STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 09/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source	E 041	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. E041 1. The facility is following the emergency preparedness plan and generator checks are being conducted and logged. 2. No other concerns identified. 3. Maintenance staff will be educated on the generator checks are being conducted and logged. 4. Audits will be conducted by the Administrator/ Designee to ensure the generator checks are being	10/5/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacie Shine LNHA — TITLE: Executive Director — (X6) DATE: 9/27/19

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

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E 041	Continued From page 1 to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition,	E 041	conducted and logged weekly times four weeks then monthly times three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 10/5/19	

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E 041	Continued From page 2 issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, it was determined the facility staff failed to follow their emergency preparedness plan. The findings include: A request was made for the generator logs on 9/5/19 at approximately 1:00 p.m. from administrative staff member (ASM) #1, the director of nursing. At 1:55 p.m., ASM #1 stated she could not provide the generator logs. She stated that they had had a flood between the walls, the maintenance office was hit, and the papers were destroyed. The former maintenance director kept all of his records on paper in binders. The binders got wet with the flood. An interview was conducted with OSM (other staff member) #1, the new maintenance director on 9/5/19 at 2:05 p.m. OSM #1 states it was his third day of employment at the facility. When asked how often is the generator tested, OSM #1 stated it's tested weekly for about 30 minutes and then monthly it's run for one to one and a half hours. While it's running, the gauges have to be checked	E 041		

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E 041	Continued From page 3 and documented. He stated the generator logs got wet in the flood and are unreadable. Therefore, he could not present any documentation of the logs since 8/7/19. He also stated the previous maintenance director did not like the computer system in place for maintenance. There is a program for maintenance documentation and duties in the computer program. The document presented from the computer program for maintenance documented in part, "Exercise generator (with no load), perform routine checks, and create entry in logbook. Recurrence: every 1-week. Category: Emergency Power Generators ...Recommendations for exercising (with no load). 1. Exercised with no load only verifies engine startup and operation, it does not verify that the generator is capable of supporting your facility or that the transfer switches are working. 2. This task should be used in conjunction with regularly scheduled tests in which the generator is loaded (load should be at least 30 percent of rated capacity). 3. Avoid running the generator for extended periods with no load. Execute prestart checklist: 1. Check engine -oil level (do not overfill). Check coolant level (caution: do not check while engine is hot). 3. Check all hoses, fan belts and mechanical components of engine. 4. Inspect fuel system - check fuel level, check for fuel leaks, ensure fuel fittings are tight, specific battery gravity checked, visually inspect fuel tank; if equipped, test the fuel leak, detection system. 5. Inspect exhausts system: ensure is tight, check for combustible materials near the system, ensure that exhaust is discharged away from building,. 6. Perform battery test on generator battery."	E 041		

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E 041	Continued From page 4 The Emergency preparedness plan documented the following, "Emergency Equipment: 3. The Maintenance Department shall maintain emergency equipment and ensure that it is operable at all times." ASM #1 was made aware of the above concern on 9/5/19 at 2:53 p.m.	E 041	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 000	INITIAL COMMENTS An announced Medicare/Medicaid abbreviated survey was conducted 9/4/19 through 9/5/19. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in the 180 certified bed facility was 164 at the time of the survey. The survey sample consisted of eight current Resident reviews, (Residents #1 through #8).	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600	F600 1. Residents #7 and #8 are now safe from abuse. 2. Each resident has the potential of being affected. 3. Staff will be re-educated on facility abuse policy and procedures to ensure residents are free from abuse.	10/5/19

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F 600	Continued From page 5 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure two of eight residents in the survey sample were free from abuse, Residents #7 and #8. On 8/6/19, Resident #8 grabbed Resident #7's arm. Resident #7 then pushed Resident #8 and Resident #8 fell with no injuries noted. The findings include: The "Facility Reported Incident" dated, 8/7/19, documented in part, "Incident date: 8/6/19. Resident's involved (Resident #7) and (Resident #8). Injuries: (A check mark was documented next to)"Yes." (Resident #7) noted with red scratches to neck and forehead...Describe Incident: Resident to resident altercation between (Resident #7) and (Resident #8). (Resident #8) was reading a book and got upset at (Resident #7) because she was on the phone. (Resident #8) grabbed (Resident #7)'s arm and (Resident #7) pushed (Resident #8). (Resident #8) fell with no injuries noted. Residents immediately separated. (Resident #8) moved to a different unit/room." The "Final Report" dated, 8/9/19, documented in part, "This is the Final Report regarding the initial FRI of allegation of abuse/mistreatment regarding (Resident #7) and (Resident #8) reported August 7, 2019...Investigation Summary: Resident to resident altercation between (Resident #7) and (Resident #8) was reported. (Resident #8) was reading a book and got upset at (Resident #7)	F 600	4. Audits will be conducted to ensure staff understanding that residents have the right to be free of abuse weekly times four weeks then monthly times three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance. Compliance Date: 10/5/19	

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because she was on the phone. (Resident #8) grabbed (Resident #7)'s arm and (Resident #7) pushed (Resident #8). (Resident #8) fell with no injuries noted. Resident were immediately separated. (Resident #8) moved to a different room/unit. (Resident #7) was noted to have red scratch marks on her neck and forehead. (Resident #8) was not noted with any injuries. Staff report that they did not witness the incident...Upon further interview with (Resident #7) by Social Worker; stated (Resident #8) does not like it when she is on her cell phone. When (Resident #8) came into the room, she started pacing around and mocking (Resident #7), repeating what she was saying. (Resident #7) said 'excuse me' and (Resident #8) went into a 'rage.' (Resident #8) told (Resident #7) she needed to get out of the room and she told her 'no.' (Resident #8) grabbed (Resident #7)'s arm and she twisted her out and away from her. By that time, they were on the floor. Upon further interview with (Resident #8) by Social Worker, stated (Resident #7) was in their room trying to decide what to wear. (Resident #7) suddenly turned around, pushed (Resident #8) down, and started hitting her. (Resident #7) and (Resident #8)'s care plans were reviewed and revised. Both residents have not had a change in mood or behavior. The residents will continue to be monitored for changes in mood or behaviors and staff will follow up with the physician as needed. Conclusion: Based on the investigation, the facility does substantiates a resident to resident altercation occurred between the residents per the residents' statements. (Resident #8) was moved to another unit in the facility with permission. Social Services met with (Resident #7) and (Resident #8) to ensure no apparent psychosocial harm. Social Services will continue

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to monitor for psychosocial harm and follow up as needed."

Resident #7 was admitted to the facility on 10/5/18 with diagnoses that included but were not limited to: dementia, depression, high blood pressure and history of suicidal ideations.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/7/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as being independent or only requiring limited assistance from the staff for her activities of daily living.

The nurse's note dated, 8/6/19 at 10:38 p.m. documented in part, "Situation: Resident was in a physical altercation with another resident [Resident #8]. Assessment: Resident has several scratches along her neck and forehead. No pain or discomfort expressed. Able to ambulate and ROM (range of motion) WNL (within normal limits).Response: Two residents were separated and police report was filed in (name of county). MD/NP (medical doctor/nurse practitioner) and RP (responsible party) made aware."

The care plan dated 1/3/19, documented in part, "Focus: I sometimes have behaviors which include: interfering with other residents care. Closing door to room when roommate request it be open. Making false allegations, becoming anxious, and refusal of ADL [activities of daily living] (showers). I sometimes have arguments with other resident that can become physical." The "Interventions" documented and dated

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1/3/19, "Attempt interventions before my behavior begin. Give me my medications as my doctor has ordered. Let my physician know if my behaviors are interfering with my daily living. Make sure I am not in pain or uncomfortable. Please refer me to my psychologist/psychiatrist as needed. Speak to me unhurriedly and in a calm voice." The "Interventions" dated, 8/7/19, documented, "Do not seat me around others who disturb me. Help me to avoid situations or people that are upsetting to me."

Resident #8 was admitted to the facility on 8/3/18 with diagnoses that included but were not limited to: anxiety disorder, insomnia, high blood pressure, dementia, and bipolar disorder (a mental disorder characterized by episodes of mania and depression) (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/7/19, coded the resident as scoring a"13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section G - Functional Status, the resident was coded as being independent in all of her activities of living except toileting, personal hygiene and bathing.

The nurse's note dated, 8/5/19 at 10:31 p.m. documented in part, "Situation: Resident got into a physical altercation with another resident [Resident #7]. Assessment: Resident's face was flushed red. No apparent injuries were found at this time.. States she was pushed to the floor but was able to ambulate with no issues and ROM (range of motion) WNL (within normal limits). Denies any pain or discomfort. Response:

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Residents were separated. (Resident #8) was moved to (room number) and a police report was filed in (Name of county). MD (medical doctor) and RP (responsible party) made aware."

The care plan dated, 9/18/18 and revised on 8/6/19, documented in part, "Focus: I sometimes have behaviors which include walking up and down hallway, making false statements, increase anxiety. I enjoy the company of male companions, pacing/paranoia/increase aggression, not easily redirected. I tend to leave my personal items in the bathroom, refusal of showers, refusal to have linens changed. I tend to remove my wander guard. I sometimes have arguments with other residents that can become physical." The "Interventions" dated, 9/18/18, documented, "Give me my medications as my doctor has ordered. Let my physician know if my behaviors are interfering with my daily living. Please refer me to my psychologist/psychiatrist as needed. Speak to me unhurriedly and in a calm voice." The "Interventions" dated 8/6/19, documented, "Do not seat me around others who disturb me. Help me to avoid situations or people that are upsetting to me."

An interview was conducted with CNA (certified nursing assistant) #1 on 9/5/19 at 9:10 a.m. regarding the process staff follows if they observe a resident striking another resident. CNA #1 stated, "First you separate the residents then notify the charge nurse."

An interview was conducted LPN (licensed practical nurse) #3, the unit manager, on 9/5/19 at 12:14 p.m. When asked what she would do if she observed a resident strike another resident, LPN #3 stated she would first separate them,

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F 600	Continued From page 10 assess bother resident. Notify the director of nursing and/or administrator. We'd have to notify the doctor/nurse practitioner and the responsible party." An interview was conducted with administrative staff member (ASM) #1, the director of nursing, on 9/5/19 at 12:45 p.m., regarding the process staff follows when a resident strikes another resident. ASM #1 stated the residents are separated. Both are assessed for injury. The director of nursing and/or administrator is notified." The facility policy, "Resident Abuse" documented in part, "It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basis human rights, including the right to be free from abuse, neglect mistreatment, and/or misappropriation of property. The facility policy, "Resident - to - Resident" documented in part, "Residents must not be subjected to about by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals." ASM #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609	F609 1. Allegations involving abuse or result in serious bodily will be	10/5/19

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F 609	Continued From page 11 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure an allegation of abuse for two of eight residents in the survey sample, (Residents #7 and #8), was immediately reported to the state agency. On 8/6/19, Resident #8 grabbed Resident #7's	F 609	reported to the administrator of the facility and other officials no later than 2 hours after the allegation is made, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 2. Each resident has the potential of being affected. 3. Staff will be re-educated on reporting allegations involving abuse or result in serious bodily injury no later than 2 hours after the allegation is made, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and other officials. 4. Audits will be conducted to ensure allegations involving abuse or result in serious bodily injury will be reported no later than 2 hours after the allegation is made, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of	

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F 609	Continued From page 12 arm. Resident #7 then pushed Resident #8 and Resident #8 fell with no injuries noted. The facility staff failed to immediately, report the physical altercation between Resident #7 and Resident #8 to the state agency. The allegation was not reported until 8/7/19. The findings include: Resident #7 was admitted to the facility on 10/5/18 with diagnoses that included but were not limited to: dementia, depression, high blood pressure and history of suicidal ideations. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/7/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as being independent or only requiring limited assistance from the staff for her activities of daily living. The nurse's note dated, 8/6/19 at 10:38 p.m. documented in part, "Situation: Resident was in a physical altercation with another resident [Resident #8]. Assessment: Resident has several scratches along her neck and forehead. No pain or discomfort expressed. Able to ambulate and ROM (range of motion) WNL (within normal limits).Response: Two residents were separated and police report was filed in (name of county). MD/NP (medical doctor/nurse practitioner) and RP (responsible party) made aware." The care plan dated 1/3/19, documented in part, "Focus: I sometimes have behaviors which include: interfering with other residents care.	F 609	the facility and other officials weekly times four weeks then monthly times three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance. Compliance Date: 10/5/19	

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Closing door to room when roommate request it be open. Making false allegations, becoming anxious, and refusal of ADL [activities of daily living] (showers). I sometimes have arguments with other resident that can become physical." The "Interventions" documented and dated 1/3/19, "Attempt interventions before my behavior begin. Give me my medications as my doctor has ordered. Let my physician know if my behaviors are interfering with my daily living. Make sure I am not in pain or uncomfortable. Please refer me to my psychologist/psychiatrist as needed. Speak to me unhurriedly and in a calm voice." The "Interventions" dated, 8/7/19, documented, "Do not seat me around others who disturb me. Help me to avoid situations or people that are upsetting to me."

Resident #8 was admitted to the facility on 8/3/18 with diagnoses that included but were not limited to: anxiety disorder, insomnia, high blood pressure, dementia, and bipolar disorder (a mental disorder characterized by episodes of mania and depression) (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/7/19, coded the resident as scoring a"13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section G - Functional Status, the resident was coded as being independent in all of her activities of living except toileting, personal hygiene and bathing.

The nurse's note dated, 8/5/19 at 10:31 p.m. documented in part, "Situation: Resident got into a physical altercation with another resident

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[Resident #7]. Assessment: Resident's face was flushed red. No apparent injuries were found at this time. States she was pushed to the floor but was able to ambulate with no issues and ROM (range of motion) WNL (within normal limits). Denies any pain or discomfort. Response: Residents were separated. (Resident #8) was moved to (room number) and a police report was filed in (Name of county). MD (medical doctor) and RP (responsible party) made aware."

The care plan dated, 9/18/18 and revised on 8/6/19, documented in part, "Focus: I sometimes have behaviors which include walking up and down hallway, making false statements, increase anxiety. I enjoy the company of male companions, pacing/paranoia/increase aggression, not easily redirected. I tend to leave my personal items in the bathroom, refusal of showers, refusal to have linens changed. I tend to remove my wander guard. I sometimes have arguments with other residents that can become physical." The "Interventions" dated, 9/18/18, documented, "Give me my medications as my doctor has ordered. Let my physician know if my behaviors are interfering with my daily living. Please refer me to my psychologist/psychiatrist as needed. Speak to me unhurriedly and in a calm voice." The "Interventions" dated 8/6/19, documented, "Do not seat me around others who disturb me. Help me to avoid situations or people that are upsetting to me."

The "Facility Reported Incident" dated, 8/7/19, documented in part, "Incident date: 8/6/19. Resident's involved (Resident #7) and (Resident #8). Injuries: (A check mark was documented next to)"Yes." (Resident #7) noted with red scratches to neck and forehead...Describe

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F 609	Continued From page 15 Incident: Resident to resident altercation between (Resident #7) and (Resident #8). (Resident #8) was reading a book and got upset at (Resident #7) because she was on the phone. (Resident #8) grabbed (Resident #7)'s arm and (Resident #7) pushed (Resident #8). (Resident #8) fell with no injuries noted. Residents immediately separated. (Resident #8) moved to a different unit/room." The "Final Report" dated, 8/9/19, documented in part, "This is the Final Report regarding the initial FRI of allegation of abuse/mistreatment regarding (Resident #7) and Resident #8) reported August 7, 2019...Investigation Summary: Resident to resident altercation between (Resident #7) and (Resident #8) was reported. (Resident #8) was reading a book and got upset at (Resident #7) because she was on the phone. (Resident #8) grabbed (Resident #7)'s arm and (Resident #7) pushed (Resident #8). (Resident #8) fell with no injuries noted. Resident were immediately separated. (Resident #8) moved to a different room/unit. (Resident #7) was noted to have red scratch marks on her neck and forehead. (Resident #8) was not noted with any injuries. Staff report that they did not witness the incident...Upon further interview with (Resident #7) by Social Worker; stated (Resident #8) does not like it when she is on her cell phone. When (Resident #8) came into the room, she started pacing around and mocking (Resident #7), repeating what she was saying. (Resident #7) said 'excuse me' and (Resident #8) went into a 'rage.' (Resident #8) told (Resident #7) she needed to get out of the room and she told her 'no.' (Resident #8) grabbed (Resident #7)'s arm and she twisted her out and away from her. By that time, they were on the floor. Upon further	F 609		

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interview with (Resident #8) by Social Worker, stated (Resident #7) was in their room trying to decide what to wear. (Resident #7) suddenly turned around, pushed (Resident #8) down, and started hitting her. (Resident #7) and Resident #8)'s care plans were reviewed and revised. Both residents have not had a change in mood or behavior. The residents will continue to be monitored for changes in mood or behaviors and staff will follow up with the physician as needed. Conclusion: Based on the investigation, the facility does substantiates a resident to resident altercation occurred between the residents per the residents' statements. (Resident #8) was moved to another unit in the facility with permission. Social Services met with (Resident #7) and (Resident #8) to ensure no apparent psychosocial harm. Social Services will continue to monitor for psychosocial harm and follow up as needed."

An interview was conducted with CNA (certified nursing assistant) #1 on 9/5/19 at 9:10 a.m., regarding the process staff follows if they observe a resident striking another resident. CNA #1 stated, "First you separate the residents then notify the charge nurse."

An interview was conducted LPN (licensed practical nurse) #3, the unit manager, on 9/5/19 at 12:14 p.m. When asked what she would do if she observed a resident strike another resident, LPN #3 stated she would first separate them, assess bother resident. Notify the director of nursing and/or administrator. We'd have to notify the doctor/nurse practitioner and the responsible party." When asked if she were involved with reporting allegations of abuse to the state agency, LPN #3 stated, "No, she reports to the DON

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(director of nursing)."

An interview was conducted with administrative staff member (ASM) #1, the director of nursing, on 9/5/19 at 12:45 p.m. regarding the process staff follows when a resident strikes another resident. ASM #1 stated the residents are separated. Both are assessed for injury. The director of nursing and/or administrator is notified." When asked why the incident between Resident #7 and Resident #8, was not reported within two hours, ASM #1 stated she believed that the two-hour requirement was only for when serious injuries occurred.

The facility policy, "Resident Abuse" documented in part, "It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basis human rights, including the right to be free from abuse, neglect mistreatment, and/or misappropriation of property. Procedure for Reporting Abuse: A. All incidents of resident abuse are to be reported immediately to the Licensed nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse coordinator or his/her designee for an investigation. B. The Abuse Coordinator of Facility will endeavor to protect the rights of residents and employees. The Administration recognized that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened. Thus, while the Administration reserves the right to suspend a suspect pending an investigation, such suspension is not to be deemed as an assessment of guilt...3. Review of

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Report: a. Once completed, the investigation's report shall be reviewed by the Director of Nursing, the Abuse Coordinator and one other Administrative staff member...Note: See state specific guidelines for abuse reporting."

The facility policy, " Resident Abuse - Resident - to - Resident" documented in part, "Residents must not be subjected to about by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals... A DOCUMENTED investigation by the Administrator, Director of Nursing, or their designee MUST be initiated within twenty -four (24) hours of our knowledge of the alleged incident. This investigation included talking with all involved (directly and indirectly), any family involved, all residents involved, and any visitor or volunteers. Involved. 8. The Administrator, Director of Nursing, or their designee. must notify the Adult Protective Service Agency and the local Ombudsman of any alleged abuse per state specific protocols of our knowledge of the alleged incident. 9. The State Department of Health is to be notified by the Administrator, Director of Nursing or their designee of the facility's knowledge of resident to resident altercations in which a resident is injured to the extent that physical interventions and/or transfer or discharge to a hospital is required per state specific protocols."

ASM #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m.

No further information was provided prior to exit.

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F 609	Continued From page 19 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.	F 609		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to complete the MDS (minimum data set) assessment within the scheduled time frame for five of eight residents in the survey sample, Resident #5, #6, #1, #7, and #8. The facility staff failed to complete the MDS assessment within the scheduled time frame 92 days from the previous assessment for Residents #5, #6, #1, #7 and #8. The findings include: 1. The facility staff failed to complete the MDS assessment within the scheduled time frame 92 days from the previous assessment for Resident #5. Resident #5 was admitted to the facility on 1/11/2013 with diagnoses that include but are not limited to: Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, rolling motions of the finders and blank expressions sometimes with emotional instability) (1), unspecified	F 638	F638 1. Resident #1, #6, #7, and #8 quarterly assessments will be complete 9/27/19. Resident #1 quarterly assessment was completed 9/18/19. Quarterly assessments will be completed within the scheduled time frame of 92 days from the previous assessment. 2. An audit will be conducted to ensure quarterly assessment have been completed within the scheduled timeframe of 92 days from the previous assessment. 3. MDS Coordinators will be re-educated by the Regional MDS Consultant/Designee on completing quarterly assessments within the scheduled timeframe of 92 days from the previous assessment. 4. Audits will be conducted by the Administrator/Designee to ensure quarterly assessment have been completed within the scheduled	10/5/19

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F 638	Continued From page 20 psychoses (major mental disorder in which person is usually detached from reality and has impaired perceptions) (2), anxiety disorder (a state of mild to severe apprehension, often without specific cause resulting in body changes such as quickened heartbeat and sweat) (3) and epilepsy (neurological disorder characterized by recurrent episodes of convulsive seizures) (4). The most recently MDS assessment, was a quarterly assessment with an ARD (assessment reference date) of 5/6/2019, and coded the resident's BIMS (brief interview for mental status) a 15 out of 15 indicating the resident was cognitively intact. A review of the MDS section of the EMR (electronic medical record), documented the following assessments. The above quarterly MDS assessment with an ARD date of 5/6/19 that was transmitted and accepted. An annual MDS assessment with an ARD 8/4/19 was in progress, but was not completed as of 9/5/19. An interview was conducted with RN (registered nurse) #1, the MDS coordinator on 9/5/19 at 5:00 PM. When asked the time frame for the completion of the MDS, RN #1 stated, "It is to be completed within 14 days, quarterly assessments within 90 days and no longer than 14 days after the set due date". When asked why there was a delay in completion, RN #1 stated "Staffing, I was the only person till May, then I've been out sick for three weeks with emergency surgery". When asked process for completion, RN #1 stated, "Social services completes sections C, D, E, Q; activities complete section F, and dietary completes section K. I have to finalize the MDS though".	F 638	timeframe of 92 days from the previous assessment weekly times four weeks then monthly times three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 10/5/19	

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Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:45 PM.

References:
1. Barron Dictionary of Medical Terms 7th edition, Kaplan
2. Barron Dictionary of Medical Terms 7th edition, Kaplan
3. Barron Dictionary of Medical Terms 7th edition, Kaplan
4. Barron Dictionary of Medical Terms 7th edition, Kaplan

2. The facility staff failed to complete the MDS assessment within the scheduled time frame for Resident #6.

Resident #6 was admitted to the facility on 12/1/2015 with diagnoses that include but are not limited to: Alzheimer's disease (progressive loss of mental ability and function, often accompanied by personality changes and emotional instability) (1), major depressive disorder (dejected state of mind with feelings of sadness, discouragement and hopelessness) (2), anxiety disorder (a state of mild to severe apprehension, often without specific cause resulting in body changes such as quickened heartbeat and sweat) (3).

The most recently submitted MDS assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/24/2019, coded that the resident's BIMS (brief interview for mental status) was a 03 out of 15 (indicating severely impaired cognition). The resident's functional status was documented in part, setup help only with transfer,

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walking in room/corridor, locomotion on/off unit and eating; two person assist with bed mobility, dressing and toilet use.

A review of the MDS section of the EMR (electronic medical record), documented the following assessments. A quarterly assessment with an ARD (assessment reference date) of 5/24/19 was transmitted and accepted. The annual assessment, with an ARD of 9/18/18 was transmitted and accepted. A significant change assessment with an ARD 8/12/19, was in progress but not completes as of 9/5/19.

An interview was conducted with RN (registered nurse) #1, the MDS coordinator on 9/5/19 at 5:00 PM. When asked the time frame for the completion of the MDS, RN #1 stated, "It is to be completed within 14 days, quarterly assessments within 90 days and no longer than 14 days after the set due date". When asked why there was a delay in completion, RN #1 stated "Staffing, I was the only person till May, then I've been out sick for three weeks with emergency surgery". When asked process for completion, RN #1 stated, "Social services completes sections C, D, E, Q; activities complete section F, and dietary completes section K. I have to finalize the MDS though".

Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:45 PM.

References:
1. Barron Dictionary of Medical Terms 7th edition, Kaplan
2. Barron Dictionary of Medical Terms 7th edition, Kaplan

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3. Barron Dictionary of Medical Terms 7th edition, Kaplan
3. The facility staff failed to complete a quarterly assessment within 92 days from the previous assessment for Resident #1.

Resident #1 was admitted to the facility on 8/17/17 with a recent readmission on 8/20/19, with diagnoses that included but were not limited to: dementia, depression, high blood pressure, anxiety disorder, and frequent falls.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date (ARD) of 5/3/19, coded the resident as scoring a "3 out of 15" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded in Section G - Functional Status as requiring extensive assistance of one or more staff members to complete her activities of daily living.

A review of the MDS section of the electronic medical record documented the following assessments. A significant change assessment with an ARD of 4/18/19 was transmitted and accepted. A significant change assessment with an ARD of 5/3/19 was documented as transmitted and accepted. A quarterly assessment with an ARD of 7/31/19 was documented as "In progress." Thus, not completed and not transmitted.

An interview was conducted with RN (registered nurse) #1, the MDS coordinator; on 9/5/19 at 10:45 a.m., RN #1 was asked to review the MDS section of the electronic medical record. When

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asked about the requirements for completing and transmitting a quarterly assessment, RN #1 stated, "I have 14 days after the ARD date." When asked what happened with the quarterly MDS assessment with an ARD of 7/31/19, RN #1 stated, "Honestly, I just got an assistant to help with MDS and I had to be out for three weeks due to emergency surgery. I am behind." When asked what reference or policy the facility uses to complete the MDS assessments, RN #1 stated, they use the RAI (resident assessment instrument) manual.

Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m.

No further information was provided prior to exit.

4. The facility staff failed to complete an annual MDS assessment with an ARD of 8/6/19 for Resident #7.

Resident #7 was admitted to the facility on 10/5/18 with diagnoses that included but were not limited to: dementia, depression, high blood pressure and history of suicidal ideation's.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/7/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as being independent or only requiring limited assistance from the staff for her activities of daily living.

A review of the MDS section of the electronic

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medical record documented the following assessments. A quarterly assessment with an ARD of 2/9/19 was transmitted and accepted. A quarterly assessment with an ARD of 5/7/19 was documented as transmitted and accepted. An annual assessment with an ARD of 8/6/19 was documented as "In progress." Thus, not completed and not transmitted.

An interview was conducted with RN (registered nurse) #1, the MDS coordinator; on 9/5/19 at 10:45 a.m., RN #1 was asked to review the MDS section of the electronic medical record. When asked about the requirements for completing and transmitting a quarterly assessment, RN #1 stated, "I have 14 days after the ARD date." When asked what happened with the annual MDS assessment with an ARD of 8/6/19, RN #1 stated, "Honestly, I just got an assistant to help with MDS and I had to be out for three weeks due to emergency surgery. I am behind."

Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m.

5. The facility staff failed to complete an annual MDS assessment with an ARD of 8/6/19 for Resident #8.

Resident #8 was admitted to the facility on 8/3/18 with diagnoses that included but were not limited to: anxiety disorder, insomnia, high blood pressure, dementia, and bipolar disorder (a mental disorder characterized by episodes of mania and depression) (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an

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assessment reference date of 5/7/19, coded the resident as scoring a"13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section G - Functional Status, the resident was coded as being independent in all of her activities of living except toileting, personal hygiene and bathing.

A review of the MDS section of the electronic medical record documented the following assessments. A quarterly assessment with an ARD of 2/9/19 was transmitted and accepted. A quarterly assessment with an ARD of 5/7/19 was documented as transmitted and accepted. An annual assessment with an ARD of 8/7/19 was documented as "In progress." Thus, not completed and not transmitted.

An interview was conducted with RN (registered nurse) #1, the MDS coordinator; on 9/5/19 at 10:45 a.m., RN #1 was asked to review the MDS section of the electronic medical record. When asked how often must assessments be completed and transmitted by, RN #1 stated, "I have 14 days after the ARD date." When asked what happened with the annual assessment of 8/6/19, RN #1 stated, "Honestly, I just got an assistant to help with MDS and I had to be out for three weeks due to emergency surgery. I am behind."

Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.

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F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 640	F640 1. Resident #1 discharge, return anticipated assessment has been completed and transmitted. 2. An audit will be conducted to ensure discharge, return anticipated assessments have been completed and transmitted within the scheduled timeframe. 3. MDS Coordinators will be re-educated by Regional MDS Consultant/Designee on discharge, return anticipated assessments being completed and transmitted within the scheduled timeframe. 4. Audits will be conducted by the Administrator/Designee to ensure discharge, return anticipated assessments are being completed and transmitted within the scheduled timeframe weekly times four weeks then monthly times three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 10/5/19	10/5/19

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reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined the facility staff failed to complete a discharge assessment within the scheduled timeframe for Resident #1.

The facility staff failed to complete and transmit a discharge, return anticipated, assessment, with an assessment reference date (ARD) of 8/17/19 for Resident #1.

The findings include:

Resident #1 was admitted to the facility on 8/17/17 with a recent readmission on 8/20/19, with diagnoses that included but were not limited to: dementia, depression, high blood pressure, anxiety disorder, and frequent falls.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date (ARD) of 5/3/19, coded the resident as scoring a "3 out of 15" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded in Section G - Functional Status as requiring extensive assistance of one or

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F 640	Continued From page 29 more staff members to complete her activities of daily living. A review of the MDS section of the electronic medical record documented the following assessments. A significant change assessment, with an ARD of 5/3/19 that was completed and transmitted. A discharge - return anticipated assessment, with an ARD of 8/17/19, documented, "In Progress." When asked how long she has to complete a discharge assessment, RN #1 stated she had 14 days after the ARD to complete it and transmit it. When asked what happened with the discharge assessment of 8/17/19, RN #1 stated, "Honestly, I just got an assistant to help with MDS assessments. I had to be out for three weeks due to emergency surgery. I am behind." Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m. No further information was provided prior to exit.	F 640		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684	F684 1. Resident #1 antibiotic is now completed. 2. An audit of residents receiving antibiotics will be conducted to ensure administered per physician's orders. 3. Licensed nurse will be re-educated by DON/Designee on administering	10/5/19

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F 684	Continued From page 30 Based on staff interview and clinical record review, it was determined the facility staff failed to ensure one of eight sampled residents, (Resident #1) received care and services in accordance with professional standards and the comprehensive care plan. The facility staff failed to administer an antibiotic, as ordered by the physician for Resident #1. The findings include: Resident #1 was admitted to the facility on 8/17/17 with a recent readmission on 8/20/19, with diagnoses that included but were not limited to: dementia, depression, high blood pressure, anxiety disorder, and frequent falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date (ARD) of 5/3/19, coded the resident as scoring a "3 out of 15" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded in Section G - Functional Status as requiring extensive assistance of one or more staff members to complete her activities of daily living. The physician order dated, 8/2/19, documented, "Macrobid Capsule (used to treat urinary tract infections) (1) 100 mg Give 100 mg (milligrams) by mouth two times a day related to personal history of urinary tract infections for 7 days." The August 2019 MAR (medication administration record) documented the above order. A "7" was documented on 8/9/19, for the 9:00 a.m. dose. A	F 684	antibiotics per physician's orders, to include checking stat book for availability. 4. Audits will be conducted by DON/Designee on ensuring resident are receiving antibiotics per physician's orders weekly times four weeks then monthly times three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 10/5/19	

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"7" indicated, "Other/see nurse's note."

The nurse's note dated, 8/9/19 at 9:42 a.m. documented the physicians order above and "pharmacy notified."

The comprehensive care plan dated, 9/6/17 and revised on 2/12/19, documented in part, "Focus: Alteration in elimination of bowel and bladder, urge incontinence, low back pain." The "Interventions" documented in part, "Encourage fluids. Evaluate frequency/timing of incontinence episodes. Monitor and report S&S (signs and symptoms) of UTI (urinary tract infection): changes in color, odor or consistency of urine, dysuria, frequency, fever, pain."

The contents of the STAT (immediate) drug supply box were reviewed. The following drug was listed as in the STAT box: Nitrofurantoin (generic name for Macrobid) 100 mg - quantity 4 capsules."

An interview was conducted with RN (registered nurse) #2 on 9/5/19 at 11:06 a.m., regarding the process staff follows if a prescribed medication is not available for administration. RN #2 stated, "First you check the STAT box. If [the medication is] not there you call the pharmacy and you call the doctor and follow their instructions."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/5/19 at 11:10 a.m., regarding the process staff follows if a prescribed medication is not available for administration. LPN #1 stated, "Usually you contact the doctor or nurse practitioner. You call the pharmacy to find out why is isn't here. If it is on hand in the STAT box, then you get it from the STAT box first, and

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F 684	Continued From page 32 then take the other steps if it's not there. The contents of the STAT box on Unit A were reviewed with LPN #1. The STAT box contents listed Macrobid as available in the STAT box. Administrative staff member #1, the director of nursing, was made aware of the above findings on 9/5/19 at 2:53 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682291.html	F 684		