STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495395	A. BUILDING _____ B. WING _____	C 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

(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 09/04 - 09/05/19 and 09/09 - 09/10/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 09/04/19-09/05/19 and 09/09/19-09/10/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 33 certified bed facility was 32 at the time of the survey. The survey sample consisted of 14 current Resident reviews and 4 closed record reviews.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 553		10/25/19

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

Electronically Signed | 09/26/2019

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F 553	Continued From page 1 plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to have one (Resident #2) of 18 residents in the survey sample, attend quarterly person centered care plan meetings and failed to conduct quarterly care plan meetings. The findings included: Resident #2 was originally admitted to the facility on 02/08/10 and readmitted on 11/10/18. Diagnoses for Resident #2 included but not limited to, Acute Kidney Failure and Dementia with lewy bodies. The current Minimum Data Set (MDS), a quarterly revision with an Assessment Reference Date	F 553	1. An off cycle person centered care plan meeting for Resident #2 has been scheduled. 2. All residents have the potential to be affected by the deficient practice. An audit for all residents due for the quarterly care plan meetings has been conducted to ensure they received an appropriate notice and acknowledgement to participate in the care plan meeting. Variances identified will result in special off cycle care plan meetings to be held with residents and/or resident representatives. 3. MDS Coordinator and social worker will utilize a calendar to coordinate the dates of the scheduled care plan meetings with the MDS assessment	

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F 553	Continued From page 2 (ARD) of 06/14/19 coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Resident #2 was coded as requiring extensive assistance requiring a two person physical assistance with toilet use, bathing, personal hygiene and bed mobility; requiring one person physical assist with transfers and dressing; and eating requiring set-up help only. During the initial tour on 09/09/19 at approximately 11:38 AM, an interview was conducted with Resident #2. She was asked if she was attending quarterly care plan meetings? She stated, "No one has approached me." An interview was conducted with Social Worker (SW) #1 on 09/10/19 at approximately 11:58 AM. When asked if Resident #2 was invited to care plan meetings SW #1 initially stated, "Resident gets invites and attends care plan meetings." After verifying information in the computer she then stated, "Her last care plan meeting was on 1/31/19 family was present;" "We lost a social worker, Resident didn't attend care plan meetings;" "She missed April and July meetings;" "No invite letters were sent out;" "We met with daughter in between." On 09/10/19 received a care plan invite letter from the Social Worker at approximately 12:00 PM. The care plan meeting invite letter was addressed to Resident #2 and her family dated on January 24, 2019. The meeting was scheduled for January 31, 2019. Received IDT (interdisciplinary team note) from Social Worker #1 on 9/10/19 at approximately	F 553	completion to ensure that the date of the meeting would coincide with the MDS calendar. MDS Coordinator will generate the person-centered care plan schedule based on MDS completion and Social Worker will generate the care plan invite for the resident and/or resident representative. 4. Administrator or designee will audit 50% of residents due for a quarterly care plan to ensure compliance and coordination with the MDS calendar for 3 months. Any variances identified will be corrected, staff counseled and reeducated as appropriate. The results of the audit will be tracked and trended and presented to the QAPI committee for additional guidance.	

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F 553	Continued From page 3 12:15 PM. The note was dated on 5/10/19 and read the following: The Social Worker met with the daughter to address a concern on 5/06/19 at 5:18 PM. Social worker #1 was asked if she had any documentation stating that a Personal Centered Care Plan meeting was held since January 2019; she stated, "No." The Administrator, the DON (Director of Nursing) and Registered Nurse #1, MDS Coordinator (Minimum Data Set Coordinator) were informed of the findings during a briefing on 09/10/19 at approximately 3:44 PM. The Administrator stated that the care plan meetings should be quarterly. She also stated that they stayed in touch with the Resident's daughter and stated "It may have been an oversight;" "The CNA (Certified Nursing Assistant), nursing and family are involved in the care plan meeting."	F 553		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would	F 622		10/25/19

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F 622	Continued From page 4	F 622		

otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

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F 622	Continued From page 5 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to convey comprehensive care plan goals for 1 of 18 residents (Resident #21), in the survey sample, after she was transferred to an acute care hospital on 8/27/19. The findings included:	F 622	1. No resident has been adversely affected by the deficient practice. Resident #21 was sent to the hospital on 8/27/2019 and returned to the facility on 8/29/2019. Resident remains at the facility and had no further hospitalizations. 2. Residents that experience a facility initiated transfer have the potential to be affected by this practice. The facility	

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F 622	Continued From page 6 Resident #21 was originally admitted to the facility 8/7/19, and readmitted on 8/29/19, after an acute care hospital stay for an infection. The current diagnoses included, osteoarthritis and a pantalar fusion with use of an external fixator of the left ankle and foot. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/14/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with transfers, extensive assistance of one person with bed mobility, locomotion, dressing, toileting, personal hygiene and bathing and supervision after set-up with walking and eating. Review of the discharge MDS assessment dated 8/27/19, it revealed Resident #21 was discharged return-anticipated. During an interview on 9/4/19, at approximately 1:45 p.m., Resident #21 stated she had been hospitalized for 2 days after an orthopedic appointment since she was been admitted to the nursing facility. She stated upon discharge from the hospital the orthopedic physician said she would require 4-6 months of antibiotic therapy because the infection was in her left lower extremity bones. The resident also stated the goals the nursing facility's staff were working towards with her were not addressed during the hospital stay. A nurse's noted dated 8/27/19, at 22:56 (10:56 PM) read; Per the Assistant Director of Nursing, a	F 622	discharge policy will be updated, and staff educated. 3. The facility will ensure that the comprehensive care plan goals of the resident are conveyed to the receiving facility. In the event the facility is informed of a resident being transferred to another facility, a copy of the resident□s care plan that includes the care plan goals, will be faxed to the receiving facility. 4. The DON or designee will audit all facility initiated transfers to ensure the care plan goals were provided to the receiving facility for 3 months. Any variances identified will be corrected, staff counseled and reeducated as appropriate. The results of the audit will be tracked and trended and presented to the QAPI committee for additional guidance.	

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F 622	Continued From page 7 report was received from the resident's orthopedic physician office stating the resident was a direct admit to a local hospital for left lower extremity cellulitis. The note further stated the resident's daughter came by and spoke with the supervisor in reference to holding Resident #21's room and the supervisor instructed the daughter that the social worker will be informed of the inquiry and would call her with details. During the pre-exit interview with the Administrator, Director of Nursing, Assistant Director of Nursing, and the MDS Coordinator on 9/10/19, at approximately 4:15 p.m., the above findings were shared with the facility's team and they were asked: how did Resident #21's care plan and or care plan goals reach the hospital staff? The Administrator stated since the resident was admitted to the hospital while out at a physician's appointment they should have sent the information by the daughter when she came in but there was no indication it was done. The Administrator further stated they would develop a more feasible mean for documents necessary for a resident care to be transferred from the facility to the hospital staff under non-facility imitated transfers to the hospital. She also stated they have a staff member who visits the hospital routinely and that may be the better answer.	F 622		
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	F 640		10/25/19

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F 640	Continued From page 8	F 640		

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, 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.

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F 640	Continued From page 9 §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 clinical record review, staff interview, and facility documentation review, the facility's staff failed to electronically transmit an encoded and completed discharge Minimum Data Set (MDS), assessment to the Centers for Medicare/Medicaid System (CMS), for 1 of 18 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 3/25/19, and was discharged from the facility to the community 4/12/19. The diagnoses included adult failure to thrive, age related physical abilities and asthma. The admission MDS assessment with an assessment reference date (ARD) of 4/1/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with locomotion, extensive assistance of two with bed mobility and transfers, extensive assistance with one dressing, eating, toileting, personal hygiene and bathing. During the Resident Assessment review, Resident #1 triggered for not having an MDS assessment completed in greater than 120 days	F 640	1. Discharge MDS for Resident #1 was submitted to CMS on 9/10/2019. 2. Residents that discharge from the facility have the potential to be affected by this practice. All the assessments over the past 12 months have been audited to ensure proper transmission to the CMS data bank. All the findings will be rectified. 3. MDS Coordinator will utilize electronic tracking tool available through electronic health records software to ensure timely completion and transmission of assessments to CMS databank. The facility will engage the software vendor in discussion regarding the upgrades to the current software on 10/9/2019. 4. MDS Coordinator will pull a weekly report for 4 weeks and will pull a monthly report for 2 months, then quarterly moving forward, to ensure discharge MDSs have been transmitted accurately and timely. Any variances identified will be corrected. The results of the audit will be tracked and trended and presented to the QAPI committee for additional guidance.	

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F 640	Continued From page 10 (the prior MDS assessment accepted in the CMS databank was dated 4/1/19), therefore, an interview was conducted with the MDS Coordinator on 9/9/19, at approximately 2:10 p.m. The MDS Coordinator stated Resident #1's discharge MDS assessment with an ARD of 4/12/19, was in the computer, it was completed 4/23/19, and it showed it had not been batched to transmit to the CMS databank. The above findings were shared with the Administrator, Director of Nursing, the Assistant Director of Nursing and the MDS Coordinator during the pre-exit meeting on 9/10/19, at approximately 4:15 p.m. The MDS Coordinator presented the validation report indicating she had transmitted the resident's 4/12/19, discharge MDS assessment to CMS on 9/10/19. The MDS Coordination also stated she had spoken with administration about the findings and they were working on a solution for locating any additional un-transmitted MDS assessments and submitting then to CMS.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review and clinical record review, it was determined that facility staff failed to ensure that the resident assessment was accurately coded for 2 of 18 residents in the survey sample. The assessment inaccurately reflected Resident	F 641	1. Modifications for Resident #33 and Resident #19 have been completed and submitted to CMS databank. 2. All residents have the potential to be affected by this deficient practice. Residents with physician orders for	10/25/19

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F 641	Continued From page 11 #33's discharge status; and the facility staff failed to accurately document the number of days that injections of Lovenox were received for Resident #19. The findings included: 1. Resident #33 was admitted to the facility on 07/25/2019. Diagnosis included but were not limited to, Stroke and Type 2 Diabetes Mellitus. Resident #33's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 08/01/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #33 as requiring extensive assistance of 1 with eating, toilet use and personal hygiene and extensive assistance of 2 with bed mobility, transfer and dressing. On 09/10/2019 at approximately 12:30 p.m., a review of Resident #33's clinical record revealed the following: An MDS assessment dated 08/14/2019 was coded as "Death in facility tracking record." The Clinical Note dated 08/13/2019 at 10:50 p.m., was reviewed and nurse documentation revealed and is documented in part, as follows: "Resident complained of Chest pain - 10/10 crushing, tightness, gripping pain. Resident alert and requesting to go to hospital. Resident very restless and anxious. Resident stated that she doesn't want to die here. VS (Vital Signs) 97.6, 98, 18, 105/69, 93 % - Nitrostat 1 dose given; VS 97.1, 77, 18, 153/62, 97 % - Nitrostat 1 dose given. Informed MD (Medical Doctor) and	F 641	Lovenox injections will be audited to ensure their MDS correctly reflects the number of injections. Residents that have expired will be audited to ensure that the section A0310F is coded correctly reflecting where the death occurred. 3. MDS coordinator will be reeducated on records review and accurate completion of MDS assessments. Education will be provided by an outside consultant group. 4. Director of Nursing or designee will audit section N0300 for 50% of residents with physician orders for Lovenox injections for 3 months to ensure accuracy. Director of Nursing or designee will audit section A0310F for 50% of expired residents for 3 months to ensure proper coding. Any variances identified will be corrected, staff counseled and reeducated as appropriate. The results of the audit will be tracked and trended and presented to the QAPI committee for additional guidance.	

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ordered to send to ER (Emergency Room) via 911. Husband at bedside and aware of the pain. Resident went to ER via 911 stretcher."

Clinical Note for 08/14/2019 at 4:32 a.m., was reviewed and nurse documentation revealed and is documented in part, as follows: "Received report from Nursing supervisor that Res (Resident) was admitted at (Hospital abbreviation name)."

On 09/10/2019 at approximately 12:45 p.m., an interview was conducted with the MDS Coordinator and she was asked if Resident #33 expired in the facility. The MDS Coordinator stated, "No, (Residents Name) was sent to the hospital and I was told that she died at 3:00 a.m. while in the ER." The MDS Coordinator was asked, "Why was Resident #33's assessment coded as "Death in the facility?" The MDS Coordinator stated, "I coded the assessment as "Death in facility" because the resident was at the hospital and per my manual instructions if the resident expires during LOA (Leave of Absence) and in the hospital less than 24 hours then I'm suppose to code the resident as "Death in facility."

An interview was conducted with the DON on 09/10/2019 at 1:10 p.m., and the DON was asked, "Where was Resident #33 when she expired?" The DON stated, "She expired in the hospital. The assessment was not coded accurately." The DON was asked, "What are your expectations of MDS nurses when documenting assessments?" The DON stated, "I expect the nurses to know what to do and be accountable."

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On 09/10/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator, Director of Nursing and MDS Coordinator was informed of the finding. The facility did not present any further information about the finding.

Definitions:

"Death in facility" - refers to when the resident dies in the facility or dies while on a leave of absence (LOA) .
Leave of Absence (LOA) - occurs when a resident has a: temporary home visit; or temporary therapeutic leave; or hospital observation stay less than 24 hours and the hospital does NOT admit the resident.

References:
Center's for Medicare and Medicaid Services Long - Term Care Facility Resident Assessment Instrument 3.0 RAI https://www.cms.gov>medicare>nursinghomequalityints>mds30ramanual.html

2. Resident #19 was admitted to the facility on 08/08/2019. Diagnoses included but were not limited to, Rheumatoid Arthritis and Type 2 Diabetes Mellitus. Resident #19's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 08/15/2019 was coded with a BIMS (Brief Interview for Mental Status) of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #19 as requiring extensive assistance of 1 for bed mobility, transfer, dressing, toilet use and personal hygiene and limited assistance of 1 with eating.

On 09/10/2019 at approximately 10:30 a.m.,

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Resident #19's clinical record was reviewed and revealed the following:

Review of the Admission MDS with an Assessment Reference Date of 08/15/2019, "Section N - N0300 Injections" - revealed that the resident was coded as receiving injections of any type for 1 (one) day during the last 7 (seven) days or since admission/entry; and review of "Section N - N0410 Medications Received" revealed that the resident was coded as receiving a anticoagulant for 7 (seven) days during the last 7 (seven) days or since admission/entry.

Review of August 2019 Medication Record revealed that Resident #19 received Lovenox 30 mg (Milligram)/0.3 ml (Milliliter) subcutaneous syringe - [Enoxaparin] - 1 inj (Injection) subcutaneous every 12 hours for DVT (Deep Vein Thrombosis) prophalaxis for 7 days during the period of August 9, 2019 through August 15, 2019.

On 09/10/2019 at 10:43 a.m., the MDS Coordinator was asked, "Can you explain why Resident #19's Admission MDS is coded as the resident received injections for one day?" The MDS Coordinator stated, "It was an oversight, should have been coded as seven days." The MDS Coordinator modified the MDS on 09/10/2019 as a correction and provided the surveyor a copy of the modified MDS.

On 09/10/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator, Director of Nursing and MDS Coordinator was informed of the finding. The facility did not present any further information about the finding.

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F 641	Continued From page 15 Definitions: Lovenox Subcutaneous - [Enoxaparin Injection] - Enoxaparin is used to prevent blood clots in the leg in patients who are on bedrest or who are having hip replacement, knee replacement, or stomach surgery. https://medlineplus.gov/druginfo/meds/a601210.html	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		10/25/19

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F 656	Continued From page 16 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to ensure that the Comprehensive Care Plan was developed within 7 (seven) days after completion of the Admission assessment for 4 Residents (Resident #24, #19, #14,#17) of 18 residents in the survey sample. The findings included: 1. For Resident #24, the facility staff failed to develop a comprehensive person-centered care plan. Resident #24 was originally admitted to the facility on 07/24/2019. The resident was discharged to the hospital on 08/05/2019 and readmitted to the facility on 08/14/2019. Diagnoses included but were not limited to, hypertension and atrial fibrillation. Resident #24's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 08/21/2019 was coded with a BIMS (Brief Interview for Mental	F 656	1. Care plans for residents #24, #19, #14, and #17 will be completed by 10/10/2019. 2. All residents have the potential to be affected by the deficient practice. Comprehensive care plans will be reviewed to ensure timely completion. 3. MDS coordinator will be reeducated on completion of comprehensive care plans. Education will be provided by an outside consultant group. 4. Director of Nursing or designee will audit comprehensive care plans of all new admissions for 1 month and 50% of new admissions for 3 months to ensure they were completed within seven days of completion of the admission assessment. Any variances identified will be corrected, staff counseled and reeducated as appropriate. The results of the audits will be tracked and trended and presented to the QAPI committee for additional guidance.	

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Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #24 as requiring extensive assistance of 2 with bed mobility, transfer and dressing, extensive assistance of 1 with toilet use and personal hygiene, physical help of 1 with bathing and supervision with set up help only for eating.

On 09/09/2019 at approximately 4:00 p.m., the surveyor requested a copy of Resident #24's Comprehensive Care Plan. The MDS Coordinator stated, "The Comprehensive Care Plan is not completed." The Director of Nursing was present.

On 09/09/2019 at approximately 5:00 p.m., an interview was conducted with the MDS Coordinator and she was asked, "When was Resident #24's Admission MDS completed?" The MDS Coordinator stated, "On 08/21/2019." The MDS Coordinator was asked, "When is the Comprehensive Care Plan due to be completed?" The MDS Coordinator stated, "Fourteen days after the Comprehensive MDS."

On 09/09/2019 at approximately 5:15 p.m., the above discussion with the MDS Coordinator were reviewed with the Director of Nursing (DON). The DON stated, "I am new to Long Term Care and not familiar with all the regulations." The DON was asked, "What are your expectations of the nurses completing the comprehensive care plans?" The DON stated, "I expect them to learn and be correct. I will do some more checking behind the nurses."

On 09/10/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator, Director of

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Nursing and MDS Coordinator was informed of the finding. The facility did not present any further information about the finding.

2. For Resident #19, the facility staff failed to develop a comprehensive person-centered care plan.

Resident #19 was admitted to the facility on 08/08/2019. Diagnoses included but were not limited to, Rheumatoid Arthritis and Type 2 Diabetes Mellitus. Resident #19's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 08/15/2019 was coded with a BIMS (Brief Interview for Mental Status) of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #19 as requiring extensive assistance of 1 for bed mobility, transfer, dressing, toilet use and personal hygiene and limited assistance of 1 with eating.

On 09/10/2019 at 10:15 a.m., Resident #19's comprehensive person centered care plan was requested but not received.

An interview was conducted with the MDS Coordinator on 09/10/2019 at 10:33 a.m., she stated, "The comprehensive care plan was not completed because the resident was discharged from the facility on 09/04/2019." The MDS Coordinator was asked, "When was Resident #19 admitted to the facility?" The MDS Coordinator stated, "August 08, 2019." The MDS Coordinator was asked, "When was the Admission MDS completed?" The MDS Coordinator stated, "August 15, 2019." The MDS Coordinator was asked, "Should the comprehensive care plan have been completed?" The MDS Coordinator

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stated, "Yes."

On 09/10/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator, Director of Nursing and MDS Coordinator was informed of the finding. The facility did not present any further information about the finding.

3. The facility staff failed to develop and implement a comprehensive person-centered care plan for Resident #14.

Resident #14 was originally admitted to the facility 7/31/19, and had never been discharged from the facility. The resident's diagnoses included bilateral deep vein thrombosis, hematuria and urinary retention.

The admission MDS assessment with an assessment reference date (ARD) of 8/7/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #14's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with eating, extensive assistance of two with bed mobility, extensive assistance of one with walking, locomotion, dressing, toileting, personal hygiene and bathing.

A review of Resident #14's person-centered care plan was conducted secondary to a physician's orders dated 8/8/19, for time voiding every six hours with bladder scan as post-void residual every six hours. If bladder scan results are greater than 250 milliliters, in and out catheterization and notify the medical team. One every six hours for urinary retention for voiding

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trial.

The care plan dated 7/31/19 read (name of resident) has urinary incontinence. The goal read; (name of resident) will remain clean, dry and free of breakdown related to incontinence. The interventions included: perineal cleansing and apply protective skin barrier after each incontinence episode. provide adult incontinence products and monitor for incontinence every two hours. Assess and report signs of impaired skin integrity or breakdown.

The care plan didn't reference urinary retention, bladder scans, post-void residuals, or in and out catheterization.

A physician's progress note dated 8/8/19 read: Foley catheter placed initially. Removed on 7/31/19, passed voiding trial by voiding twice. Foley had been inserted 8/8/19, due to a failed voiding trial, Macrobid (an antibiotic) was started earlier this week. Another physician's progress note dated 8/13/19, read; Bladder scan 300 milliliters at lunch, resident was in and out cathed. Denies dysuria today. Due around dinner today for another post void residual.

The above findings were shared with the Administrator, Director of Nursing, the Assistant Director of Nursing and the MDS Coordinator during the pre-exit meeting on 9/10/19 at approximately 4:15 p.m. The MDS Coordinator stated she had spoken with administration about the findings and they were working on a solution for she had not completed comprehensive care plans due to the heavy workload.

4. The facility staff failed to develop a

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comprehensive person-centered care plan for Resident #17.

Resident #17 was admitted to the facility on 7/30/19 with diagnoses that included but not limited to Hypertension and Muscle Weakness.

Resident #17's most recent MDS (Minimum Data Set) an admission assessment with an ARD (assessment reference date) of 08/06/19 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #17 was coded as requiring extensive assistance requiring a two person physical assistance with bed mobility, transfers and toilet use; requiring one person assist with locomotion on and off the unit, dressing, personal hygiene and bathing; and eating requiring set-up help only.

On 09/10/19 at approximately 10:30 AM Registered Nurse #1 (RN #1, MDS Coordinator) was approached to provide a copy of Resident #17's Comprehensive Care Plan. RN #1, (MDS Coordinator) stated, "I didn't do her Comprehensive Care Plan."

On 09/10/19 at approximately, 11:50 AM, an interview was conducted with RN #1. She was asked if Resident #17's comprehensive care plan completed? She stated, "No." She was then asked should it have been completed? She stated, "Yes;" "I didn't complete the comprehensive, related to the turn-over of admissions and discharges." She stated "Moving forward I've spoken with administration about coming up with a plan."

On 09/10/19 at approximately 3:44 PM a pre-exit

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F 656	Continued From page 22 interview was conducted with the Administrator, Director of Nursing (DON) and Registered Nurse #1. No further comments were voiced. The facility Policy titled: Comprehensive Person-Centered Care Planning. "Comprehensive Care Plan" means an interdisciplinary communication tool developed after completion of a comprehensive MDS and review of the care Area Assessments (CAAs). POLICY: A person centered comprehensive that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident. To the extent practicable, the resident/resident representative will be provided with opportunities to participate in the care planning process. PROCEDURE: section III-A comprehensive care plan for each resident must be developed within seven days of the completion of the resident's MDS assessment. Section IV-The comprehensive care plan shall be developed by a Care Planning/Interdisciplinary Team which includes at a minimum: The resident's attending physician, a licensed nurse responsible for caring for the resident, a nursing assistant responsible for the resident's care, a member of food and nutrition services staff, a social worker, activities worker, Rehab. Therapists, consultants and others as appropriate or necessary to meet the needs or request of the resident.	F 656		
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	F 758		10/25/19

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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 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.

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HARBOR'S EDGE	ONE COLLEY AVENUE NORFOLK, VA 23510

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F 758	Continued From page 24 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of the facility's policy, the facility staff failed to ensure 1 of 18 residents in the survey sample (Resident #24) did not receive "as needed" anti anxiety medication Ativan for greater than 14 days without the physician and/or prescribing practitioner thoroughly evaluating the resident for the appropriateness of continuous "as needed" use and indication of the duration of use. The findings included: Resident #24 was originally admitted to the facility on 07/24/2019. The resident was discharged to the hospital on 08/05/2019 and readmitted to the facility on 08/14/2019. Diagnoses included but were not limited to, hypertension and atrial fibrillation. Resident #24's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 08/21/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #24 as requiring extensive assistance of 2 with bed mobility, transfer and dressing, extensive assistance of 1 with toilet use and personal hygiene, physical help of 1 with bathing and supervision with set up help only for eating. On 09/09/2019 at approximately 2:00 p.m., Resident #24's clinical record was reviewed and	F 758	1. The physician has reviewed anti-anxiety medication Ativan orders for Resident #24 for appropriateness of continuous as needed use and rationale has been documented in resident□s medical record. 2. All residents with PRN orders for anti-anxiety medications will be reviewed to ensure orders contain stop dates and MD rationale is included for continued use. 3. Nursing staff and physicians will be educated on unnecessary PRN psychotropic medication use. The prescribing practitioner will thoroughly evaluate the resident for the appropriateness of continuous as needed use and indication of the duration of use and document the rationale in the medical record. 4. DON or designee will audit 50% of all as needed orders of psychotropic medications for 3 months in addition to monthly pharmacy reviews to ensure appropriate rational for continued use and stop dates on orders. Any variances identified will be corrected, staff counseled and reeducated as appropriate. The results of the audits will be tracked and trended and presented to the QAPI committee for additional guidance.	

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revealed a physician order for Ativan (Lorazepam) 0.5 mg (Milligram) tablet- 1 tab By Mouth Once Daily as Needed for anxiety. Order Date, 08/14/2019 and start Date 08/14/2019.

The Medication Administration Record for August 2019 was reviewed and revealed that Resident #24 was administered Ativan 0.5 mg tablet [Lorazepam] 1 (one) tab by mouth once daily as needed for anxiety on 08/14, 08/15, 08/16, 08/17, 08/18, 08/19, 08/22, 08/23, 08/24, 08/25, 08/27, 08/28, 08/29, 08/30 and 08/31/19.

Medication Administration Record for September 2019 was reviewed and revealed that Resident #24 was administered the Ativan 0.5 mg tablet 1 (one) tab by mouth once daily as needed for anxiety on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07 and 09/08/19.

A Physician Note dated 08/15/2019 was reviewed and revealed the following: "Anxiety-PRN (as needed) Ativan started in hospital for feeling claustrophobic in CT (Computerized Tomography) scan. Counseled goal to d/c (Discontinue) Ativan and not reorder once current supply runs out."

Physician Note dated 08/22/2019 was reviewed and revealed the following: "Anxiety / Depression: First dose of Sertraline (zoloft)on 08/21; pt (Patient) understands that his Ativan is only once prn for severe anxiety."

Pharmacist Consultation Report dated 08/30/2019 was reviewed and revealed the following:
"Comment: (Resident Name) has a PRN order for an anxiolytic, without a stop date: Lorazepam prn must have a stop date in the order and eMAR

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per CMS (Center's for Medicare and Medicaid Services) regs.
Recommendation:
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-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order.
The Consultation Form provided the following responses for the Physician to elect a response from: "I accept the recommendation above, please implement as written; I accept the recommendation above WITH THE FOLLOWING MODIFICATIONS; I decline the recommendation above and do not wish to implement any changes due to the reasons below." The physician elected the response: "I decline the recommendation above and do not wish to implement any changes due to the reasons below. Rationale: "Severe Anxiety." Physician's Response was dated 09/04/19.

On 09/10/2019 at approximately 3:30 p.m., after review of Resident #24's clinical record, there was no evidence that the physician indicated the duration for the PRN order as required.

On 09/10/2019 at approximately 11:26 a.m., an interview was conducted with the DON and she stated, "I expect the nurses to review the medications and if they note that a resident has a PRN psychotropic medication and it does not

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F 758	Continued From page 27 have a stop date they should escalate notification to the physician to re-evaluate resident. We should be escalating to clarify with the physician if to make the medication routine." On 09/10/2019 at approximately 4:00 p.m., at the pre-exit meeting the Administrator, Director of Nursing and MDS Coordinator was informed of the finding. The facility did not present any further information about the finding.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's policy, the facility staff failed to ensure that food was prepared, distributed and served under sanitary conditions.	F 812	1. All expired items were immediately disposed. No resident has been adversely affected by the deficient practice. 2. All foods have been inspected for	10/25/19

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F 812	Continued From page 28 The finding included: On 09/04/19 at approximately 11:10 AM an initial tour of the kitchen was conducted with Other Staff # 4. The following was observed during the tour: 2 - 4 lb containers of classic Hummus with use by date 9/01/19. (Located in the Walk-in refrigerator) 1 large pan of fresh salmon not dated or labeled. (Located in the walk-in refrigerator) 1 container of ranch dressing opened (1/2 filled) no opened date listed. (Located in the reach-in refrigerator) 3 loaves of bread found in dry storage with expiration dates of 8/31/19. The above findings were discussed with the Food Service Manager (FSD-Other Staff #2) on 09/05/19 at approximately 10:15 AM. She was asked what should have been done with the above concerns. The FSD stated, "Anything expired should be discarded" and "Anything not labeled or dated should be." On 09/10/19 at approximately 3:44 PM a pre-exit interview was conducted with the Administrator, Director of Nursing (DON) and Registered Nurse #1. No further comments were voiced. Policy entitled: Food Dates and disposition. The dining services will label and date all prepared foods with the date prepared and disposed of food items after three days for prepared foods and by manufactures expiration date for commercially packaged food items complying with all rules and regulations. PROCEDURE: Labels will be attached to all prepared food items with date prepared. Foods are removed from	F 812	proper labeling and disposition dates. Any findings have been corrected. 3. Dining staff will be reeducated on food date and labeling policy. 4. Dietary manager will monitor for compliance by inspecting kitchen weekly for 1 month and once a month for 3 months to ensure compliance with food labeling and dating. Any findings will be corrected, staff counseled and reeducated as appropriate. The results of the inspections will be tracked and trended and presented to the QAPI committee for additional guidance.	

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F 812	Continued From page 29 original packaging will be placed into containers or wrapped in a manner to maintain quality and labeled identifying the product along with the current date. DISPOSITION: Prepared food items will be disposed in a proper manner 3 days after the date of preparation. Expired foods will be disposed of prior to the date of expiration. DOCUMENTATION: Prepared foods will have an affixed label or marked on a disposable container with the current date.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		10/25/19

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to use clean equipment and perform appropriate hand hygiene during wound care for 1 of 18 residents (Residents #27), in the survey sample. The findings included: Resident #27 was originally admitted to the facility 8/10/19 and had not been discharged from the facility. The resident's diagnoses included; an abdominal surgical wound related to a ventral hernia causing a small bowel obstruction. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/17/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with eating and walking, supervision of one person with bathing, extensive assistance of one person with locomotion, limited assistance of one with bed mobility, dressing, toileting, and personal hygiene. In section "M" (Skin Condition) the resident was coded as having a surgical wound present. A Physician's order dated 9/3/19 read: Change abdominal wound packing with 1/4 plan packing and cover with gauze and hypafix tape twice daily. The current care plan dated 8/11/19 read: Disruption of skin surface layers and tissue	F 880	1. No resident has been adversely affected by the deficient practice. 2. All residents with orders for wound care have the potential to be affected by the deficient practice. RN #2 has been educated on the use of clean equipment and hand hygiene during wound care. 3. Nursing staff will be reeducated on appropriate hand hygiene and use of clean equipment during wound care. 4. Wound care and hand hygiene education will be conducted annually and as needed. Assistant Director of Nursing or designee will conduct wound care observations on a bi-weekly basis for 90 days to ensure proper hand hygiene and clean equipment used. Any variances identified will be corrected, staff counseled and reeducated as appropriate. The results of the audits will be tracked and trended and presented to the QAPI committee for additional guidance.	

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related to a surgical incision to the abdomen. The goal read; The surgical incision will heal without complication. The interventions included; reinforce initial dressing and change as indicated. Use strict aseptic techniques. Inspect the wound regularly, noting characteristics and integrity. Assess amounts and characteristics of drainage. Caution the resident not to touch the wound.

Resident #27's surgical wound care was observed on 9/4/19, at approximately 1:30 p.m. Registered Nurse (RN) #2 washed her hands, the resident pulled down her pants to expose the wound. RN #2 removed the old dressing, removed her gloves, applied a new pair of gloves. RN #2 removed gauze from the package, held it over the trash can and poured normal saline on to the gauze, and cleaned the wound from inner to outer area. She wet another gauze and again cleaned from inner to outer and the same for a third time. RN #2 then removed her gloves and patted the wound with a dry gauze. RN #2 then changed her gloves, obtained the packing from the bottle. She opened her personal scissors (RN#2's name was engraved on the scissors) which were removed from her pocket, cut the packing and inserted the packing into the abdominal opening using a cotton tip applicator. RN #2 then applied an abdominal pad followed by application of hypafix tape. RN #2 gathered all products utilized and trashed the table protectors and the unused saline; she then removed her gloves washed her hands and returned her personal scissors to her pocket without cleaning them.

An interview was conducted with Registered Nurse (RN) #2, on 9/10/19. RN #2 stated the scissors during Resident #27's wound care were

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her personal scissors and she had cleaned then after her last use but she didn't clean them after removing them from her pocket or prior to cutting the products to complete Resident #27's wound care. RN#2 also stated she normally only washes her hands before and after wound care not in between or when going from soiled to clean. RN #2 reviewed the facility's protocol for wound care and returned later stating, yeah the policy stated the scissors should have been cleaned prior to cutting the products and handwashing is required after removing the soiled dressings, before cleaning the wound and prior to applying the new dressing.

On 9/10/19 at approximately 4:15 p.m., the above findings were shared with the Administrator, Director of Nursing, the Assistant Director of Nursing and the MDS Coordinator. An opportunity was provided for additional information to be introduced but none was offered.