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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2586	A. BUILDING _____ B. WING _____	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE NORTHERN VIRGINIA	5000 FAIRBANKS AVENUE ALEXANDRIA, VA 22311

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F 000	Initial Comments An unannounced biennial State Licensure Inspection Survey was conducted 08/27/2019 through 08/28/2019. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 121 bed facility was 31 at the time of the survey. The survey sample consisted of 5 current Resident reviews (Residents #1-#5).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140(A) Based on observation, family interview, staff interview, clinical record review, and facility documentation review, the facility staff failed for 1 resident (Resident #2) in the survey sample of 5 residents, to follow their policy and procedure regarding reporting, and investigating an allegation of physical abuse. The Findings included: Resident #2 was an 84 year old who was admitted to the facility on 7/17/19. Resident #2's diagnoses included Metabolic Disorder, Heart Failure, and Hypertension. The Minimum Data Set, which was an Admission Assessment, with an Assessment Reference Date of 7/24/19 was reviewed. Resident #2 was coded as being able to understand and be understood by	F 001	12VAC 5-371-140(A) Correct deficiency: CNA A was removed from Resident #2's care team assignment on 7/23/19. Facility Reported Incident form submitted to Office of Licensure & Certification on 9/18/19. Investigation was performed on 7/23/19 and documentation of that investigation will be completed by 9/20/19. Results of investigation will be reported to Office of Licensure & Certification by 9/20/19. Prevent recurrence of deficiency: Director of Nursing received in-service education from Executive Director on 9/5/19 regarding policy concerning resident abuse, neglect or exploitation. Special attention was paid to the reporting procedure. By 9/20/19 CNA A will receive in-service education from the Director of Nursing regarding safe resident handling and abuse prevention. Maintain compliance: For the period of 7/23/19 through 12/31/19 the Director of Nursing will monitor the performance of CNA A to ensure no further incidents of rough handling of residents occur. Director of Nursing will report any and all incidents to Executive Director where there is any allegation of abuse, neglect or exploitation. Executive Director will investigate all allegations and make report to the state regulatory agency as warranted. Date of completion: 9/20/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Gardner, Administrator | TITLE | (X6) DATE: 9/18/2019

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F 001	Continued From Page 1 others. In addition, he was coded as requiring the extensive physical assistance of two persons for bed mobility and transfers. On 8/27/19 at approximately 1:00 PM., an observation was conducted of Resident #2 in his room. He was clean and dressed appropriately. His wife and niece were present. His niece stated that on 7/20/19 CNA A "handled her uncle too roughly, causing bruises on both of his wrists, and she also raised her voice when talking to us." She further stated that she'd reported the incident to the Unit Manager on the day of the incident, and the Director of Nursing (Employee B) on Monday. She stated that they had attended a meeting with the Director of Nursing a few days after the incident, and that things had improved with CNA A. On 8/27/19 a review was conducted of facility documentation, revealing a Progress Note signed by the Director of Nursing (DON-Employee B) on 7/23/19. An excerpt read, "7/23/19 15:09 P.M. Meeting was held in DON office attended by wife, niece, writer, SW [Social Worker] and Charge Nurse regarding family concerns of recent incidents (Saturday 7/20) when the team members did not allow wife and niece to be present during care even though resident provide consent for wife and niece to be present. Wife and niece raises concerns regarding team member strength during care that may cause bruise and one of team member raised her voice when answering wife questions. Writer explained that the bruise may also caused by anticoagulant." On 8/27/19 an interview was conducted with the Director of Nursing (Employee B). She stated that Resident #2's niece informed her of the bruises on Monday July 22, 2019. She stated that she didn't suspend the CNA, conduct a written investigation	F 001		

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F 001	Continued From Page 2 or report the allegation to any outside agency. She did not collect witness statements or interview the resident or other residents and staff. She stated that other facility staff met with the family three days after the incident. When asked why a Facility Reported Incident (FRI) had not been submitted to the Office of Long Term Care, the DON said, "I wasn't thinking about the FRI because we wanted to investigate first, usually concrete incidents are reported." On 8/28/19 an interview was conducted with the Social Worker (Employee E). She confirmed that Resident #2's niece had informed the Unit Manager, and the Director of Nursing of the incident, and that a meeting was held with the family three days after the incident. On 8/28/19 a review was conducted of facility documentation, revealing a Resident Protection from Abuse, Neglect and Exploitation policy # 0042 dated August, 2017. An excerpt read, "Any staff person who is accused of resident abuse, neglect, mistreatment or misappropriation of property will be suspended from employment while the investigation is conducted. Any allegation of abuse, involuntary seclusion, neglect, mistreatment, misappropriation of resident property or the occurrence of an injury of unknown origin, will be promptly reported to appropriate licensing agencies and the investigation initiated promptly. Notification for incidents in the Health Care facility is immediate and accomplished by completing the Facility Reported Incident form and faxing to the Virginia Department of Health, Office of Licensure and Certification...The results of all investigations will be reported to interested state agencies within five (5) days of receipt of the allegation."	F 001		

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F 001	Continued From Page 3 No further information was received. 12VAC 5-371-210(F)(1) Based on staff interview and facility documentation review, the facility staff failed to ensure that three previously licensed Certified Nursing Assistants were in good standing. The Findings Included: On 8/28/19 a review was conducted of employee records, along with the Human Resources Coordinator (Employee M). Three of the 10 records reviewed revealed previously licensed Certified Nursing Assistants (CNA) who license had not been verified that they were in good standing. CNA C was hired on 8/16/17. Her license had not been verified until 8/28/17. CNA D was hired on 5/2/19. Her license had not been verified until 6/18/19. CNA E was hired on 12/27/17. Her licensed had not been verified until 1/8/18. The Human Resources Coordinator was asked about the importance of verifying the current licenses. She stated, "To make sure that they are qualified and legally able to work with the residents. The staffing coordinator usually does that. She is not here." The facility did not provide a hiring policy. No further information was received. 12VAC 5-371-340(A)	F 001	12VAC 5-371-210(F)(1) Correct deficiency: The Health Services Staffing Coordinator ensured, soon after they were hired, that certificates were in good standing for the Certified Nursing Assistants identified as deficient during the survey. Prevent recurrence of deficiency: All Department Coordinators received in-service training from the Executive Director on 9/12/2019 regarding the policy on the requirement that all team member licenses and/or certificates will be verified prior to start of employment. Maintain compliance: For the period from 8/28/2019 through 12/31/2019 the Executive Director, or designee, will review the Human Resources file of every new hire team member to ensure their license or certificate was verified prior to their hire date. Date of completion: 9/20/2019	

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F 001	Continued From Page 4 Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure that dietary staff effectively wore hair restraints while working in the kitchen. The Findings included: On 8/28/19 at 9:00 A.M., an observation was conducted of the facility kitchen. There were two Dietary Supervisors present, (Employee N and Employee O). Employee N stated that she was preparing sandwiches for lunch that were for the healthcare center residents. Employee O was asked to describe the effectiveness of Employee N's hairnet. He stated that all of her hair wasn't restrained, and that her bangs, which were approximately 2.5 inches long, were not covered. In addition, she had curls touching her right cheek that were outside of the hair restraint. When asked about the importance of effectively wearing a hair restraint, Employee N stated that residents "could choke" on hair in their food. On 8/28/19 a review was conducted of facility documentation, revealing a Food Safety policy dated January, 2016. An excerpt read, "Employees wear approved hair restraints and clean uniforms, aprons, and shoes. Men with beards and/or mustaches wear appropriate beard restraints." No further information was received. 12VAC 5-371-250(D) Based on observation, staff interview, and clinical record review, the facility staff failed to ensure that 1 resident (Resident #1) in the survey sample of 5	F 001	12VAC 5-371-340(A) Correct deficiency: Following identification by the Surveyor on 8/28/2019 Employee N adjusted her hairnet so that it effectively restrained her hair. Prevent recurrence of deficiency: By 9/20/2019 the Director of Dining Services, or designee, will provide in-service training to all team members who are involved in resident food preparation or service regarding the proper application of hair restraints. Maintain compliance: For time period 9/15/2019 through 12/31/2019 the Director of Dining Services, or designee, will conduct an audit once daily of hairnet use and proper placement and document. Date of completion: 9/20/2019	

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F 001	Continued From Page 5 residents, had an Admission Assessment that was signed as completed by a Registered Nurse. The Findings included: Resident #1 was a 94 year old who was admitted to the facility on 7/19/19. Resident #1's diagnoses included Heart Failure, and Hypertension. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 7/26/19 was reviewed. Resident #1 was coded as having a Brief Interview of Mental Status Score of 6, indicating moderately impaired cognition. On 8/28/19 at 11:40 A.M., an observation was conducted of Resident #1 in her room. She was dressed appropriately. There were three visitors in her room who were family members, including her son. On 8/28/19 a review was conducted of Resident #1's clinical record. She did not have a pressure ulcer at that time. The Admission Assessment dated 7/19/18 was reviewed. An excerpt read, "Head to toe skin assessment done. First stage pressure ulcer on upper mid spine noted, skin reddened intact measured 6 cm long. Meplex apply for prevention." The Assessment was signed by Licensed Practical Nurse A. On 8/28/19 at 11:45 A.M., an interview was conducted with the Unit Manager (LPN B) at the nurse's station, in the presence of Surveyor B. She stated the Resident #1 did not currently have a pressure ulcer. When asked who does the Admission Assessments, the Unit Manager stated, "The Unit Manager, I do them." When asked if it was in her (as an LPN) scope of practice to measure and stage pressure ulcers, she stated "No, an LPN can't stage. We call the wound care	F 001	12VAC 5-371-250(D) Correct deficiency: On 9/6/2019 the Director of Nursing e-signed the admission assessment for Resident #1 stating, "I have reviewed and agree with this assessment." Prevent recurrence of deficiency: By 9/20/2019 the Director of Nursing, or designee, will provide in-service education to all licensed nursing staff regarding the importance of having each resident admission assessment coordinated by a Registered Nurse who signs, dates and certifies completion of the assessment. Maintain compliance: For time period 9/15/2019 through 12/31/2019 the Director of Nursing, or designee, will review all resident admission assessments within 72 hours of admission to ensure each assessment is coordinated by a Registered Nurse who signs, dates and certifies completion of the assessment. Date of completion: 9/20/2019	

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F 001	Continued From Page 6 nurse. She comes here on Tuesdays." No further information was received. 12VAC 5-371-340(A) referencing 12VAC 5-421-610 Based on observation, staff interview and facility documentation review, the facility staff failed to ensure that food was stored in a dry location not exposed to splashes. The Findings included: On 8/28/19 at 9:00 A.M., an observation was conducted of the facility kitchen. The Dietary Supervisor, (Employee O) escorted the surveyor to a storage room that was one flight below, and directly underneath the kitchen. Their were several rows of pipes attached to the ceiling above the dry food storage. There was water splashing down from the area where the pipes were affixed to the ceiling. The Dietary Supervisor stated, "The water leaks down every time they run the dishwasher." On 8/28/19 a review was conducted of facility documentation, revealing a work order dated 6/3/19. An excerpt read, "Ground Level - Underneath Main Kitchen - Dry Food Storage. Water on Floor. On 8/28/19 at 12:45 P.M., an interview was conducted with the Maintenance Manager (Employee C) in the conference room, with Surveyor B present. Employee C stated, "I would call it a water leak. I saw it once about two weeks ago. I am not sure of the impact it could have on the food."	F 001	12VAC 5-371-340(A) referencing 12VAC 5-421-610 Correct deficiency: Following identification by the Surveyor on 8/28/2019 Employee N moved all food in the storage room away from the area that was affected by the water leak coming from the ceiling. Prevent recurrence of deficiency: By 10/5/2019 contractor, OMID Plumbing, will replace faulty floor drain and supply pipes next to central prep table in Main Kitchen and seal all holes that pass through to the Dry Storage Room below. Maintain compliance: For time period 10/5/2019 through 12/31/2019 the Director of Dining Services, or designee, will conduct an audit once daily to ensure no water is leaking into the Dry Storage Room from the sink drain next to the prep table in the Main Kitchen. Date of completion: 10/5/2019	

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F 001	Continued From Page 7 On 8/28/19 a review was conducted of facility documentation, revealing a Water Leaks, Water Damages, and Mold Remediation policy dated February 3, 2016. An excerpt read, "contain and repair any water leaks, repair damages, and remedy mold immediately or as soon as possible..." No further information was received. 12VAC5-371-360(E)(4) Based on observation, Resident and staff interview, clinical record review and facility documentation the facility staff failed to maintain accurate clinical record for 1 Resident (#5) in a survey sample of 31 Residents. For Resident #5 the facility staff failed ensure that the Physicians orders were updated to include the new order for Honey Thickened Liquid. The findings included: Resident #5, a 94 year old man admitted to the facility on 9/6/14 with diagnoses of but not limited to Protein mal-nutrition, Dementia with behavioral disturbance, CHF (congestive heart failure), Parkinson's Disease, Neuritis (inflammation of nerves) and Neuralgia (nerve pain). Most recent MDS (Minimum Data Set) codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 1 indicating severe cognitive impairment. Resident speech is coded as unclear and when interview attempted was only able to say yes and smile. Resident was coded at #3 - Extensive Assistance and #2 - 1 person physical assistance for eating.	F 001	12VAC 5-371-360(E)(4) Correct deficiency: The correct and current physician diet order is dated 5/23/2019 and states "regular diet, regular texture and regular (thin) liquid." On 9/11/2019 the Director of Nursing corrected the resident care plan to reflect the current physician's order for regular diet, regular texture and regular (thin) liquid. Prevent recurrence of deficiency: By 9/20/2019 the Director of Nursing, or designee, will provide in-service education to all licensed staff regarding the importance of nurses updating resident care plans to reflect current physician diet orders. Maintain compliance: For time period 9/15/2019 through 12/31/2019 the Director of Nursing, or designee, will conduct a weekly audit of resident diet orders to ensure the order matches the care plan. Date of completion: 9/20/2019	

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F 001	Continued From Page 8 On 8/28/19 during clinical record review it was found that the Resident #5's Care Plan does not match the Physicians orders. Care Plan with revision date of 8/5/19 read in part: Goal: Will consume > 75% of meals with honey thickened liquids as ordered, I will have no s/s of dehydration I will have no skin issues, I will have a problem with constipation [sic], I will be kept comfortable as per Hospice. Provide diet as ordered, provide honey thick liquids as ordered, Monitor monthly weights, Monitor for dehydration. Date initiated 8/5/19 Revision on 8/5/19 However the signed Physicians orders dated 8/1/19 read: Regular diet, Regular texture, Regular (thin) liquid consistency. Order Status - ACTIVE Order Date - 5/23/19 Start Date - 5/23/19 End Date - (NONE PROVIDED) On 8/28/19 at 10:25 AM an interview was conducted with the DON, when asked about the thin liquids on the physicians order and the thickened liquids on the care plan, she submitted a copy of the Physicians order for Thickened liquids dated 7/18/19 at 8:37 AM. The Resident's liquids had been downgraded from thin liquids to Honey Thick on 7/18/19. She stated that somehow the order didn't get transcribed to the physician's orders she stated she was unaware of how this happened.	F 001		

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F 001	Continued From Page 9 On 8/28/19 during the end of day meeting the Acting Administrator was made aware of the findings and no new information was provided. 12VAC5-371-220(A) Based on observation, Resident and staff interview, clinical record review and facility documentation the facility staff failed to provide assistance with ADL's for a dependent resident. For Resident #5 the facility staff failed ensure that the Resident had assistance with eating meals. The findings included: Resident #5, a 94 year old man admitted to the facility on 9/6/14 with diagnoses of but not limited to Protein mal-nutrition, Dementia with behavioral disturbance, CHF (congestive heart failure), Parkinson's Disease, Neuritis (inflammation of nerves) and Neuralgia (nerve pain). Most recent MDS (Minimum Data Set) codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 1 indicating severe cognitive impairment. Resident speech is coded as unclear and when interview attempted was only able to say yes and smile. Resident was coded at #3 - Extensive Assistance and #2 - 1 person physical assistance for eating. On 8/28/19 at 8:43 AM observation of 4th floor dining were made and found 4 women sitting at a table near the window, Resident #5 sitting in his wheelchair alone at a table near the wall, at another table near the wall was a woman sitting alone. No Staff were visible when observation was made.	F 001	12VAC 5-371-220(A) Correct deficiency: For Resident #5 at lunch on 8/28/2019 a staff person was present to provide assistance with eating. Prevent recurrence of deficiency: By 9/20/2019 the Director of Nursing, or designee, will provide in-service education to direct care staff regarding the need to provide assistance with eating to all residents who require assistance with eating. Maintain compliance: For time period 9/15/2019 through 12/31/2019 the Director of Nursing, or designee, will conduct a weekly audit of the Task Care Record for Resident #5 to ensure that assistance with eating has been provided at each meal. Date of completion: 9/20/2019	

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F 001	Continued From Page 10 At approximately 8:45 AM an interview with Employee F was conducted and when asked the process for meals on this floor she stated that the food is cooked in the main kitchen and carried over in carts. She also stated that she serves the food and cleans the dining area. She will provide set up assistance if needed by the Resident. Resident #5 was sitting at the table a clothing protector around his neck and a plate in front of him containing a blueberry muffin. The resident was attempting to eat the muffin with a fork and was struggling due to the trembling of his hands. The pieces of muffin would fall off of the fork due to the tremors in his hands. Resident was observed with a glass of orange juice however he did not drink it during the observation. Resident was observed to cough briefly X 2 during meal. At 9:00 AM LPN C entered the dining area walked around and stopped by Resident #5's table fed him one bite of his muffin and then she said "Good Morning" to the other Residents and left the area. At 9:10 AM Resident #5 observed attempting to eat a long strip of bacon with his fork. He managed to get the strip on the fork and after several attempts to get it to his mouth his hand was shaking so badly he dropped the bacon off the fork and had to start over again. On 8/28/19 at 10:25 AM an interview was conducted with the DON who stated that a Resident who is coded as extensive assist with physical assist of 1 staff should have a staff member sitting with him feeding him. When asked what dictates the care of the Resident and she answered the care plan. When asked if he was care planned as assistance with meals she reviewed the care plan and indicated that it was	F 001		

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F 001	Continued From Page 11 not addressed on the care plan. On 8/28/19 during the end of day meeting the Acting Administrator was made aware and no further information was provided 12VAC5-371-250(G) Based on observation, Resident and staff interview, clinical record review and facility documentation the facility staff failed to develop and implement a comprehensive care plan. For Resident #5 the facility staff failed ensure that the Resident's care plan included physical assistance of one staff for eating The findings included: Resident #5, a 94 year old man admitted to the facility on 9/6/14 with diagnoses of but not limited to Protein mal-nutrition, Dementia with behavioral disturbance, CHF (congestive heart failure), Parkinson's Disease, Neuritis (inflammation of nerves) and Neuralgia (nerve pain). Most recent MDS (Minimum Data Set) codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 1 indicating severe cognitive impairment. Resident speech is coded as unclear and when interview attempted was only able to say yes and smile. Resident was coded at #3 - Extensive Assistance and #2 - 1 person physical assistance for eating. On 8/28/19 at 8:43 AM observation of 4th floor dining were made and found 4 women sitting at a table near the window, Resident #5 sitting in his wheelchair alone at a table near the wall, at another table near the wall was a woman sitting	F 001	12VAC 5-371-250(G) Correct deficiency: On 9/11/2019 the Director of Nursing corrected the care plan of Resident #5 to reflect their need for physical assistance of one staff with eating. Prevent recurrence of deficiency: By 9/20/2019 the Director of Nursing, or designee, will provide in-service education to all licensed staff regarding the importance of updating resident care plans to reflect the resident needs that were identified in their current assessment. Maintain compliance: For time period 9/15/2019 through 12/31/2019 the MDS Coordinator, or designee, will conduct a weekly audit of any new resident assessments to ensure any changes have been properly reflected in the resident care plan. Date of completion: 9/20/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2586	A. BUILDING _____ B. WING _____	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE NORTHERN VIRGINIA	5000 FAIRBANKS AVENUE ALEXANDRIA, VA 22311

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F 001	Continued From Page 12 alone. No Staff were visible when observation was made. At approximately 8:45 AM an interview with Employee F was conducted and when asked the process for meals on this floor she stated that the food is cooked in the main kitchen and carried over in carts. She also stated that she serves the food and cleans the dining area. She will provide set up assistance if needed by the Resident. Resident #5 was sitting at the table a clothing protector around his neck and a plate in front of him containing a blueberry muffin. The resident was attempting to eat the muffin with a fork and was struggling due to the trembling of his hands. The pieces of muffin would fall off of the fork due to the tremors in his hands. Resident was observed with a glass of orange juice however did not drink it during the observation. Resident was observed to cough briefly X 2 during meal. At 9:00 AM LPN C entered the dining area walked around and stopped by Resident #5's table fed him one bite of his muffin and then she said "Good Morning" to the other Residents and left the area. At 9:10 AM Resident #5 observed attempting to eat a long strip of bacon with his fork. He managed to get the strip on the fork and after several attempts to get it to his mouth his hand was shaking so badly he dropped the bacon off the fork and had to start over again. On 8/28/19 during clinical record review it was found that the Resident has a care plan that does not address his need for assistance with meals. On 8/28/19 at 10:25 AM an interview was conducted with the DON who stated that a	F 001		

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F 001	Continued From Page 13 Resident who is coded as extensive assist with physical assist of 1 staff should have a staff member sitting with him feeding him. When asked what dictates the care of the Resident and she answered the care plan. When asked if he was care planned as assistance with meals she reviewed the care plan and indicated that it was not addressed on the care plan. On 8/28/19 during the end of day meeting the Acting Administrator was made aware and no further information was provided. 12VAC5-371-300(A) Based on observation, Resident and staff interview, clinical record review and facility documentation the facility staff failed to ensure medication / treatment was provided in a timely manner as ordered. For Resident #5 the facility staff failed ensure that the Resident received ordered antifungal medication for rash to scrotum and perineal area in a timely manner. The findings included: Resident #5, a 94 year old man admitted to the facility on 9/6/14 with diagnoses of but not limited to Protein mal-nutrition, Dementia with behavioral disturbance, CHF (congestive heart failure), Parkinson's Disease, Neuritis (inflammation of nerves) and Neuralgia (nerve pain). Most recent MDS (Minimum Data Set) codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 1 indicating severe cognitive impairment. Resident speech is coded as unclear and when interview attempted was only able to say yes and	F 001	12VAC 5-371-300(A) Correct deficiency: The medication for Resident #5 was received by the community at 3:50am on 8/21/2019 and administered as soon as the resident awoke later that morning. Prevent recurrence of deficiency: By 9/20/2019 the Director of Nursing, or Designee, will provide in-service education to all licensed staff that if a medication order is longer than 250 characters then the order must be faxed directly to the pharmacy and retain the fax confirmation sheet. Maintain compliance: For time period 9/15/2019 through 12/31/2019 the Director of Nursing, or designee, will conduct a weekly audit of fax confirmation pages to ensure that all orders longer than 250 characters have been faxed to the pharmacy. Date of completion: 9/20/2019	

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F 001	Continued From Page 14 smile. Resident was coded at #3 - Extensive Assistance and #2 - 1 person physical assistance for eating. On 8/28/19 during clinical record review it was noted that the resident received an order on 8/19/19 at 3:07 PM for Nystatin Powder (an Anti-Fungal). Excerpts from the Nursing Progress Notes read: "8/19/19 3:07 PM - Resident seen by Hospice Nurse, order given to sprinkle nystatin to scrotum and affected peri- area." "8/19/19 at 10:20 PM Nystatin Powder apply to scrotum topically every day and evening shift for rashes, and peri rectal excoriation Sprinkle Nystatin to scrotum and perineal area BID [two times a day] and after every incontinent episode. On order." "8/20/19 at 2:21 PM Awaiting pharmacy to supply" "8/20/19 at 3:15 PM Awaiting pharmacy to supply" On the (Medication Administration Report) MAR dated 8/19/19 and 8/20/19 the medication is coded as #9 which means awaiting from Pharmacy. On 8/28/19 at 10:40 an interview was conducted with the DON who stated that the nurse on duty who took the order called the pharmacy with the order but the pharmacy did not send it on the evening run. She stated that the following day (8/20/19) the Nystatin still did not come on the day shift run and the nurse on evening shift phoned the pharmacy and was told to fax the order over.	F 001		

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F 001	Continued From Page 15 The DON submitted copy of Progress note an excerpt from that note read: 8/20/19 at 3:20 PM "Nystatin powder awaiting pharmacy to supply. [Name redacted] called talked to [name redacted] and confirmed it will be on the next delivery" The DON also provided a delivery confirmation slip from Pharmacy showing the Nystatin Powder arrived at the facility on 8/21/19 at 3:50 AM. The first dose was used on 8/21/19. On 8/28/19 during the end of day meeting the Acting Administrator was made aware and no further information was provided	F 001		