cushion was on her left side, and an air mattress overlay was in place on her bed. At approximately 12:30 p.m., Resident #46 was heard yelling in her room, "I can't breath, I can't breath." Staff went to the room and Resident #46 was observed with the head of her bed up, a lunch tray was in the room, Resident #46 was attempting to sit up in the bed. Staff went to the room and assisted her.

The electronic record was reviewed at approximately 3;15 p.m., on 06/18/2019. Included in the documentation was the following note: "05/18/2019 19:46 [7:46 p.m.] Patient's bed alarm sounding off, patient found in the floor, between her bed and wall. Appears that patient had thrown her legs over the side of the bed. And d/t [due to] contractures in her legs, caused her whole body to fall. Patient states that she was making cookies when asked what had happened...Patient assisted back into bed, alarm in place and on. Wedge under patient's right side. Bed in low position.."

The clinical record was reviewed for bed/side rail assessments. Two quarterly data collection tools, one dated 03/12/2019 and the other dated

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03/19/2019, were reviewed. There was a section on the tool, "SIDE RAILS" with a yes or no question, "Is the resident using Side Rails?" Both tools were checked "Yes" and the type entered was "Bil [bilateral] quarterly". Further instructions on the form were: "If yes, complete additional Side Rails Evaluation. Side rails include bed rails, grab bars, assist rails." There were no "Side Rails Evaluation" observed in the clinical record.

The care plan was reviewed. There was no mention of bed/side rails on the care plan. There were no physician orders, consent, or attempts at alternatives to bed/side rails documented in the clinical record.

At approximately, 11:50 a.m., on 06/20/2019 the maintenance director was interviewed about measuring beds to ensure they were the proper size for a resident's height and weight with the use of bed/side rails. He stated that he had not measured the beds but that mattresses were ordered from the same company that the bed frames came from to ensure proper fit. He was asked about the air mattress overlay used by Resident #46. He stated, "She is hospice, they bring in their own beds and mattresses and install them...that air overlay is over the LAL mattress (low air loss)... I can see if the mattress fits the bed, I don't need to measure it..." The DON was asked why bed alarms were used in the facility. She stated, "To alert staff when they are trying to get out of bed and they can try to get to them before they fall."

A system wide failure regarding side rails was identified by the survey team and Immediate Jeopardy was called at 5:02 p.m., on 06/20/2019.

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Resident #46 was included in the immediacy due to her lack of assessment for the use of her bed/side rails, her history of falls, and the use of a bed alarm to alert staff when she was trying to get out of bed.

During the plan of removal the facility staff identified 48 residents with bed/side rails in use in the facility. Resident #46 was one of those residents. After a side rail evaluation was completed on 06/20/2019, it was determined by the facility staff that side rails were not indicated for Resident #46.

On 06/24/2019 a walk through of the facility was conducted by the survey team. There were no bed/side rails on Resident #46's bed.

During a meeting with facility staff on 06/24/2019 at approximately 4:30 p.m., the DON was asked if the bed/side rails had been up at the time of Resident #46's fall from her bed. She stated that she had been unable to find a witness statement regarding the fall and was unable to determine by the SBAR if the bed/side rails had been in the up position or not.

No further information was obtained prior to the exit conference on 06/24/2019.

3. Resident #89 was admitted to the facility on 01/31/2018 with the following diagnoses, but not limited to: Alzheimer's Disease, weight loss, Chronic diastolic heart failure, anxiety, history of TIA (transient ischemic attacks), history of falls, and abnormal posture.

A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/29/2019,

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assessed Resident #89 as severely impaired in her cognitive status with a summary score of "03".

On 06/18/2019 at approximately 12:00 p.m., Resident #89 was observed lying in her bed. A tab alarm was observed on her bed, and bilateral bed/side rails were in use.

The clinical record was reviewed on 06/19/2019. The note dated 06/18/2019 written by the interdisciplinary team documented that Resident #89 continued to need her bed alarm. (A copy of the note was requested but was not received.)

The care plan was reviewed. A focus areas, "At Risk for Falls r/t [related to] poor safety awareness...frequent falls" was observed. Interventions included but were not limited to: "Resident has Velcro self release seatbelt for safety; Tab alarm in Bed-check function & placement Q [every] shift..." Another focus area: "...ADL self-care" included the following intervention: "Bed Mobility: The resident requires assistance from staff with bed mobility." There was no mention of side rails on the care plan.

There were no physician orders, consent or attempts at alternatives prior to the implementation of bed/side rails documented in the clinical record.

On 06/20/2019 at approximately 11:50 a.m., a meeting was held with the DON, the administrator and the maintenance director. The DON was asked why bed alarms were used in the facility. She stated, "To alert staff when they are trying to get out of bed and they can try to get to them before they fall."

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F 700	Continued From page 27 A system wide failure regarding bed/side rails was identified by the survey team and Immediate Jeopardy was called at 5:02 p.m., on 06/20/2019. Resident #89 was included in the immediacy due to her lack of assessment for the use of her bed/side rails, her history of falls, and the use of a bed alarm to alert staff when she was trying to get out of bed. During a meeting with the DON (director of nursing), the corporate nurse consultant and the administrator on 06/21/2019 at approximately 11:30 a.m. The DON was asked why Resident #89 had bed/side rails. She stated,"I don't know why she had them, she's not using them for bed mobility." During the plan of removal the facility staff identified 48 residents with bed/side rails in use in the facility. Resident #89 was one of those residents. After a bed/side rail evaluation was completed on 06/20/2019, it was determined by the facility staff that bed/side rails were not indicated for Resident #89. On 06/24/2019 a walk through of the facility was conducted by the survey team. There were no bed/side rails on Resident #89's bed. A meeting was held with the facility administrator, DON and corporate nurse consultant on 06/24/2019 at approximately 4:40 p.m., the DON was asked why the IDT had elected to leave Resident #89's bed alarm on during their last meeting. She stated, "They continued the bed alarm because she sits up in the bed. It is to alert them before she gets up."	F 700		

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No further information was obtained prior to the exit conference on 06/24/2019.
4. Resident # 18 was admitted to the facility 12/19/15 with a readmission date of 3/12/19. Diagnoses for Resident # 18 included, but were not limited to: syncope and collapse, unspecified abdominal pain, history of falling, Parkinson's disease, and depression.

The most recent MDS (minimum data set) was a significant change assessment and had Resident # 18 with severe impairment in cognition with a total summary score of 00 out of 15.

On 6/20/19 at approximately 4:45 p.m. Resident # 18 was observed in bed with bed/side rails up.

A review of the clinical record revealed there was no assessment for the use of the bed/side rails, and also documented several falls for the resident. The current POS (physician order summary) dated 6/2019 included an order for "Bed alarm when in bed...." The care plan for falls also included interventions for "Bed alarm every shift check for function and placement each shift."

On 6/20/19 at 5:00 p.m. the DON (director of nursing) was asked for the purpose of both a bed alarm, and bed rails. The DON stated "The alarm is to alert staff for safety reasons if the resident doesn't or can't use the call bell, or they are at a high risk for falls." The DON was then asked if a resident attempted to get up, and had the bed/side rails up, what would or could happen. She replied "Well, I guess they have the potential to get tangled up like [name of Resident # 1]."

No further information was provided prior to the

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exit conference.

5. Resident # 80 was admitted to the facility 6/4/18 with diagnoses to include, but not limited to: congestive heart failure, difficulty walking, muscle weakness, history of falling, and high blood pressure.

On 6/20/19 at 4:30 p.m. Resident # 80 was conserved in bed with the bed/side rails up.

A review of the clinical record revealed the resident had recently had a fall on 6/16/19 at 3:00 p.m. in the bathroom, with no injury. A nurses' note documented the administrative nurse on call was notified, and due to concerns of the resident's history of "getting out of bed" was instructed to put a pad alarm on the bed.

Further review of the clinical record failed to reveal an assessment for the use of the bed/side rails in use.

On 6/20/19 at 5:00 p.m. the DON (director of nursing) was asked for the purpose of both a bed alarm, and bed/side rails. The DON stated "The alarm is to alert staff for safety reasons if the resident doesn't or can't use the call bell, or they are at a high risk for falls." The DON was then asked if a resident attempted to get up, and had the bed/side rails up, what would or could happen. She replied "Well, I guess they have the potential to get tangled up like [name of Resident # 1]."

No further information was provided prior to the exit conference.

6. Resident # 97 was admitted to the facility on

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5/16/19 with diagnoses that included anemia, hypertension, obstructive uropathy, diabetes mellitus, hyperlipidemia, Parkinson's Disease, metabolic encephalopathy, generalized muscle weakness, history of falling, dysarhtia and anarhria, malignant neoplasm of the prostate, areteiosclerotic heart disease, and chronic kidney disease.

According to a Quarterly Review Minimum Data Set, with an Assessment Reference Date of 6/13/19, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

At 1:10 p.m. on 6/20/19, observation of Resident # 97's room noted that 1/4 bed/side rails located at the head of the resident's bed were in the raised position. Also observed was a concave mattress on his bed. Resident # 97 was not in bed at the time of the observation.

Resident #97's most recent fall occurred on 6/6/19 when an S-BAR (Situation-Background-Assessment-Commendation) report noted the following, "Confused and mumbling most of the night. Observed coming out of bed and on to floor on knees. Resident observed trying to climb out of bed and went to his knees. We put him back into bed."

Review of Resident # 97's Electronic Health Record noted the following order: 6/17/19 - Tab alarm for use in bed. Check function and placement q (every) shift - every shift related to muscle weakens's (generalized), other abnormalities of gait and mobility, history of falling, other lack of coordination.

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F 700	Continued From page 31 Further review of Resident # 97's Electronic Health Record revealed there was no order for the use of 1/4 bed/side rails, no assessment for the use of the 1/4 bed/side rails, no consent signed by his Responsible Party for the use of 1/4 bed/side rails, and the use of 1/4 bed/side rails was not a part of his care plan. No further information was provided prior to the Exit Conference on 6/24/19.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		7/22/19

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F 758	Continued From page 32 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 and staff interview, the facility failed to ensure two of 24 residents in the survey sample (Residents # 48 and 97) were free of unnecessary psychotropic medications. Residents # 48 and 97 both had an as needed (PRN) psychotropic medication ordered for more than 14 days without a stop date. The findings include: 1. Resident # 97 was admitted to the facility on 5/15/19, and readmitted on 5/27/19 with diagnoses that included anxiety disorder, depression, chronic obstructive pulmonary	F 758	F758 1. Resident #97 no longer resides in the facility. For resident #48, physician order was obtained to include a stop date on PRN lorazepam of 7/17/19. 2. Residents currently residing in the center have the potential to be affected. Quality review of all residents currently with PRN orders for psychotropic medications has been completed and physician orders to include a stop date or rationale for continued use have been received. 3. In-servicing will be provided by the DCS/Designee to physicians and	

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F 758	Continued From page 33 disease, acute and chronic respiratory failure with hypoxia, generalized muscle weakness, history of falling, dysphagia, dyspnea, non-rheumatic mitral valve insufficiency, and adjustment disorder with mixed anxiety and depressive mood. According to a Medicare 14-Day Minimum Data Set with an Assessment Reference Date of 6/10/19, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 11 out of 15. Resident # 97 had the following physician's order, dated 5/28/19: Lorazepam Tablet 0.5 mg (milligrams). Give 0.25 mg by mouth every 6 hours as needed for anxiety related to generalized anxiety disorder. Start date 5/28/19. The as needed (PRN) order extended longer than 14 days, and there was no stop date listed for the order. (NOTE: Lorazepam [Ativan] is a short acting benzodiazepine used to treat anxiety and irritability with psychiatric or organic disorders. Given orally, it has an onset of one hour with a peak of two hours. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722.) At 10.15 a.m. on 6/19/19, the Director of Nursing (DON) was advised of the finding and acknowledged that there was no stop date for the Lorazepam order. At 7:30 a.m. on 6/20/19, the DON was interviewed again regarding Resident # 97's PRN Lorazepam order. Asked if the resident's physician was not aware of the 14 day requirement, the DON replied, "He is now." The findings were reviewed during a meeting at	F 758	Licensed Nurses regarding guidelines for PRN psychotropic medications. The Interdisciplinary team will meet weekly to review resident with prn f psychotropic medications to ensure there is appropriate diagnosis for usage with a stop date and/or rationale for continued use. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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11:50 a.m. on 6/20/19 that included the Administrator, DON, Maintenance Director, and the survey team.
2. Resident #48 was originally admitted to the facility on 02/02/19 and most recently readmitted on 2/27/19. Diagnoses for Resident #48 included hyperlipidemia, depression, anxiety, hypertension, diabetes type 2, hypothyroidism, cervical disc disorder, and gastro-esophageal reflux disease (GERD). The most recent minimum data set (MDS) dated 05/03/19, which was a 30 day assessment, assessed Resident #48 as severely cognitive impaired with a score of 6 for daily decision making.

Resident #48's clinical record was reviewed on 06/19/19 at 3 p.m. Included on the physician order sheet was an order that stated, "Lorazepam Tablet 05 MG (milligrams). Give 1 tablet by mouth every 8 hours as needed for AGITATION. Order Date: 04/20/2019. Start Date 04/30/19." There was not an end date documented for the Lorazepam.

A review of the pharmacy consultation report for the period of May 1 - May 31, 2019 documented the following: "[name of resident], has a PRN (as needed) order for an anxiolytic (anxiety) which has been in place for greater than 14 days without a stop date. Recommendation: Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Rationale for Recommendation: CMS requires that PRN orders for non-psychotropic drugs to be limited to 14 days unless the prescriber documents the diagnosed specific

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condition being treated, the rationale for the extended time period, and the duration for the PRN order."

A review of the Physician/Prescriber's response documented the following: "I decline the recommendations above and do not wish to implement any changes due to the reasons below. Rationale: Patient is hospice, requires this for symptomatic control." The report was signed and dated by the physician on 06/03/19.

A review of the medication administration records (MAR) for May 2019 and June 2019 documented the Lorazepam was administered on May 13, May 18, May 19, May 23, May 26, and June 15.

A review of Resident #48's clinical record did not document an order for hospice. On 06/20/19 at 7:45 a.m., the director of nursing (DON) was interviewed regarding the Lorazepam order and the physician's rationale to continue the order was that the resident was on hospice. The DON stated after a review of the resident's clinical record, the physician was mistaken and it was determined the resident was not currently on hospice and had never been on hospice. The DON stated the physician must have mixed up Resident #48 with another resident when he signed the pharmacy consultation report. The DON was asked about the order for the PRN Lorazepam, which did not have a stop day. The DON stated she was aware of the regulation; however, it was determined during the recent QA (Quality Assurance) meeting that the facility's physicians were not aware of the regulation. The DON stated she had spoken with the facility physicians and the facility was working to identify the residents who are on PRN antipsychotic

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KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

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F 758	Continued From page 36 medications. No additional information was provided to the survey team prior to the exit conference on 06/24/19 AT 5:00 p.m.	F 758		
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 ensure expired medications were not available for	F 761	F761 1. The identified bottles of lorazepam in	7/22/19

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F 761	Continued From page 37 administration in two of two medication rooms, and also failed to ensure insulin was properly labeled on one of 6 medication carts. 1. The medication room refrigerators on the East hall and West hall contained three bottles each of Lorazepam (an antianxiety medication) which were expired and available for administration. 2. The medication cart on the 400 unit contained two vials of improperly labeled insulin. Findings include: 1. On 6/18/19 the medication room on the East hall was inspected with RN (registered nurse) # 1. The refrigerator contained three opened bottles of Lorazepam. The bottles were not dated. RN # 1 was asked about the medications, and if an opened date was needed on each one. RN # 1 stated "Those aren't mine; we store the other residents on the other hall in this refrigerator as well. I do not have any residents on that medication right now; those must belong to the other nurse. If they were mine, they would have been dated when I opened them. The only way now to know when they were opened would be to go back on the narcotic sheet to see when it was first given..." At 4:15 p.m. on 6/18/19 the medication room refrigerator on the West hall was inspected with RN # 2. Three bottles of Lorazepam were noted in the refrigerator, opened, and without an open date on them. RN # 2 was asked about the bottles. She stated "Well, the seal has been broken on one bottle, and the other two already have the dropper in them, so they are definitely open..."	F 761	the east and west medication rooms were discarded by the DCS on 6/18/19. The two identified bottles of insulin in the west medication cart were discarded on 6/19/19. 2. Residents currently residing in the center have the potential to be affected. Observations have been conducted by the DCS/designee of the medication carts and medication rooms to identify further expired biologicals. 3. In-servicing will be provided to licensed nurses by the DCS/designee regarding the policy for insulin storage and disposal of expired biologicals from the medication carts and medication rooms. Random weekly observations will be conducted by the DCS/designee of weekly x four (4) weeks then monthly x two (2) months to ensure that there are no expired biologicals present in the medication carts and medication rooms. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 761	Continued From page 38	F 761		

The DON (director of nursing) was asked for the facility policy for labeling and storage of medications 6/18/19 at 4:30 p.m.

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 package insert for the Lorazepam directed "Discard opened bottle after 90 days."

The administrator and DON were informed of the above findings during a meeting with facility staff 6/20/19 beginning at 11:50 a.m.

No further information was provided prior to the exit conference.

2. On 06/19/2019 at approximately 9:30 a.m., the storage cart on the 400 unit was inspected. The top drawer of the cart contained two opened vials of Humulin 75/25 insulin. One of the vials was dated with discard date of 06/28/2019. The other vial was labeled with two different "opened" dates. One date was 5/12/2019 and the other was 5/15/2019.

LPN (licensed practical nurse) #1 who was giving medications, was asked what dates should be on the bottles of insulin. She stated, "I thought they should have the opened date on them not the discard date."

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F 761	Continued From page 39 The DON (director of nursing) was interviewed at approximately 9:35 a.m.,regarding the labeling of insulin. She stated the bottles should be labeled with the date they were open. She went to the medication cart and looked at the insulin bottles. She stated, "This one [the one with the discard date] is not labeled right...it should be the date they opened it, not the discard date...this other one has two dates on it and both of them are out of the time frame...we need to throw both of them away." The policy for the storage of insulin was requested. The facility policy, "Storage and Expiration Dating if Medications, Biologicals, Syringes and Needles" was presented. Per the facility policy: "...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 primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date when opened." Also presented were "Insulin Storage Recommendations" used by the facility. Per those recommendations once opened Humulin 75/25 could be stored for 28 days. The above information was discussed in a meeting with the DON and administrator on 06/20/2019 at approximately 11:50 a.m. No further information was obtained prior to the exit conference on 06/24/2019.	F 761		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration.	F 835		7/22/19

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F 835	Continued From page 40 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on survey findings and staff interviews, the facility administrator failed to ensure that resources regarding the use of side rails were used effectively and efficiently to maintain the highest practicable well-being of each resident. Information regarding the 2017 regulatory requirements for side rails was available to the facility administrator but not implemented. Findings were: An onsite survey was conducted from 06/18/2019 through 06/24/2019. During the survey deficient practice was identified in the area of quality of care at F700. The scope and severity was cited at a level IV, pattern. The facility failed to provide alternative measures to residents in lieu of side rails, failed to assess residents for the risk of entrapment prior to the implementation of side rails, failed to obtain informed consents prior to the use of side rails, and failed to provide ongoing assessment and monitoring of side rails in use. Immediate Jeopardy and Substandard quality of care were identified on 06/20/2019. While discussing and reviewing the facility's plan of removal, an assessment and consent developed by the corporate office with revision dates of 04/2018 and 05/2018 respectively, were presented. The administrator was asked where the forms had come from. He stated, "They came from the corporate office." The revision dates on	F 835	F 835 1. The facility administrator was educated on the facility side rail policy and the federal regulation on side rails on 6/20/2019 by the Regional Director of Clinical Services 2. Residents in the facility have the potential to be affected. No residents were affected 3. The facility administrator will be educated by the Regional Vice President of Operations on his duty to maintain and guide the implementation of facility policies and procedures in compliance with corporate, state, federal, and other regulatory guidelines. The Regional Director of Clinical Services or designee will conduct random visits monthly to validate compliance with implementation of policies and procedures for the next six months. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain compliance.	

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F 835	Continued From page 41 the two forms were pointed out to the administrator. He was asked if the revision dates indicated the forms were implemented by the corporate office and should have been put into use at the facility at that time. He stated, "Yes." He was asked how the information was communicated to the facility. He stated, "An email was sent to either the administrator or the DON [director of nursing]". He was asked if he had received the email. He stated, "I don't recall ever seeing it." He was asked if the former DON had received it should it have been communicated to him. He stated, "Yes." The job description for the facility administrator was reviewed and included the following "Duties and Responsibilities:... Maintain and guide the implementation of facility policies and procedures in compliance with corporate, state, federal, and other regulatory guidelines." No further information was provided prior to the exit conference on 06/24/2019.	F 835		
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. §483.70(i)(1) In accordance with accepted	F 842		7/22/19

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F 842	Continued From page 42	F 842		

professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 43 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 24 residents in the survey sample: Resident # 84. Findings include: Resident # 84 was admitted to the facility 9/1/18 with a readmission date of 3/12/19. Diagnoses for Resident # 84 included, but was not limited to: unspecified abdominal pain, Parkinson's disease, gout, high blood pressure, and dementia. The most recent MDS (minimum data set) was a significant change in status assessment dated 4/3/19. Resident # 84 was coded with severe cognitive impairment with a total summary score of 00 out of 15. During review of Resident # 84's electric medical record (EMR) on 6/19/19 at 3:30 p.m. it was noted a hospital discharge summary for another resident was scanned into Resident # 84's record. The documentation was dated 5/15/19.	F 842	F842 1. The hospital discharge summary for another resident that was scanned into Resident # 84's electronic medical record has been removed. 2. Residents currently residing in the center have the potential to be affected. Observations will be conducted by the DCS/designee of scanned documents into the electronic medical record for accuracy. 3. In servicing will be provided to the medical record staff on ensuring the correct documents are scanned into the correct electronic medical record. Random weekly observations will be conducted by the DCS/designee for five random residents per week for three (3) months to ensure documents scanned into the electronic medical record are accurate. 4. Results of the reviews will be discussed by the administrator/designee at the	

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F 842	Continued From page 44 On 6/20/19 at 8:30 a.m. the medical record staff, OS (other staff) # 1 was asked about the scanned documentation. OS # 1 stated "This scanning into a computerized record is totally new to me; I did not realize I had scanned the wrong information into the wrong record. I can assure you, it won't happen again." The administrator and DON were informed of the above findings during a meeting with facility staff 6/20/19 beginning at 11:50 a.m. No further information was provided prior to the exit conference.	F 842	Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 865		7/22/19

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F 865	Continued From page 45 Based on an overview of the facility's Quality Assurance and Performance Improvement (QAPI) Program, staff interview, and the identification of Immediate Jeopardy and Substandard Quality of Care in the area of Quality of Care, specifically Federal Tag F-700 (Bedrails), the facility's QAPI Program failed to identify a systemic problem with the use of bedrails, and failed to develop a mitigation program to address the problem. The findings were: During the survey process, the survey team identified a systemic problem with the facility's use of 1/4 bedrails that resulted in the identification of Immediate Jeopardy and Substandard Quality of Care. The facility was using 1/4 bedrails for residents who were not individually assessed for the need of bedrails, who were not offered alternative measures before the use of bedrails, who did not have an order for bedrails, who did not have a care plan for bedrails, and for whom no consent had been obtained from the resident or the resident's Responsible Party for the use of bedrails. At approximately 3:30 p.m. on 6/24/19, the Administrator was interviewed regarding the facility's QAPI Program. After a general overview of the program, the Administrator was asked if the facility's use of 1/4 bedrails had been identified as a problems by QAPI. The Administrator said it had not. Asked why the siderails had not been identified as a problem, the Administrator said they (the facility) were so focused on the use of only 1/4 bedrails, that changes to the regulatory language	F 865	F865 1. The facility Quality Assurance team was educated on the facility side rail policy and the federal regulation for side rails on 7/8/2019 by the Regional Director of Clinical Services. 2. Residents in the facility have the potential to be affected. No residents were affected 3. The facility QA team will be educated by the Regional Vice President of Operations on their duty to maintain an effective quality assurance improvement system to identify systemic problems and implementation of plans to mitigate risk. The facility will conduct monthly quality assurance committee meetings to identify facility concerns and implement plans and process changes as necessary to mitigate risk facility wide. Regional Clinical Director or designee will validate compliance monthly x 6 months. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.	

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F 865	Continued From page 46 for bedrails usage seemed to slip between the cracks, and was missed. The Administrator could offer no other explanation for identifying the bedrail problem before it was identified by the survey team.	F 865		