STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 10/10/2019

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/08/2019 through 10/10/2019. 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	The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegations in the 25 67. The facility is completing the allegation of compliance because it is required by State and F ederal law . The facility disagrees with and	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/8/19 through 10/10/19. Four complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 119 at the time of the survey. The survey sample consisted of 44 current resident reviews and 5 closed record reviews.	F 000	disputes the deficiencies as stated and the scope and severity at which they are cited . F urther , the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the stated deficiencies . The facility reserves its right to dispute , appeal and contest the stated deficiencies and take any action related to or arising therefrom in any other forum as needed	
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 572	F 572 It is the practice of this facility to provide residents with information regarding resident rights and rules upon admission . As indicated in the statement of deficiencies , Resident #73on admission refused to sign the paperwork when presented to him . On October 14,2019 the resident representative was provided with information regarding resident's rights and facility rules on behalf of the resident .	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Greene — TITLE: Administrator — (X6) DATE: 10/28/19

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

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F 572	Continued From page 1 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that one of 49 residents in the survey sample, Resident #73, was provided with information regarding resident rights and facility rules upon admission. The findings include: Resident #73 was admitted to the facility on 6/4/18 with the diagnoses of but not limited to osteomyelitis, dysphagia, herpes viral, mood disorder, anxiety disorder, dementia, neuropathy, pancreatitis, diabetes, peripheral vascular disease, alcohol abuse, adjustment disorder, high blood pressure, and heart disease. The 90 day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/30/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for transfers, toileting, and bathing; extensive transfers for hygiene, dressing, and bed mobility; and supervision for eating. A review of the clinical record failed to reveal any evidence that Resident #73 had any advance	F 572	II Who did this audit and when? On October 22, 2019 the Admin Assistant / Medical Record completed a 100% audit was completed to identify any other residents with the same deficient practice. Were there any other residents with an issue? If not please state that no other resident were found to be affected III On October 22, 2019 the NHA completed education for the Admissions /Marketing persons regarding the regulation and requirement for residents or the Resident representative to receive information about resident rights and rules upon admission and that if a resident refuses to sign admission paperwork, that the paperwork reflects such and that copies of the paperwork is provided to the resident despite refusal to sign. RECEIVED OCT 30 2019 VDH/OLC	

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F 572	Continued From page 2 directives. This investigation then lead to the discovery that the facility had no evidence that the resident was provided with information regarding resident rights and facility rules. On 10/9/19 at 10:27 a.m., ASM #1 (Administrative Staff Member), the Administrator was provided a list of multiple residents, including Resident # 73 regarding the Advance Directives. On 10/9/19 at 6:02 p.m., ASM #1 stated she could not provide evidence regarding Resident #73's Advance Directives. A copy of the Advance Directive for Resident #73 was requested, if he had any, and the page from his Admission Contract that reflected that information was provided at the time of admission for Advance Directives. None was provided. On 10/10/19 at 3:00 PM, in an interview with OSM #7, the Business Office Manager, she was asked about the evidence that Resident #73 was provided with information regarding the completion of Advance Directives at the time of admission. She stated that his admission file did not have an admission contract in it. OSM #7 stated that "usually, when admissions get their contract signed they give it to me and then I put it in the file cabinet in the business office. We give them the contract when they come in but he refused to sign. He was offered a couple times to sign but he did not. I have no evidence that one was offered or that he was provided an admission contract. It was not documented that he was provided any and just refused to sign it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here when he was admitted is no longer here." When asked if there was anything at all in his record that	F 572	IV The admissions department or designee will maintain a log of incoming admissions to ensure all new admissions receive information regarding resident's right and facility rules. The administrator or designee will conduct audits of the admission logs and admission paperwork to ensure accuracy and compliance. This audit will take place 5 days per week for 2 weeks then weekly for 4 weeks. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted, by the facility Administrator, to the Quality Assessment Performance Improvement (QAPI) committee for its review and recommendations monthly. V The facility alleges compliance of these tasks on or before 11/8/2019	

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F 572	Continued From page 3 reflected he was provided with an Admissions Contract that also included information regarding his rights, facility rules, and pertinent contact information (i.e., Ombudsman information, State Agency information, Adult Protective Services information, etc.) she stated there was not. Policies and procedures were requested from her at this time regarding these concerns. None were provided, other than a policy for Advance Directives and a blank copy of an Admission Contract form that contained the above information for which there was no evidence Resident #73 was provided. On 10/10/19 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey.	F 572		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent	F 574	F 574 It is the practice of this facility to provide residents on admission with information regarding pertinent contact information of local and state individuals and agencies for the resident's protection I As indicated in the statement of deficiencies, Resident # 73 on admission refused to sign the paperwork when presented to him. On October 16, 2019 the resident representative was provided with information regarding resident's pertinent contact information of local and state individuals and agencies for the resident's protection	

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F 574	Continued From page 4 State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and	F 574	II Who did this audit and when? On October 16, 2019, the Admin Assistant/Medical Records completed a 100% audit was completed to identify any other residents with the same deficient practice. Were there any other residents with an issue? If not please state that no other resident were found to be affected III On October 22, 2019 the NHA completed education for the Admissions /Marketing persons regarding the regulation and requirement for residents or the Resident representative to receive on admission, information regarding pertinent contact information of local and state individuals and agencies and that if a resident refuses to sign admission paperwork, that the paperwork reflects such and that copies of the paperwork is provided to the resident despite refusal to sign.	

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F 574	Continued From page 5 (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that 1 of 49 residents in the survey sample, Resident #73, was provided with information regarding pertinent contact information of local and state individuals and agencies for the resident's protection upon admission. The findings include: Resident #73 was admitted to the facility on 6/4/18 with the diagnoses of but not limited to osteomyelitis, dysphagia, herpes viral, mood disorder, anxiety disorder, dementia, neuropathy, pancreatitis, diabetes, peripheral vascular disease, alcohol abuse, adjustment disorder, high blood pressure, and heart disease. The 90 day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/30/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for transfers, toileting, and bathing; extensive transfers for hygiene, dressing, and bed mobility; and supervision for eating.	F 574	IV The admissions department or designee will maintain a log of incoming admissions to ensure all new admissions receive information regarding resident's pertinent contact information of local and state individuals and agencies. The administrator or designee will conduct audits of the admission logs and admission paperwork to ensure accuracy and compliance. This audit will take place 5 days per week for 2 weeks then weekly for 4 weeks. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted, by the facility Administrator, to the Quality Assessment Performance Improvement (QAPI) committee for its review and recommendations monthly. V The facility alleges compliance of these tasks on or before 11/8/2019	

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F 574	Continued From page 6 A review of the clinical record failed to reveal any evidence that Resident #73 had any advance directives. This review and investigation then lead to the discovery that the facility had no evidence that the resident was provided with information regarding contact information of local and state individuals and agencies for the resident's protection (i.e., Ombudsman, State Agency complaint and hot line information, Adult Protective Services information, etc.) upon admission. On 10/9/19 at 10:27 a.m., ASM #1 (Administrative Staff Member), the Administrator was provided a list of multiple residents, including Resident # 73, regarding Advance Directives. On 10/9/19 at 6:02 p.m., ASM #1 stated she could not provide the information that was requested. A copy of the Advance Directive for Resident #73 was requested, if he had any, and the page from his Admission Contract that reflected that information was provided at the time of admission for Advance Directives. None was provided. On 10/10/19 at 3:00 PM, in an interview with OSM #7, the Business Office Manager, she was asked about the evidence that Resident #73 was provided with information regarding the completion of Advance Directives at the time of admission. She stated that his admission file did not have an admission contract in it. She stated that "usually, when admissions get their contract signed they give it to me and then I put it in the file cabinet in the business office. We give them the contract when they come in but he refused to sign. He was offered a couple times to sign but he did not. I have no evidence that one was offered or that he was provided an admission contract. It was not documented that he was	F 574		

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F 574	Continued From page 7 provided any and just refused to sign it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here when he was admitted is no longer here." When asked if there was anything at all in his record that reflected he was provided with an Admissions Contract that also included information regarding his rights, facility rules, and pertinent contact information (i.e., Ombudsman information, State Agency information, Adult Protective Services information, etc.) she stated there was not. Policies and procedures were requested from her at this time regarding these concerns. None were provided, other than a policy for Advance Directives and a blank copy of an Admission Contract form that contained the above information for which there was no evidence Resident #73 was provided. On 10/10/19 at 3:30 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey.	F 574		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578	F 578 It is the practice of this facility to periodically review advanced directives with residents and to provide residents with information on admission regarding Advance Directives.	

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F 578	Continued From page 8 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to meet advance directive requirements for two of 49 residents in the survey sample, Residents #13 and #73. The facility staff failed to evidence that the facility policy for advanced directives was implemented to review with Resident #13 periodically her Advance Directives, to determine if she wanted to change	F 578	I As indicated in the statement of deficiencies, Resident # 73 on admission refused to sign the paperwork when presented to him for Advance Directives. On October 16, 2019 the resident representative was provided with information regarding resident's Advance Directive options. The Social Services Director reviewed advanced directives with Resident #13 and # 73 on October 28, 2018. The review has been documented in the medical chart. II The Social Services staff completed a facility wide review of residents to address their Advanced Directive status. Any changes that the resident or Resident Representative wished to have completed were done. Moving forward the social services department will review and discuss advance directives with the resident representative during the time of scheduled care plan review.	

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F 578	Continued From page 9 or maintain them as written. Staff failed to provide Resident #73 information at the time of admission regarding advance directives; and failed to evidence that a periodic review of the resident's advance directive status was conducted with the resident. The findings include: 1. The facility staff failed to evidence that the facility policy for advanced directives was implemented to review with Resident #13 periodically her Advance Directives, to determine if she wanted to change or maintain them as written. Resident #13 was admitted to the facility on 10/25/16 with the diagnoses of but not limited to metabolic encephalopathy, depression, poisoning, thyrotoxic crisis, dysphagia, Alzheimer's disease, neuropathic bladder, Parkinson's disease, high blood pressure, bipolar disorder, anxiety disorder, and kidney failure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/3/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing; limited assistance for hygiene, toileting, and dressing; and supervision for transfers and eating. A review of the clinical record revealed that Resident #13 had an Advance Directive, dated 9/15/2001, but no evidence that a periodic review had been conducted with the resident regarding if she wished to make any changes to the Advance Directives or maintain them as written.	F 578	III On October 22, 2019 the NHA completed education for the Admissions /Marketing persons regarding the regulation and requirement for residents or the Resident representative to receive on admission, information regarding Advance Directives and that if a resident refuses to sign admission paperwork, that the paperwork reflects such and that copies of the paperwork is provided to the resident despite refusal to sign. On October 16, 2019 the NHA completed education for the Social Services staff regarding periodic review and documentation of advanced directive reviews.	

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F 578	Continued From page 10 On 10/9/19 at 9:14 a.m., an interview was conducted with OSM #3 (Other Staff Member), the Director of Social Services, who has been at the facility only since June 2019. When asked about completing periodic reviews of residents' advance directives, OSM #3 stated, "I have not but I can start." When asked if the Social Services Department has a process for periodic reviews of advance directives, OSM #3 stated, "I wasn't told when I came but they could have been doing one. I was only here with the old social services director for one day. It could have slipped her mind." A review of the facility's policy on Advance Directives documented, "It is the resident's right to formulate an Advance Directive, to request, refuse, and/or discontinue medical or surgical treatment....4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capabilities. Such discussions and any advance directive(s) that the resident executes will be documented in the resident' medical record....6. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to Advance Directives, decisions made regarding treatments or experimental research as preferences may change over time. 7. Decisions regarding Advance Directives and treatment will be addressed with any significant change or improvement...." On 10/10/19 at 1:03 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware	F 578	IV The admissions department or designee will maintain a log of incoming admissions to ensure all new admissions receive information regarding resident's pertinent contact information of local and state individuals and agencies. The administrator or designee will conduct audits of the admission logs and admission paperwork to ensure accuracy and compliance. This audit will take place 5 days per week for 2 weeks then weekly for 4 weeks. Any discrepancy noted during the audit will be addressed at that time. RECEIVED OCT 30 2019 VDH/OLC	

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F 578	Continued From page 11 of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to evidence that Resident #73 was provided with information at the time of admission regarding advance directives; and failed to evidence that a periodic review of the resident's advance directive status was conducted with the resident. Resident #73 was admitted to the facility on 6/4/18 with the diagnoses of but not limited to osteomyelitis, dysphagia, herpes viral, mood disorder, anxiety disorder, dementia, neuropathy, pancreatitis, diabetes, peripheral vascular disease, alcohol abuse, adjustment disorder, high blood pressure, and heart disease. The 90 day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/30/19 coded the resident as being cognitively intact in ability to make daily life decisions. On 10/8/19 at approximately 1:30 PM, an interview was conducted with Resident #73. He expressed no concerns with his stay at the facility or regarding Advance Directives. A review of the clinical record failed to reveal any evidence that Resident #73 had any advance directives or that a periodic review had been conducted with the resident regarding whether or not he wished to develop any advance directives. On 10/9/19 at 9:14 a.m., an interview was conducted with OSM #3 (Other Staff Member), the Director of Social Services, who has been at the facility only since June 2019. When asked about completing periodic reviews of residents'	F 578	The Social Services staff will maintain an ongoing log of Advance Directive reviews to ensure that each resident has at least a quarterly review, and documentation of such review, of their Advance directive. This review will also have a random audit by the facility administrator. V The facility alleges compliance of these tasks on or before 11/8/2019	

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F 578	Continued From page 12 advance directives, OSM #3 stated, "I have not but I can start." When asked if the Social Services Department has a process for periodic reviews of advance directives, OSM #3 stated, "I wasn't told when I came but they could have been doing one. I was only here with the old social services director for one day. It could have slipped her mind." On 10/9/19 at 10:27 a.m., ASM #1 (Administrative Staff Member), the Administrator was provided a list of multiple residents, including Resident #73, and to provide asked to provide evidence of a periodic review of advance directives for these residents. On 10/9/19 at 6:02 p.m., ASM #1 stated she could not provide a periodic review of advance directives for any of the residents as requested. A copy of the Advance Directive for Resident #73 was requested, and the page from his Admission Contract that reflected Advanced Directive information was provided at the time of admission. None was provided. On 10/10/19 at 3:00 PM, in an interview with OSM #7, the Business Office Manager, she was asked about the evidence that Resident #73 was provided with information regarding the completion of Advance Directives at the time of admission. OSM #7 stated that Resident #73's admission file did not have an admission contract in it. OSM #7 stated, "Usually, when admissions get their contract signed they give it to me and then I put it in the file cabinet in the business office. We give them the contract when they come in but he refused to sign. He was offered a couple times to sign but he did not. I have no evidence that information about Advanced Directives was offered. It was not documented that he was provided any and just refused to sign	F 578		

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F 578	Continued From page 13 it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here when he was admitted is no longer here." A review of the facility's policy on Advance Directives documented, "It is the resident's right to formulate an Advance Directive, to request, refuse, and/or discontinue medical or surgical treatment....1. On admission, the facility will determine if the resident has executed an Advance Directive and if not, determine whether the resident would like to formulate an Advance Directive....3. The facility will provide information in a manner easily understood by the resident or resident representative about the right to refuse medical or surgical treatment and formulate an advance directive. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capabilities. Such discussions and any advance directive(s) that the resident executes will be documented in the resident' medical record....6. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to Advance Directives, decisions made regarding treatments or experimental research as preferences may change over time. 7. Decisions regarding Advance Directives and treatment will be addressed with any significant change or improvement...." On 10/10/19 at 1:03 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey.	F 578		

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F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	F 584 It is the practice of this facility to maintain a homelike environment for Residents. I No specific resident identified in the statement of deficiencies. II Overnight on 10/9/2019 the Housekeeping director worked to strip wax from the hallway floors of North Wing. The odor was eliminated at that point. Additional walk troughs the next day revealed that the odor was eradicated. The facility policy for Housekeeping has been revised to include information on 'odor control' RECEIVED OCT 30 2019 VDH/OLC	

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F 584	Continued From page 15 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to maintain a homelike environment for one of two units, the north unit. The facility staff failed to maintain the north unit in a homelike manner free from odors. A stale, musty and persistent urine odor was noted on the unit on 10/8/19 and 10/9/19. The findings include: A stale, musty, urine odor was observed throughout the north unit on the following dates and times: 10/8/19 at approximately 5:00 p.m. 10/9/19 at 8:07 a.m. (confirmed by a second surveyor) 10/9/19 at 10:51 a.m. 10/9/19 at 3:08 p.m. (confirmed by a second surveyor) 10/9/19 at 4:13 p.m. On 10/9/19 at 4:30 p.m., an interview was conducted with OSM (other staff member) #2 (the environmental services director). OSM #2 was asked what was being done to contain musty urine odors on the north unit. OSM #2 stated, "We are making sure all of the beds are stripped first thing in the morning. Each bed is being wiped down and disinfected. Bathrooms are being scrubbed on a weekly and daily basis. Floors are scrubbed twice a day. Some residents there (north unit) have incontinence issues and urinate behind the bed and on the wall. The other	F 584	III The environmental services director changed the chemicals used on the North Wing to a product that is more effective at removing urine odors. IV The environmental services director or designee will conduct daily audits Monday through Friday to ensure maintenance of homelike environment free from odors. Any discrepancy noted with the audit will be corrected at that time. Results of the audit will be submitted by the Housekeeping director monthly to the QAPI committee for its review and recommendations. V The facility dutifully alleges compliance of these tasks on or before 11/8/2019. RECEIVED OCT 30 2019 VDH/OLC	

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F 584	Continued From page 16 thing that they do is urinate in the air conditioning units. That I really can't do too much about. Once the urine goes in (name of maintenance director) will take the unit out and hose them down and try to clean them but it's an ongoing issue." When asked if he had noticed urine odors on the north unit, OSM #3 stated that he had noticed odors in the rooms where a couple of particular residents urinate on the wall. OSM #3 agreed that there were odors. OSM #2 stated his philosophy was not to use deodorizers, but to find and eliminate the source. On 10/9/19 at 6:02 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the clinical regional vice president) were made aware of the above concern. On 10/10/19 at 10:05 a.m., OSM #2 reported the wax on the floor in the north unit had been stripped during the night and the odor had improved. The facility document titled, "Importance and Responsibilities of Housekeeping" documented, "To maintain clean, healthful surroundings for patients, staff and visitors. To minimize the potential for cross-infection. To maintain cleanliness, order, and safety. Basic cleaning techniques. Odor control." The document did not document specific information regarding odor control. No further information was presented prior to exit.	F 584		
F 609	COMPLAINT DEFICIENCY Reporting of Alleged Violations	F 609		

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F 609 SS=D	Continued From page 17 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documentation review, and staff interview, the facility staff failed to immediately report and allegation of abuse to the State Agency for one of 49 sampled residents, Resident #314. On 3/24/2019, facility staff observed Resident #10 holding a pillow over Resident #314's face. The	F 609	F 609 It is the practice of this facility to immediately report allegations of abuse to the State Agency. I As stated in the 2567, the incident was reported on 3/25/19 but not within a 2- hour timeframe. Resident # 314 had no injury from the event and no longer resides in the facility. Past non-compliance cannot be corrected. Staff responsible for timely reporting of the event no longer work at the facility. II The Director of Nursing completed a review of facility reportable incidents, retro 6 months, to ensure reporting was within compliance. All reports were found to be in compliance. RECEIVED OCT 30 2019 VDH/OLC	

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F 609	Continued From page 18 facility staff did not report this allegation of abuse to the State Agency until 3/25/19. The Findings included: Resident #314 was admitted to the facility on 03/10/2016. Her diagnoses included depression, dysphagia (difficulty swallowing), and Alzheimer's disease. Resident #314's most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 05/05/2019. The Brief Interview for Mental Status (BIMS) scored Resident #314 at a 4, indicating profound impairment. Resident #314 was coded as requiring extensive assistance of one person for bed mobility, total dependence on two or more people for transfers, and total dependence on one person for dressing. Resident #10 was admitted to the facility on 2/11/2013. Diagnoses include but are not limited to, Alzheimer's disease, anxiety disorder and depression. The resident was coded as severely impaired of cognition on the quarterly MDS assessment with and ARD of 7/9/19. Review of a Facility Reported Incident (FRI) documented the following: Report date: "3/25/19 Incident Date: 3/24/19. Residents Involved: [Name of Resident #10 and room number] [Name of Resident #314 and room number]. Incident Type: Allegation of abuse/mistreatment." The following was hand written: "Resident to Resident." "Describe incident, including location, and action taken: On 3/24/19 at 21:12 (9:12 p.m.) [Name of Resident #10] entered [Name of Resident #314]'s room and was followed by a nurse. He [Resident #10] was observed holding a bed pillow over the face of [Name of Resident	F 609	III On 6/17/2019 all staff were reeducated via in-service regarding the requirement of abuse reporting within two hours. Resources regarding abuse and facility incident reporting were made available in the form of a binder on each unit. Any facility reportable incident to be reported to DON/ADON immediately after occurrence.	

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F 609	Continued From page 19 #314] while forcefully pushing down. The residents were separated. [Name of Resident #314] was examined for injuries and none were observed." Under "Employee action initiated or taken:" the FRI documented, "Immediately protected and assessed [Name of Resident #314] for injury, Notified RP [responsible party] and Physician for both residents. Notified law enforcement and all appropriate administrative personnel Transferred [Name of Resident #10 to name of hospital], Maintaining 1-1 upon his return until seen by psychiatrist for further eval [evaluation) [Name of Resident #314] will be transferred out of unit to [Name of unit]." The incident of abuse itself was investigated on a prior abbreviated survey. On review of the FRI, it was noted that there was a delay in reporting the incident to the State Agency. The FRI documented the incident as occurring on 03/24/2019 at 9:12p.m. Review of the facsimile transmission sheets evidenced that the incident was not reported to the State Agency until 03/25/2019 at 13:29 (1:29 p.m.) and 13:54 (1:54 p.m.). Two copies of the same report were faxed to the State Agency. A review of the facility policy on abuse revealed the following: "2. Suspected abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within 2 hours." Administrative Staff Member (ASM) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of concerns regarding the reporting of this incident at the end of day meeting on 10/09/2019. Neither ASM #1 nor ASM #2 had any further information regarding the	F 609	On October 14, 2019 the facility Administrator reviewed the regulation F 609 and time frames for reporting with the department heads and the resources which were placed at the nursing units for staff to utilize. IV The Facility Administrator or DON will monitor all allegations of abuse for timely reporting, daily 7 days per week. Any discrepancy noted during the audit / review will be addressed immediately with a report being filed and action steps taken to ensure compliance. V The facility alleges compliance of these tasks on or before 11/8/2019. RECEIVED OCT 30 2019 VDH/OLC	

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F 609	Continued From page 20 incident.	F 609		
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 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	F 622	It is the practice of this facility to evidence required documentation for hospital transfers to include care plan goals, resident care needs and advance directive information. I Past non-compliance cannot be corrected for Resident's # 80 & # 100. Resident # 80 no longer resides at the facility. II The DON and NHA reviewed the transfer to hospital checklist to ensure that everything that is required for transfer is on the checklist.	

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F 622	Continued From page 21 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. (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	F 622	The reviewed checklist will be utilized by Licensed nursing staff upon preparation of resident transfer out of the facility; and signed off by the nursing supervisor, as complete, at the time of transfer. III The DON or ADON or Staff Development Coordinator conducted in-servicing for Licensed staff regarding • transfer documentation requirements and use of the transfer checklist. • Documentation via change in condition form or SBAR or in the Nursing notes regarding the resident transfer and admission to the hospital. In the event that the resident is a direct admit to the hospital while at an appointment such as dialysis or wound clinic, the Licensed nurse will notify the Responsible party and send appropriate information to the hospital to include care plan goals, a medication list, MD orders and Advance directive.	

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F 622	Continued From page 22 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 clinical record review, facility documentation review, and staff interview, the facility staff failed to evidence required documentation for a hospital transfer for two of 49 residents, Residents #80 and #100. The findings included: 1. The facility staff failed to ensure Resident #80's comprehensive care plan goals were provided to the receiving hospital at the time of transfer on 9/28/19. Resident #80 was admitted to the facility on 06/05/2019. His diagnoses included heart failure (1), muscle weakness, and dysphagia (difficulty swallowing). Resident #80's most recent Minimum Data Set (MDS) assessment was a Medicare 5 Day assessment with an Assessment Reference Date (ARD) of 09/28/2019. The Brief Interview for Mental Status (BIMS) scored Resident #80 at a 15, indicating no impairment. A review of Resident #80's medical record revealed Resident #80 was transferred to the hospital on 09/28/2019 following an episode of vomiting up blood. Further review failed to	F 622	Newly hired Licensed staff will receive this education during orientation. IV The DON or ADON will audit transfer checklists, the following business day to ensure compliance with completion and submission of necessary documentation on resident transfer. Any discrepancy noted with the audit will be corrected by sending the necessary information to the hospital at that time. The checklist will be filed in the resident's record. The DON or ADON will monitor the daily census report to identify if any resident was a direct admit to the hospital to ensure compliance with submission of necessary documentation being sent to the hospital. Any discrepancy noted with the audit will be corrected by sending the necessary information to the hospital at that time. The checklist will be filed in the resident's record.	

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F 622	Continued From page 23 evidence any documentation that the comprehensive care plan goals were sent with Resident #80 on transfer to the hospital. On 10/10/19 at 9:29 a.m., RN #1, the unit manager, was interviewed. RN #1 stated, "We run the face sheet, med [medication] list, change of documentation form, and put it in the blue folder. There is a check off list in there." When asked if the facility retains a copy of the checklist, RN #1 stated, "It is given to the DON (director of nursing)." On 10/10/19 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing), were informed of these concerns. ASM #2 was asked if she had a copy of the checklist from the blue folder for Resident #80's 9/28/19 hospitalization. ASM #2 stated she would have check. Policies were requested regarding the hospital transfer procedure. On 10/10/19 at 12:05 p.m., ASM #2 stated a checklist for Resident #80's 9/28/19 hospitalization could not be located. ASM #2 stated the checklist was the facility policy. A review of the document, "Transfer to Hospital Checklist," revealed, in part, the following: "This form is to be completed for each resident who is transferred to the hospital (ER [Emergency Room] or direct admission). After each task is completed, the nurse will enter their initials. The form will be filed in the hard chart on the unit." No further information was provided prior to exit. 1. Heart failure is a condition in which the heart	F 622	Results of the audit(s) will be submitted by the DON monthly to the QAPI committee for its review and recommendations. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 622	Continued From page 24 can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. - https://medlineplus.gov/heartfailure.html 2. Resident #100 was transferred to the hospital on 9/5/19. The facility failed to evidence that any required resident-specific information regarding resident care, including advance directive information and care plan goals, was provided to the hospital on transfer. Resident #100 was admitted to the facility on 6/1/18 and most recently readmitted on 9/13/19 with diagnoses including, but not limited to, cerebral palsy (1) and ESRD (end stage renal disease) (2). On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 9/20/19, Resident #100 was coded as having no communication difficulties, and as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status. A review of Resident #100's clinical record revealed the following progress note, dated 9/13/19: "Resident arrived via stretcher from [name of hospital]. Readmission following initiation of dialysis (3)...Lungs sound clear, abd (abdomen) soft and bowel sounds active." Further review of the record revealed no evidence of any documentation in the progress notes regarding Resident #100's transfer and admission to the hospital.	F 622		

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F 622	Continued From page 25 On 10/9/19 at 4:19 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated Resident #100 had been directly admitted to the hospital on 9/5/19 so that dialysis could be started. When asked about the process for sending documents related to the resident's care needs to the receiving hospital, LPN #2 stated, "We try to send a face sheet, a med (medication) list, and the advance directive. We notify the doctor, call for transport, and notify the RP (responsible party)." When asked if she documents that she has send the information, LPN #2 stated, "To be honest, not usually." On 10/9/19 at 4:33 p.m., RN (registered nurse) #2, the nursing supervisor, was interviewed. She stated the facility sends a blue folder with the resident who is being transferred to the hospital. The blue folder includes a notice of the facility bed-hold policy, a face sheet, a change of condition form, and an up to date care plan. When asked if staff document the information sent with residents, RN #2 stated, "No, not usually." On 10/10/19 at 9:29 a.m., RN #1, the unit manager, was interviewed. RN #1 stated, "We run the face sheet, med [medication] list, change of documentation form, and put it in the blue folder. There is a check off list in there." When asked if the facility retains a copy of the checklist, RN #1 stated, "It is given to the DON (director of nursing)." On 10/10/19 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing), were informed of these concerns. ASM #2 was asked if she had a copy	F 622		

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F 622	Continued From page 26	F 622		

of the checklist from the blue folder for Resident #100's 9/5/19 hospitalization. She stated she would have to look to see. Policies were requested regarding the hospital transfer procedure.

On 10/10/19 at 12:05 p.m., ASM #2 told the surveyor she had not located the checklist for Resident #100's 9/5/19 hospitalization. She stated, "This checklist is what we have for the policy."

A review of the document, "Transfer to Hospital Checklist," revealed, in part, the following: "This form is to be completed for each resident who is transferred to the hospital (ER [Emergency Room] or direct admission). After each task is completed, the nurse will enter their initials. The form will be filed in the hard chart on the unit."

No further information was provided prior to exit.

(1) "Cerebral palsy is a group of disorders that affect a person's ability to move and to maintain balance and posture." This information is taken from the website https://medlineplus.gov/cerebralpalsy.html.

(2) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm.

(3) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When

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F 622	Continued From page 27 your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.	F 622		
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 interview, clinical record review, and facility document review, it was determined that the facility staff failed to accurately code an MDS (minimum data set) assessment for two of 49 residents in the survey sample; Residents #73 and #46. The facility staff incorrectly coded Resident #73 on the 9/30/19, 90-day MDS assessment as receiving an anticoagulant. Resident #73's record failed reveal a physicians order for and or administration of an anticoagulant. The facility incorrectly coded Resident #46's 8/13/19 quarterly MDS (minimum data set) for restraints. The findings include: 1. Resident #73 was admitted to the facility on 6/4/18 with the diagnoses of but not limited to osteomyelitis, dysphagia, herpes viral, mood	F 641	F 641 It is the practice of this facility that resident assessments accurately reflect the resident's status. I On 10/10/19 the MDS nurse completed and submitted corrected MDS's for Residents # 46 and #73.	

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F 641	Continued From page 28 disorder, anxiety disorder, dementia, neuropathy, pancreatitis, diabetes, peripheral vascular disease, alcohol abuse, adjustment disorder, high blood pressure, and heart disease. The 90 day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/30/19 coded the resident as being cognitively intact in ability to make daily life decisions. Section N, "Medications" resident #73 was coded as on an anticoagulant medication during the look back period. A review of the physician's orders, current and discontinued, revealed that the physician did not prescribe an anticoagulant for Resident #73 and anticoagulant was not administered to the resident. The resident was prescribed Plavix (1) on 5/13/19. This medication was not an anticoagulant. On 10/10/19 at 10:20 AM, an interview was conducted with LPN #4, the MDS nurse. LPN #4 stated, "He (Resident #73) was on Plavix which is a blood thinner, ordered 5/13/19. It is not an anticoagulant." When asked what procedures are used to accurately code the MDS, she stated the RAI manual (Resident Assessment Instrument). On 10/10/19 at 1:03 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey. (1) Plavix - is in a class of medications called antiplatelet medications. It works by preventing platelets (a type of blood cell) from collecting and forming clots that may cause a heart attack or	F 641	II The MDS nurses conducted an audit of residents on Plavix to verify that none of the other residents on Plavix were coded as an anticoagulant. Any discrepancy noted during the audit was corrected at that time with submission of a corrected MDS. The MDS nurses conducted an audit of residents with side rails that are used for positioning, to verify that none of the other residents with side rails were coded as having a restraint. Any discrepancy noted during the audit was corrected at that time with submission of a corrected MDS. The MDS nurses will utilize a drug book to verify therapeutic categories during coding. If a bed rail is present, MDS nurse will verify that a bed rail/ assist bar evaluation is completed to identify if the side rail is an enabler or a restraint before coding as a restraint.	

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F 641	Continued From page 29 stroke. Information obtained from https://medlineplus.gov/druginfo/meds/a601040.html According to the RAI manual 3.0 Version 1.16 dated October 2018, Page 1.7 documented: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status... And on Page 1-8 documented: In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident ' s medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident ' s actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. And on Page N-9, documented: Anticoagulants such as Target Specific Oral	F 641	III The DON or NHA will conduct a review of the RAI manual "Definition of physical restraints" and RAI definition of an anticoagulants as opposed to an antiplatelet with the MDS nurses IV The 2nd MDS nurse or in the alternative, a licensed nurse will conduct audits of anticoagulant and restraint coding 5 days per week for 2 weeks, then weekly for 4 weeks to ensure coding accuracy. Any discrepancy noted during the audit will be corrected at that time. The RNAC will submit results of the audit monthly to the QAPI committee for its review and recommendations. V The facility alleges compliance of these tasks on or before 11/8/2019. RECEIVED OCT 30 2019 VDH/OLC	

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F 641	Continued From page 30 Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant. 2. The facility incorrectly coded Resident #46's 8/13/19 quarterly MDS (minimum data set) for restraints. Resident #46 was admitted to the facility on 2/29/16; diagnoses include, but are not limited to, history of a stroke and diabetes (1). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 8/13/19, Resident #46 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring staff supervision only for bed mobility and transfers from one surface to another. In section P0100A, Resident #46 was coded with side rails being used daily as a restraint. On 10/8/19 at 12:42 p.m. and 3:10 p.m., Resident #46 was observed sitting in a wheelchair in his room. At both observations, one side rail was in the up position. In an interview on 10/8/19 at 12:42 p.m., Resident #46 stated he had requested the side rail, and that he uses it "all the time" for positioning. Resident #46 stated the facility staff had gone over the risks and benefits of the side rail with him, and that he had signed a consent form. When asked if the side rail restricts his movement at all, Resident #46 stated, "No. It helps me." On 10/10/19 at 10:21 a.m., LPN (licensed practical nurse) #4, the MDS coordinator, was interviewed. When asked about Resident #46's side rail being coded as a restraint on the 8/13/19, quarterly MDS assessment, LPN #4	F 641		

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F 641	Continued From page 31 stated, "He is weak on one side from his stroke. He uses that side rail to get in and out of bed. It was an error. It is not a restraint. It is an enhancer." When asked what she uses as a reference for completing accurate MDS assessments, LPN #4 stated, "I use the RAI (resident assessment instrument) manual." On 10/10/19 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1 October 2019 revealed, in part, the following: "DEFINITION PHYSICAL RESTRAINTS Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body...Identify all physical restraints that were used at any time (day or night) during the 7-day lookback period. After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use." No further information was provided prior to exit. (1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		

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F 655	Continued From page 32 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be	F 655	F 655 It is the practice of this facility to develop baseline care plans per regulation. I Information regarding communication via Spanish language was added to the care plan on 10/11/2019. Several staff members in the facility speak fluent Spanish and translate her needs. A Spanish communication board was set up for the resident to communicate with non-Spanish speaking staff. II Base line care plans will include 'native language' if the resident is not bilingual in their native language as well as English.	

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F 655	Continued From page 33 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, facility document review, and clinical record review, it was determined that the facility staff to develop a baseline care plan for one of 49 residents in the survey sample, Resident #264. The facility staff failed to develop a baseline care plan for Resident #264's communication. She speaks only Spanish. The findings include: Resident #264 was admitted to the facility on 10/7/19; diagnoses include, but are not limited to, a broken leg, dementia (1) and a recent history of encephalopathy (2). She had not been at the facility long enough for the completion of an MDS (minimum data set) assessment. On 10/9/19 at 3:45 p.m., Resident #264 was observed lying in her bed. Her daughter and son-in-law were at her bedside. Her daughter stated, "She only speaks Spanish. We are a little concerned about how she will be able to tell the staff what she needs." A review of Resident #264's admission nursing assessment revealed, in part, the following: "COMMUNICATION: Other Language: Spanish...Neurological: Oriented to Person, Place, Time, and Situation." A review of Resident #264's baseline care plan,	F 655	The Social Services staff will complete an audit of residents in the facility that may speak in a language other than the dominant 'English' to determine if they require communication accommodation. Such accommodations will be reflected in the care plan. III The DON or NHA will complete an educational review for the Licensed nurses and Interdisciplinary team regarding baseline care plan completion. Newly hired Licensed staff will receive this education during orientation. IV The DON/ADON or IDT team member will review the baseline Care plan, on the next business day, following admission to ensure language barriers and communication accommodations are included when applicable. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 655	Continued From page 34 dated 10/7/19, failed to reveal evidence of regarding Resident #264 communication differences because she only speaks Spanish. On 10/9/19 at 4:08 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked how she was communicating with Resident #264, who was assigned to her, CNA #2 stated, "I really haven't had a conversation with her. I don't speak Spanish. She doesn't understand me and I don't understand her. Another CNA speaks Spanish, though, I think." On 10/9/19 at 4:18 p.m., RN (registered nurse) #1, the unit manager, was interviewed about how the facility staff were going to be able to communicate with Resident #264. RN #1 stated, "We have an interpreter (telephone) line. We have access to an interpreter 24/7. The CNAs come to us and the nurses access it." On 10/10/19 at 9:39 a.m., during an interview with RN #1, when asked the purpose of the care plan, RN #1 stated, "For a guided direction of both initial assessment of the patient to the goals and intentions of success of the patient. It should follow where the patient is at the time, what the interventions are, and then the goals of those interventions." When asked who is responsible for developing a baseline care plan, RN #1 stated, "The admitting nurse is responsible, with the follow up of the ADON (assistant director of nursing) or me. It will eventually become my responsibility." When asked if communication should have been included in Resident #264's baseline care plan, RN #1 stated, "Yes. It should have been included." On 10/10/19 at 10:55 a.m., ASM (administrative	F 655		

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F 655	Continued From page 35 staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, "Baseline Care Plan Standard of Practice," revealed, in part, the following: "The baseline care plan is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission, and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan...The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission." No further information was provided prior to exit. (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (2) "Encephalopathy is a general term describing a disease that affects the function or structure of your brain." This information is taken from the website https://www.healthline.com/health/hepatic-encephalopathy.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 36 §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. (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	F 656	F 656 It is the practice of this facility to develop and implement a comprehensive plan of care I Past non-compliance cannot be corrected for obtaining monthly weights on Resident # 38. If the weight is stable please include it here. Resident # 3 was assessed on 10/10/19 and a toileting program is not indicated due to severe cognitive impairment. Her care plan was updated accordingly. RECEIVED OCT 30 2019 VDH/OLC	

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F 656	Continued From page 37 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, facility document review, and clinical record review, it was determined that the facility staff failed to implement the comprehensive plan of care for two of 49 residents in the survey sample, Residents #38 and #3. The facility staff failed to follow the comprehensive plan of care to obtain monthly weights for Resident #38, in August and September 2019. The facility staff failed to implement Resident #3's comprehensive care plan for a toileting program after the resident fell on 6/24/19. The findings include: 1. Resident #38 was admitted to the facility on 8/20/13, and was most recently readmitted on 1/1/19, with diagnoses that include, but are not limited to, COPD (chronic obstructive pulmonary disease) (1), dementia with behavioral disturbances (2) and heart failure. On the most recent MDS (minimum data set), an annual assessment with an assessment reference date of 7/30/19, Resident #38 was coded as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). A review of the physician's orders for Resident #38 revealed the following order dated 8/1/19: "Monitor weight monthly." Further review of Resident #38's clinical record revealed no evidence of weights for the resident	F 656	II The Assistant DON will complete an audit of resident care plan interventions to identify any that are no longer indicated. Any discrepancy with the audit will be corrected at that time with revision of the care plan. Care Plan interventions post fall will be discussed in morning IDT meeting to determine appropriateness. Weights will be obtained per MD order and recorded in the medical chart. The DON / ADON will conduct an audit of monthly weights to identify any weights not obtained per order	

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F 656	Continued From page 38 in August and September 2019. A review of Resident #38's comprehensive care plan dated 7/15/19 revealed, in part, the following: [Resident #38] is at nutritional risk r/t (related to) generalized muscle weakness...resident will avoid unintentional significant weight change through review period...Assess weight monthly." On 10/9/19 at 4:08 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked who is responsible for obtaining residents' monthly weights, CNA #2 stated, "Usually we do it on the day shift. Sometime around the first of the month." On 10/9/19 at 4:19 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked the process for obtaining residents' monthly weights, LPN #2 stated, "They are assigned to the day shift. The list goes to the unit manager, and then she gives them out to the day shift nurses to make sure they get done." On 10/10/19 at 9:29 a.m., RN (registered nurse) #1 was interviewed. RN #1 stated, "The nurses are responsible to notify the CNAs to get the weights. I give the list to the nurses, who are then to follow up with the CNAs in their section. I would like to have them done by the 15th of each month. That way we can follow up with plenty of time still left in the month." When asked the purpose of the care plan, RN #1 stated, "For a guided direction of both initial assessment of the patient to the goals and intentions of success of the patient. It should follow where the patient is at the time, what the interventions are, and then the goals of those interventions." When asked who is	F 656	III The DON will complete an educational review for the Unit Managers and ADON to ensure they are following up on staff obtaining weights on their units per MD order. The DON/ADON will re-educate nursing staff via in servicing regarding obtaining weights as ordered and updating / revising and following care plan interventions. Newly hired Licensed staff will receive this education during orientation.	

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F 656	Continued From page 39 responsible for making sure a resident's care plan is followed, RN #1 stated, "The nurse that is taking care of the patient should be looking at the care plan. The responsibility for following up on that is mine." On 10/10/19 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, "Comprehensive Care Plans Standard of Practice," revealed, in part, the following: "Approaches defined in the comprehensive care plan will be implemented unless the resident refuses to allow." No further information was provided prior to exit. (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. 2. The facility staff failed to implement Resident #3's comprehensive care plan for a toileting program after the resident fell on 6/24/19. Resident #3 was admitted to the facility on 4/11/18. Resident #3's diagnoses included but were not limited to high blood pressure, chest	F 656	IV The DON/ADON will conduct an audit of interventions post resident fall to ensure the intervention has been implemented. This audit will take place, as soon as possible but at the latest, on the next business day following the fall. The audit will be an ongoing audit as part of the AM clinical meeting and fall review. Any discrepancy noted during the audit will be corrected at that time. Results of the audit will be submitted by the DON or ADON to the QAPI committee for its review and recommendations monthly. The DON/ADON will conduct an audit of monthly weights to ensure that weights are completed timely and completed. The audit will conducted by the 5th of each month to ensure that each resident has a monthly weight for the month. Any discrepancy noted during the audit will be corrected at that time. Results of the audit will be submitted by the DON or ADON to the QAPI committee for its review and recommendations monthly. The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 656	Continued From page 40 pain and muscle weakness. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/30/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section J coded Resident #3 as not sustaining any falls since the prior assessment. Review of Resident #3's clinical record and fall investigations revealed that on 6/24/19 the resident slid out of bed and reported that she had to use the bathroom. No injury was sustained. Resident #3's comprehensive care plan dated 4/17/18, with a revised on date of 6/24/19, documented, "FALLS: (Resident #3) is at risk for falls...explore toileting program before and after meals and at bed times as resident will allow..." Further review of Resident #3's clinical record failed to reveal a bowel and bladder assessment after 6/24/19 and failed to reveal any evidence that a toileting program had been explored or implemented for Resident #3 after 6/24/19. On 10/9/19 at 4:51 p.m., an interview was conducted with RN (registered nurse) #2 regarding falls and care plans. RN #2 stated a resident's care plan should be reviewed and revised after each fall. RN #2 stated the revision should include, the date and time of the fall. It should include what new intervention will be implemented for the resident. RN #2 stated IDT (interdisciplinary team) meetings are conducted after each fall and the team discusses the new intervention and updates the care plan. RN #2 was asked to explain the facility process for toileting programs. RN #2 stated toileting programs include rounding and toileting a resident every two hours. When asked how staff evidences that a toileting program is being	F 656	V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 656	Continued From page 41 completed, RN #2 stated the toileting program should appear on CNA (certified nursing assistant) charting and should document that toileting was attempted every two hours, the amount of urine and if the toileting was effective. On 10/9/19 at 6:02 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the clinical regional vice president) were made aware of the above concern. On 10/10/19 at 9:39 a.m., an interview was conducted with RN #1 (unit manager). RN #1 was asked to explain the purpose of a care plan. RN #1 stated, "The purpose of the care plan is for a guided direction of both initial assessment of a patient to the goals and intentions of success of the patient. A care plan should follow what the patient is at the time, what the interventions are and then the goals of those interventions that are added or encouraged in all disciplines." RN #1 was asked who makes sure the care plan is followed on a daily basis. RN #1 stated, "The nurse that is with that individual at that day should be looking at that care plan while she is working. The responsibility as I have currently learned in this new position that is something I will follow up on." The facility document titled, "Reviewing and Revising the Care Plan-Guideline" documented, "4. Any immediate intervention placed on the care plan will be implemented at that time..." No further information was presented prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 42 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for one of 49 residents in the survey sample, Resident #3. The facility staff failed to review and/or revise Resident #3's comprehensive care plan after the resident fell on 7/10/19.	F 657	F 657 It is the practice of this facility to review and/or revise the comprehensive care plan as indicated I The care plan for Resident # 3 was reviewed and updated on 10/23/19 however past non-compliance cannot be corrected. As written in the statement of deficiencies Resident #3 had no injury associated with this fall. II Members of the Interdisciplinary team will complete an audit of resident care plans against post fall interventions to identify that the interventions were placed on the care plan and are in place. The review will include determination of any that are no longer indicated which can be resolved. Any discrepancy with the audit will be corrected at that time with revision of the care plan. RECEIVED OCT 30 2019 VDH/OLC	

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F 657	Continued From page 43 The findings include: Resident #3 was admitted to the facility on 4/11/18. Resident #3's diagnoses included but were not limited to high blood pressure, chest pain and muscle weakness. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/30/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section J coded Resident #3 as not sustaining any falls since the prior assessment. Review of Resident #3's clinical record and fall investigations revealed the resident slid out of the wheelchair on 7/10/19. No injury was sustained. Further review of Resident #3's clinical record (including nurses' notes, the fall investigation and Resident #3's comprehensive care plan dated 4/17/18) failed to reveal evidence that the facility staff reviewed and/or revised the resident's care plan for the 7/10/19 fall. On 10/9/19 at 4:51 p.m., an interview was conducted with RN (registered nurse) #2 regarding falls and care plans. RN #2 stated a resident's care plan should be reviewed and revised after each fall. RN #2 stated the revision should include the date of the fall, and the time of the fall. It should include what new intervention will be implemented for the resident. RN #2 stated IDT (interdisciplinary team) meetings are conducted after each fall and the team discusses the new intervention and updates the care plan. On 10/9/19 at 6:02 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the clinical regional vice president) were made aware of the	F 657	Falls with care plan interventions post fall will be discussed in morning IDT meeting, 5 days per week, Monday through Friday, to determine appropriateness and will be documented in the care plan. III The DON or ADON will complete education for the licensed nurses how to update / revise a care plan post fall. Newly hired Licensed staff will receive this education during orientation. The DON or NHA will review the regulatory requirement for updating care plans with the IDT team. IV The DON or ADON or UM or MDS nurse will review care plans 5 days per week in the AM IDT meeting to ensure that a new intervention was placed on the care plan post fall and that the approach has been implemented. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted, by the DON, to the QAPI committee monthly for its review and recommendations.	

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F 657	Continued From page 44 above concern. The facility document titled, "Reviewing and Revising the Care Plan- Guideline' documented, "2. With a change in condition, the charge nurse, the unit manager or a member of the IDT team will review the care plan and identify which care plan is to be updated with a new or modified intervention. The charge nurse/unit manager or member of the IDT team will add the new intervention to the care plan..." No further information was presented prior to exit.	F 657	V The facility alleges compliance of these tasks on or before 11/8/2019. recommendations.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for the administration of Digoxin for one of 49 residents in the survey sample, Resident #34. LPN (licensed practical nurse) #1 failed to auscultate Resident #34's apical pulse for a full minute prior to administering Digoxin to the resident. The findings include: Resident #34 was admitted to the facility on 4/23/19 with the diagnoses of but not limited to congestive heart failure, alcohol abuse, anxiety	F 658	F 658 It is the practice of this facility to follow professional standards of practice for the administration of medications to include Digoxin I Past non-compliance cannot be corrected. Resident # 34 had no negative outcome from the licensed nurse taking the apical pulse for 15 seconds and multiplying x4 as opposed to listening to the apical pulse for a full minute	

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F 658	Continued From page 45 disorder, adjustment disorder, high blood pressure, atrial fibrillation, pulmonary edema, liver cirrhosis, and kidney failure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring limited assistance for dressing and supervision for all other areas of activities of daily living. On 10/09/19 at 8:15 AM, LPN #1 (Licensed Practical Nurse) was observed preparing medications for administration to Resident #34. Prior to preparing any medications, LPN #1 obtained an apical pulse for Resident #34. She obtained the pulse for approximately 15 seconds. When asked what the resident's pulse was, LPN #1 stated 88. When asked if she took the residents pulse for 15 seconds, obtained the number 22 and then multiplied by 4, LPN #1 stated, "yes." She was then observed preparing medications for Resident #34 which included Digoxin (1) 0.25 mg (milligrams), 1 tablet. On 10/9/19 at 3:11 PM, in an interview with LPN #1, when asked how she took the apical pulse for Res #34 she stated, "I usually do 15 seconds and multiply it." When asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "A full minute." When asked if she followed professional standards of practice for obtaining the apical pulse for the administration of Digoxin to Resident #34, LPN #1 stated, "I did not." A review of the drug information provided by the facility from their drug handbook, "Mosby's 2020 Nursing Drug Reference, Thirty-Third Edition" on	F 658	II The DON or ADON Identified residents receiving digoxin for future monitoring. Additional directions will be added to digoxin orders to prompt the licensed nurse to listen to the apical pulse for one full minute. III The DON/ADON conducted re-education for licensed nurses regarding: • the professional standard of obtaining an apical pulse prior to administration of digoxin • and medication pass principles Newly hired Licensed staff will receive this education during orientation	

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F 658	Continued From page 46 page 409, documented, "Nursing Considerations. Assess: Apical pulse for 1 min (minute) before giving product; if pulse <60 (less than 60) in adult...take again in 1 hr (hour); if <60 in adult, call prescriber..." On 10/10/19 at 11:33 AM, ASM #2 (Administrative Staff Member) was made aware of the findings. When asked what professional standard of practice the facility follows, ASM #2 stated, "Lippincott." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007, Lippincott Company, page 495, "The Apical pulse provides the most accurate assessment of the pulse rate and is the preferred site whenever the peripheral pulses are difficult to assess or the pulse rhythm is irregular....To determine the apical pulse, count the heartbeats for 1 full minute." (1) Digoxin is used to treat heart failure and abnormal rhythms.	F 658	IV The DON/ADON or designee will conduct random competency testing of licensed nurses as they obtain apical pulses for digoxin/Lanoxin administration. Each nurse will have a competency test completed for this audit. Any discrepancy noted during the audit will be addressed at that time with re-education to the licensed nurse. The DON will submit results of the audit to the QAPI committee monthly for its review and recommendations. V The facility alleges compliance of these tasks on or before 11/8/2019.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document	F 684	F 684 It is the practice of this facility to ensure treatment and care in accordance with professional standards of practice and the person-centered care plan. I Past non-compliance cannot be corrected for obtaining monthly weights on Resident # 38.	

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F 684	Continued From page 47 review, and clinical record review, it was determined that the facility staff failed to ensure treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for one of 49 residents in the survey sample, Resident #38. The facility staff failed to follow the physician's order to obtain Resident #38's monthly weights in August and September 2019. The findings include: Resident #38 was admitted to the facility on 8/20/13 and most recently readmitted on 1/1/19 with diagnoses including, but not limited to, COPD (chronic obstructive pulmonary disease) (1), dementia with behavioral disturbances (2) and heart failure. On the most recent MDS (minimum data set), a an annual assessment with an assessment reference date of 7/30/19, Resident #38 was coded as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status). A review of the physician's orders for Resident #38 revealed the following order dated 8/1/19: "Monitor weight monthly." Further review of Resident #38's clinical record revealed no evidence of weights for the resident for August and September 2019. A review of Resident #38's comprehensive care plan dated 7/15/19 revealed, in part, the following: [Resident #38] is at nutritional risk r/t (related to) generalized muscle weakness...resident will avoid unintentional significant weight change through review	F 684	II Weights will be obtained per MD order and recorded in the medical chart. The DON / ADON will conduct an audit of monthly weights to identify any weights not obtained per order III The DON will complete an educational review for the Unit Managers and ADON to ensure they are following up on staff obtaining weights on their units per MD order. The DON/ADON will re-educate nursing staff via in servicing regarding obtaining weights as ordered. Newly hired nursing staff will receive this education during orientation. RECEIVED OCT 30 2019 VDH/OLC	

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F 684	Continued From page 48 period...Assess weight monthly." On 10/9/19 at 4:08 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked who is responsible for obtaining residents' monthly weights, CNA #2 stated, "Usually we do it on the day shift. Sometime around the first of the month." On 10/9/19 at 4:19 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked the process for obtaining residents' monthly weights, LPN #2 stated, "They are assigned to the day shift. The list goes to the unit manager, and then she gives them out to the day shift nurses to make sure they get done." On 10/10/19 at 9:29 a.m., RN (registered nurse) #1 was interviewed. RN #1 stated, "The nurses are responsible to notify the CNAs to get the weights. I give the list to the nurses, who are then to follow up with the CNAs in their section. I would like to have them done by the 15th of each month. That way we can follow up with plenty of time still left in the month." On 10/10/19 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition,	F 684	IV The DON/ADON will conduct an audit of monthly weights to ensure that weights are completed timely and completed. The audit will conducted by the 5th of each month to ensure that each resident has a monthly weight for the month. Any discrepancy noted during the audit will be corrected at that time. Results of the audit will be submitted by the DON or ADON to the QAPI committee for its review and recommendations monthly. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 684	Continued From page 49 Rothenberg and Chapman, page 124. (2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.Information obtained from https://medlineplus.gov/druginfo/meds/a682301.html	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services for the treatment of a pressure injury for one of 49 residents in the survey sample, Resident #3. The facility staff failed to complete Resident #3's physician prescribed pressure injury treatments on multiple dates from March 2019 through May	F 686	F 686 It is the practice of this facility to provide care and services for the treatment of pressure injuries. I As indicated in the statement of deficiency, the wound for Resident # 3 is not a pressure ulcer (bedsore) and is classified as an arterial wound which is caused from lack of circulation. Past non-compliance for signing for wound treatments cannot be corrected. Failure to sign may indicate just a failure to sign the treatment administration record and not necessarily that the treatment was not completed. The facility wound team is following Resident # 3 on a weekly basis. The facility has hired a new wound nurse (RN) who will chair the wound care team.	

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F 686	Continued From page 50 2019. The findings include: Resident #3 was admitted to the facility on 4/11/18. Resident #3's diagnoses included but were not limited to high blood pressure, chest pain and muscle weakness. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/30/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section M coded Resident #3 as not having any pressure injuries but as having one venous or arterial ulcer. Resident #3's comprehensive care plan dated 4/17/18 and revised on 9/11/19 documented, "(Resident #3) has actual skin impairment r/t (related to) Arterial wound of the left heel with potential for further impairment r/t decreased mobility and incontinence." Review of Resident #3's clinical record revealed a note signed by the wound care physician on 3/6/19 that documented Resident #3 presented with an unstageable deep tissue injury (1) on the left heel measuring three centimeters in length by three centimeters in width. A physician's order dated 3/6/19 documented, "cleanse the left heel with normal saline, pat dry, apply betadine (2) and cover with hydrocellular foam (3) every day." Review of Resident #3's March 2019 TAR (treatment administration record) and nurses' notes failed to reveal evidence that the physician ordered treatment was completed on 3/20/19,	F 686	II The DON/ADON/ Wound care nurse completed a facility wide skin sweep to identify if any residents had skin areas that the facility was not already aware of. No new areas of concern were identified during the audit. III The DON / ADON has completed education for licensed nurses on completion of wound care measurements weekly and documentation of completion of treatments. Newly hired Licensed staff will receive this education during orientation	

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F 686	Continued From page 51 3/26/19, 3/29/19 or 3/31/19 (as evidence by blank spaces instead of a check mark and nurses' initials). This treatment was discontinued on 4/1/19. A physician's order dated 4/1/19 documented to apply skin prep (4) to the left heel every shift. Review of Resident #3's April 2019 TAR and nurses' notes failed to reveal evidence that the physician ordered treatment was completed during the night shift on 4/7/19. This treatment order was discontinued on 4/9/19 and another treatment order was implemented. A physician's order dated 4/25/19 documented to apply calcium alginate (5) to the left heel and cover with hydrocellular foam every other day. Review of Resident #3's May 2019 TAR and nurses' notes failed to reveal evidence that this physician ordered treatment was completed as ordered/scheduled on 5/6/19, 5/24/19 and 5/30/19. NOTE: This wound was later classified as an arterial wound by the wound care physician after May 2019. On 10/9/29 at 4:51 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked how the nurses evidence that a treatment has been completed. RN #2 stated, "They would need to go in and complete the treatment on the resident and sign off the date, time and initials on the dressing then sign off on the TAR and depending on the treatment, can make note on what the wound was like, the effectiveness of treatment and if (the resident)	F 686	IV The DON/ ADON will complete a review of the treatment administration records to ensure completion, and documentation of residents with ordered wound treatments, daily 5 days per week, for 2 weeks then twice a week for 2 weeks then weekly X 4. Any discrepancy noted during the audit will be corrected at that time and re-education will be provided to the nurse to ensure understanding of the need to sign for completed treatments. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 686	Continued From page 52 had any pain. When asked what a treatment not signed off on the TAR means, RN #2 stated, "If it's not signed off you can't evidence that it's done." On 10/10/19 at 10:52 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "Skin System Guideline" documented, "Based on the comprehensive assessment of a resident, the facility must ensure that: 1. Residents who enter the facility without a pressure sore will not develop a pressure sore unless the individual's clinical condition demonstrates it was unavoidable. 2. A resident having a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing...9. Dressings will be completed per physician order..." No further information was presented prior to exit. (1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple	F 686		

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F 686	Continued From page 53 discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions." This information was obtained from the website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdfhttps://www.ncbi.nlm.nih.gov/pubmed/20081568 (2) "Betadine (Povidone-iodine) is a topical antiseptic that provides infection protection against a variety of germs for minor cuts, scrapes, and burns." This information was obtained from the website: https://betadine.com/ (3) Hydrocellular foam is a dressing used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/20081568 (4) Skin prep "forms a barrier between the patient's skin and adhesives to help preserve skin integrity and prevent insult or injury during removal of tapes and films." This information was obtained from the website:	F 686		

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F 686	Continued From page 54 https://www.healthykin.com//p-869-smith-and-nephew-skin-prep.aspx?gclid=EAIaIQobChMI35qLrbaZ5QIVF-DICh1kIAG7EAQYAiABEgK1DPD_BwE (5) Calcium alginate is used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4525879/	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure implementation of a fall intervention per the comprehensive care plan to ensure a safe environment for one of 49 residents in the survey sample, Resident #3. On 6/24/19, Resident #3 sustained a fall and the resident's comprehensive care plan was revised to explore a toileting program. The facility staff failed to implement this intervention and the resident sustained three more falls on 7/1/19, 7/4/19 and 7/10/19. The findings include: Resident #3 was admitted to the facility on 4/11/18. Resident #3's diagnoses included but	F 689	F 689 I Resident # 3 was assessed on 10/10/19 and a toileting program is not indicated due to severe cognitive impairment. Her care plan has been updated accordingly. Resident #3 did not have any injury related to the falls on 7/1/19, 7/4/19 or 7/10/19. There is nothing to show a correlation between the toileting program and subsequent falls.	

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F 689	Continued From page 55 were not limited to high blood pressure, chest pain and muscle weakness. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/30/19, coded the resident's cognitive skills for daily decision making as severely impaired. Section J coded Resident #3 as not sustaining any falls since the prior assessment. Review of Resident #3's clinical record and fall investigations revealed that on 6/24/19 the resident slid out of bed and reported that she had to use the bathroom. No injury was sustained. Resident #3's comprehensive care plan dated 4/17/18 and revised on 6/24/19 documented, "FALLS: (Resident #3) is at risk for falls...explore toileting program before and after meals and at bed times as resident will allow..." Further review of Resident #3's clinical record failed to reveal a bowel and bladder assessment after 6/24/19 and failed to reveal any evidence that a toileting program had been explored and or implemented after 6/24/19. Resident #3 sustained other falls with no injuries on 7/1/19, 7/4/19 and 7/10/19. On 10/9/19 at 4:51 p.m., an interview was conducted with RN (registered nurse) #2 regarding falls and care plans. RN #2 stated a resident's care plan should be reviewed and revised after each fall. RN #2 stated the revision should include the date of the fall, the time of the fall, and any new interventions that will be implemented for the resident. RN #2 stated IDT (interdisciplinary team) meetings are conducted after each fall. RN #2 stated the team discusses the new intervention and updates the care plan. RN #2 was asked to explain the facility process	F 689	II The Assistant DON will complete an audit of resident care plan interventions to identify any that are no longer indicated. Any discrepancy with the audit will be corrected at that time with revision of the care plan. Care Plan interventions post fall will be discussed in morning IDT meeting to determine appropriateness. III The DON/ADON will re-educate nursing staff via in servicing regarding obtaining weights as ordered and updating / revising and following care plan interventions. Newly hired nursing staff will receive this education during orientation.	

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F 689	Continued From page 56 for toileting programs. RN #2 stated toileting programs include rounding and toileting a resident every two hours. When asked how staff evidences that a toileting program is being completed, RN #2 stated the toileting program should appear on CNA (certified nursing assistant) charting and should document that toileting was attempted every two hours, the amount of urine and if the toileting was effective. On 10/9/19 at 6:02 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the clinical regional vice president) were made aware of the above concern. The facility policy titled, "Fall Prevention" documented, "More than half of all falls that occur in long term care facilities are related to medically diagnosed conditions and many residents have more than one condition that would put them at risk. Many of these conditions are not curable, but relief of symptoms or treatment of reversible aspects may have significant impact on functional mobility. Solutions to Prevent Unsafe Transfer or Ambulation: Evaluate and treat causes of motor restlessness (bladder or bowel urgency, discomfort, hunger or thirst)..." On 10/10/19 at 1:00 p.m., ASM #1 stated the facility did not have a policy regarding toileting programs. No further information was presented prior to exit.	F 689	IV The DON/ADON will conduct an audit of interventions post resident fall to ensure the intervention has been implemented. This audit will take place, as soon as possible but at the latest, on the next business day following the fall. The audit will be an ongoing audit as part of the AM clinical meeting and fall review. Any discrepancy noted during the audit will be corrected at that time. Results of the audit will be submitted by the DON or ADON to the QAPI committee for its review and recommendations monthly. V The facility alleges compliance of these tasks on or before 11/8/2019	
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education.	F 730	F 730 It is the practice of this facility to have C N A's complete 12 hours of annual training.	

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F 730	Continued From page 57 The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to evidence that four out of 5 employee records reviewed, (CNA [certified nursing assistant] #4, CNA #5, CNA #6 and CNA #7), received the required 12 hours of annual training. The findings include: On 10/10/19 at approximately 9:00 AM, a review of the training records for 5 CNA's (Certified Nursing Assistants) was conducted. The following was noted: - CNA #4 did not have the required 12 hours of annual training. Only 9.5 hours was documented as tracked in the electronic training and education system. Additional trainings provided were on paper and had no documented hours associated and tracked. - CNA #5 did not have documented evidence of any of the 12 hours of annual trainings documented and tracked in the electronic training and education system. Any trainings provided were on paper and had no documented hours associated and tracked. - CNA #6 did not have the required 12 hours of annual training. Only 30 minutes was documented and tracked in the electronic training	F 730	I The employees affected by the deficient practice will complete the required education hours however, past non-compliance for the prior 12 months cannot be corrected. The hours of education will be associated and tracked on a personal tracking form for each employee by the SDC or DON/ADON. II The HR director or Staff development coordinator will complete a 100% audit of C N A's to identify any employees not in regulatory compliance with the 12 hours of required training. Any discrepancy in the audit will be corrected with additional hours of education being provided to those employees. Training may be completed by didactic education, via seminars or via computer-based trainings.	

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F 730	Continued From page 58 and education system. Any trainings provided were on paper and had no documented hours associated and tracked. - CNA #7 did not have documented evidence of any of the 12 hours of annual trainings documented and tracked in the electronic training and education system. Any trainings provided were on paper and had no documented hours associated and tracked. On 10/10/19 at 9:39 AM, in an interview with OSM #5 (Other Staff Member) the Director of Human Resources, when asked about the above trainings, OSM #5 stated, "When they are hired I set them up in (the electronic training and education system) and tell them what they need to do. Then it is up to them to do the modules. When asked who follows up to ensure what is supposed to be done is completed, OSM #5 stated, "They should go on once a month and do what they have to do. It is their responsibility to complete and to check monthly." When asked who is responsible for monitoring, supervising and tracking that the trainings are being completed, OSM #5 stated, "Managers were supposed to be responsible to ensure that it was being done. They have access to see all of their staff in the system. We have had change over. I guess we need to implement department heads to check." A policy on the required trainings was requested at this time. On 10/10/19 at 10:40 AM, OSM #5 provided a page from the employee handbook, page 44, which documented, "Learning Requirements: All staff members must attend New Employee Orientation, department orientation, job specific training and all facility wide in-services and "Town	F 730	III The DON or ADON or staff development coordinator will provide education to facility nursing aides on the 12 hour /annual education requirement to remain in regulatory compliance to include abuse prevention training and dementia training. Newly hired C N A staff will receive this education during orientation. IV The Administrator or designee will conduct monthly audits of employee education sign in sheets, to ensure compliance is met and maintained. Any discrepancy noted during the audit will be addressed with the individual employee. Results of the audit will be submitted to the QAPI committee by the NHA or SDC monthly, for its review and recommendations. V The facility alleges compliance of these tasks on or before 11/8/2019. RECEIVED OCT 30 2019 VDH/OLC	

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F 730	Continued From page 59 Hall" meetings. Employees will be compensated for all approved company-specific required training." On 10/10/19 at 1:03 PM, ASM #1 (Administrative Staff Member) the Administrator, was notified of the findings. When asked about a policy regarding required staff education and training, ASM #1 stated that there was no policy, just the page from the employee handbook. No further information was provided by the end of the survey.	F 730		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758	F 758 It is the practice of this facility to ensure that residents remain free of un-necessary drugs I A stop date for the Lorazepam for Resident #63 was obtained. II The DON/ADON or Social Services staff completed a review of PRN psychotropic medications to identify any that exceed the 14-day rule for review by the physician. Any PRN psychotropic medications without a 14- day end date, was brought to the attention of the attending MD for review.	

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F 758	Continued From page 60 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. §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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a resident remained free of unnecessary medication for one of 49 residents in the survey sample, Resident #63. Resident #63 was prescribed lorazepam solution (1) on 9/17/19 with no stop date. The facility staff failed to ensure the physician completed an evaluation for the continued use of the medication, beyond 14 days and failed to ensure the physician documented the appropriateness of the continued use of the medication or duration for the use of the medication.	F 758	III The DON/ADON /SDC /designee completed educational review of the regulation regarding PRN psychotropic medications with the licensed nurses. Newly hired Licensed staff will receive this education during orientation. IV Orders for new psychotropic medications will be reviewed daily 5 days per week in the daily IDT team meeting to ensure there is an end date for any new PRN psychotropic medications or that the MD has approved the medication to go beyond the 14 days. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted to the QAPI committee for its review and recommendations. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 758	Continued From page 61 The findings include: Resident #63 was admitted to the facility on 11/16/17. Resident #63's diagnoses included but were not limited to heart failure, mood disorder and difficulty swallowing. Resident #63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/20/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section N coded Resident #63 as having received anti-anxiety medication seven out of the last seven days. Review of Resident #63's clinical record revealed a physician's order dated 7/8/19 for Hospice services. Further review of Resident #63's clinical record revealed a physician's order dated 9/17/19 for lorazepam solution, two milligrams/milliliter- 0.5 milligrams by mouth every four hours as needed for anxiety or restlessness. The order did not contain a stop date or specified duration for the as needed anti-anxiety medication. Review of Resident #63's October 2019 MAR (medication administration record) revealed the resident was administered as needed lorazepam solution twice on 10/3/19. Further review of Resident #63's clinical record failed to reveal physician documentation that that Resident #63 had been evaluated for the continued use of lorazepam solution, the appropriateness for the continued use of the medication or a duration for the as needed order. Resident #63's comprehensive care plan dated 12/9/17 documented, "PSYCHOTROPIC	F 758		

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F 758	Continued From page 62 MEDICATIONS: (Resident #63) uses psychotropic medications r/t (related to) mood disorder, adjustment disorder, Behavior management...Administer PSYCHOTROPIC medications as ordered by physician. Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate at least quarterly..." On 10/9/19 at 5:16 p.m., a telephone interview was conducted with ASM (administrative staff member) #5 (Resident #63's physician). ASM #5 was asked about the facility process for prescribing as needed anti-anxiety medication. ASM #5 stated he tries to avoid prescribing as needed anti-anxiety medication but sometimes he will write an as needed order for less than 14 days. ASM #5 stated if the order must be renewed, he documents a note to explain why. ASM #5 stated sometimes he must prescribe as needed anti-anxiety medication for psychiatric residents and residents receiving hospice. ASM #5 stated usually the hospice patients are managed by comfort measures from hospice. ASM #5 stated he has explained the protocol for prescribing as needed anti-anxiety medications to the hospice companies but sometimes they do not comply. Resident #63's clinical record failed to contain documentation by a hospice physician regarding the as needed lorazepam solution. On 10/9/19 at 6:02 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the clinical regional vice president) were made aware of the above concern. The facility policy titled,	F 758		

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F 758	Continued From page 63 "Mood/Behavior/Psychoactive Medication Review Standard of Practice" documented, "Type of PRN (as needed) Order: PRN orders for psychotropic medications, excluding antipsychotics. Time Limitation: 14 days. Exception: Order may be extended beyond 14 days if the attending physician or prescribing practitioner believes is appropriate to extend the orders. Required Action: Attending physician or practitioner should document the rationale for the extended time period in the medical record and indicate a specific duration." No further information was presented prior to exit. (1) "Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761	F 761 It is the practice of this facility to label and store medications according to professional standards of practice. I The Unit Manager disposed of both bottles of Ativan found in the Medication room refrigerator.	

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F 761	Continued From page 64 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label and store medication according to professional standards for one of two medication storage rooms, the south unit, medication storage room. The facility staff failed to label an open bottle of lorazepam intensol (1) and failed to discard one open bottle of lorazepam intensol per manufacturer's instructions in the south unit, medication storage room. The findings include: On 10/8/19 at 2:06 p.m., observation of the south unit, medication storage-room refrigerator was conducted with LPN (licensed practical nurse) #3. The following was observed: -One open bottle of lorazepam intensol with no labeled open date or labeled modified expiration date. -One open bottle of lorazepam intensol that was labeled with an open date of 6/4/19. The manufacturer's boxes containing the bottles of lorazepam intensol documented to discard the	F 761	II Licensed staff will date medications when opened and verify before use that a medication has not reached the expiration date before administration. III The DON/ADON /SDC will provide education via in servicing for the licensed staff regarding the requirement of dating multi-dose medication bottles/vials when opening, checking the expiration date on medication before use, and not to use and disposal of medication if it is expired. Newly hired Licensed staff will receive this education during orientation.	

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F 761	Continued From page 65 medication 90 days after being opened. At this time, an interview was conducted with LPN #3. LPN #3 was asked about the facility process for labeling lorazepam intensol. LPN #3 stated, "Label them with the day we open them and put my initials so they know I'm the one who did it." When asked why, LPN #3 stated, "That way they know when it was opened and how long until it expires." LPN #3 was asked if lorazepam intensol has a modified expiration date after being opened. LPN #3 stated she was not aware of one. LPN #3 was shown the manufacturer's box for lorazepam intensol. LPN #3 confirmed the open bottle of lorazepam intensol with no labeled open date or labeled modified expiration date should have been labeled when opened and the open bottle of lorazepam intensol labeled with an open date of 6/4/19 should have been discarded. The manufacturer's instructions for lorazepam intensol documented, "Discard opened bottle after 90 days." On 10/9/19 at 6:02 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the clinical regional vice president) were made aware of the above concern. The facility/pharmacy policy titled, "MEDICATION STORAGE IN THE FACILITY" documented, "Expiration Dating: D. Certain medications or package types...once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency...F. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a 'date opened' sticker on the	F 761	IV The charge nurses will monitor the storage of medication to ensure multi -dose medications are dated when opened and disposed of as indicated. The Unit Managers/Supervisors/ DON or ADON/designee will complete random audits of the Medication rooms, Medication carts and treatment carts to ensure that medications are dated when opened and discarded if out of date. This audit will be conducted weekly for 8 weeks, then randomly. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted, by the DON, to the QAPI committee for its review and recommendations monthly. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 761	Continued From page 66 medication and enter the date opened and/or the new date of expiration...G. The nurse will check the expiration date of each medication before administering it. H. No expired medication will be administered to a resident. I. All expired medications will be removed from the active supply and destroyed in the facility..." No further information was presented prior to exit. (1) Lorazepam intensol is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842	F 842 It is the practice of this facility to maintain a complete and accurate medical record. I Past non-compliance for a transfer progress notes for Resident # 100 cannot be corrected.	

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F 842	Continued From page 67 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842	II The DON/ADON/designee conducted an audit of resident transfers over the previous 3 months to identify areas of noncompliance upon transfer. Any discrepancy cannot be corrected but will be used as a teaching tool for licensed staff. Licensed staff will utilize a resident transfer checklist to ensure compliance with transfer and documentation guidelines. The Nursing supervisor will sign off on its completion at the time of transfer. III The DON/ADON/ designee will complete an educational review for licensed Nursing staff regarding transfer and documentation requirements to include use of the transfer to hospital checklist. Newly hired Licensed staff will receive this education during orientation. RECEIVED OCT 30 2019 VDH/OLC	

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F 842	Continued From page 68 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 49 residents in the survey sample, Resident #100 and #73. The facility staff failed to include a progress note regarding Resident #100's transfer to the hospital on 9/5/19 in the resident's clinical record. The findings include: Resident #100 was admitted to the facility on 6/1/18 and most recently readmitted on 9/13/19 with diagnoses including, but not limited to, cerebral palsy (1) and ESRD (end stage renal disease) (2). On the most recent MDS (minimum data set), a , a significant change assessment with an assessment reference date of 9/20/19, Resident #100 was coded as having no communication difficulties, and as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status. A review of Resident #100's clinical record revealed the following progress note, dated 9/13/19: "Resident arrived via stretcher from [name of hospital]. Readmission following initiation of dialysis (3)...Lungs sound clear, abd (abdomen) soft and bowel sounds active." Further review of the record revealed no evidence	F 842	IV The DON/ADON or designee will review the transfer checklist, on the next business day, during the IDT meeting to ensure compliance with the required documentation on transfer. Once reviewed the checklist will be added to the resident medical record. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted, by the DON monthly, to the QAPI committee for its review and recommendations. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 842	Continued From page 69 of any documentation in the progress notes regarding Resident #100's transfer and admission to the hospital. On 10/9/19 at 4:19 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated Resident #100 had been directly admitted to the hospital on 9/5/19 so that dialysis could be started. When asked about the process for writing a note regarding a resident's transfer to the hospital, LPN #2 stated, "Yes, the nurse who is taking care of the patient should write the note." On 10/10/19 at 9:29 a.m., RN #1, the unit manager, was interviewed. When asked if the nurse taking care of a patient who is transferred to the hospital should write a note, RN #1 stated, "Absolutely. Many things have to be done. After those things are done, the nurse should write a note." When asked why this note is important, RN #1 stated, "The chart should tell the resident's story." On 10/10/19 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing), were informed of these concerns. No further information was provided prior to exit.	F 842		
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	F 880	F 880 It is the practice of this facility to serve food in a sanitary manner in the main dining room.	

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F 880	Continued From page 70 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, 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	F 880	I There were no residents identified in the statement of deficiency. There was not a negative outcome as a result of the alleged deficient practice. II Staff serving meals will handle plates in a sanitary manner to avoid cross contamination. The main dining room will be monitored daily by a member of management to ensure compliance III The DON/ADON/designee will provide the nursing staff and department heads with education on serving meals in a sanitary manner without contamination of the plate. All new nursing hires will receive this education as a part of general orientation. RECEIVED OCT 30 2019 VDH/OLC	

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F 880	Continued From page 71 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to serve food in a sanitary manner in the main dining room. When removing the plates from the tray, OSM (other staff member) #5, activities director was observed with her thumb on the food, contact surface area of the residents' plates for the resident she served. The findings include: On 10/8/19 at 5:35 PM, an observation was made of the main dining room during the dinner meal. Fifteen residents were in the dining room waiting to be served dinner. Two staff members were observed transferring meal trays from the steam table to the residents, and then removing the plates, cups, etc., from the tray to the table	F 880	IV The administrator or DON/ADON will conduct daily random audits of the main dining room and resident tray passes on the halls to ensure that resident meals are set up in a sanitary manner without cross contamination. The audit will take place 5 days per week across all 3 meals, for 1 week, then 5 days per week for 1 meal for 4 weeks. Any discrepancy noted in the audit will be addressed at that time with education provided to the staff member. Results of the audit will be submitted by the ADON to the QAPI committee for its review and recommendations	

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F 880	Continued From page 72 placed in front of each resident. OSM #6 (Other Staff Member) the Activities Director was one of the staff members. She was observed serving approximately half of the 15 residents in the dining room. For each resident, she was observed arriving at the table with a tray of the resident's meal. She was then observed removing each item from the tray and placing it on the table in front of the resident. When removing the plates from the tray, she was noted to have her thumb on the food, contact surface area on the top side of the plate rim. On 10/9/19 at 3:05 PM, in an interview with OSM #5, when asked how plates are removed from the tray and served to residents, OSM #5 stated, and demonstrated with her hand, "underneath and set it down in front of them." When asked if plates should be handled with the thumb on the food contact surface on top of the plate, OSM #5 stated, "No." When asked why, OSM #5 stated, "For infection control reasons. You don't want to put your fingers on the plate." A review of the facility policy, "Preventing Foodborne Illness - Food Handling" documented, "3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents." On 10/10/19 at 1:03 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey.	F 880		
F 947	Required In-Service Training for Nurse Aides	F 947		

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F 947 SS=D	Continued From page 73 CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to evidence that three out of 5 employee records reviewed, (CNA [certified nursing assistant] #5 #6 and #7) received and completed required dementia care in -service training. The findings include: On 10/10/19 at approximately 9:00 AM, a review of the training records for 5 CNA's (Certified Nursing Assistants) was conducted. The following was noted:	F 947	F 947 It is the practice of this facility that required in-service training hours are met and include 12 hours of training which includes abuse prevention training as well as dementia training. I The employees affected by the deficient practice will complete the required education hours however, past non-compliance for the prior 12 months cannot be corrected. The hours of education will be associated and tracked on a personal tracking form for each employee by the SDC or DON/ADON. II The HR director or Staff development coordinator will complete a 100% audit of C N A's to identify any employees not in regulatory compliance with the 12 hours of required training. Any discrepancy in the audit will be corrected with additional hours of education being provided to those employees. Training may be completed by didactic education, via seminars or via computer-based trainings.	

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F 947	Continued From page 74 - CNA #4 did not have the required 12 hours of annual training. Only 9.5 hours was documented as tracked in the electronic training and education system. Additional training's provided were on paper and had no documented hours associated and tracked. - CNA #5 did not have any documented evidence of required dementia care in-service training. - CNA #6 did not have any documented evidence of required dementia care in-service training. - CNA #7 did not have any documented evidence of required dementia care in-service training. On 10/10/19 at 9:39 AM, in an interview with OSM #5 (Other Staff Member) the Director of Human Resources, when asked about the above trainings, OSM #5 stated, "When they are hired I set them up in (the electronic training and education system) and tell them what they need to do. Then it is up to them to do the modules. When asked who follows up to ensure what is supposed to be done is completed, OSM #5 stated, "They should go on once a month and do what they have to do. It is their responsibility to complete and to check monthly." When asked who is responsible for monitoring, supervising and tracking that the training's are being completed, OSM #5 stated, "Managers were supposed to be responsible to ensure that it was being done. They have access to see all of their staff in the system. We have had change over. I guess we need to implement department heads to check." A policy on the required training's was requested at this time. On 10/10/19 at 10:40 AM, OSM #5 provided a	F 947	III The DON or ADON or staff development coordinator will provide education to facility nursing aides on the 12 hour /annual education requirement to remain in regulatory compliance to include abuse prevention training and dementia training. Newly hired C N A staff will receive this education during orientation. IV The Administrator or designee will conduct monthly audits of employee education sign in sheets, to ensure compliance is met and maintained. Any discrepancy noted during the audit will be addressed with the individual employee. Results of the audit will be submitted to the QAPI committee by the NHA or SDC monthly, for its review and recommendations. V The facility alleges compliance of these tasks on or before 11/8/2019.	

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F 947	Continued From page 75 page from the employee handbook, page 44, which documented, "Learning Requirements: All staff members must attend New Employee Orientation, department orientation, job specific training and all facility wide in-services and "Town Hall" meetings. Employees will be compensated for all approved company-specific required training." On 10/10/19 at 1:03 PM, ASM #1 (Administrative Staff Member) the Administrator, was notified of the findings. When asked about a policy regarding required staff education and training, ASM #1 stated that there was no policy, just the page from the employee handbook. No further information was provided by the end of the survey.	F 947		