| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| FRANCIS N SANDERS NURSING HOME, INC | 7385 WALKER AVE GLOUCESTER, VA 23061 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 07/09/2019 through 07/11/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare standard survey was conducted 07/09/19 through 07/11/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.<br><br>The census in this 55 certified bed facility was 41 at the time of the survey. The survey sample consisted of 21 resident reviews. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal | F 550 | | 8/18/19 |

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

Electronically Signed | 07/29/2019

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| F 550 | Continued From page 1<br>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to maintain dignity for one resident (Resident #97) in a sample size of 21 residents.<br><br>The findings included:<br><br>For Resident #97, a facility staff member was standing over him in the dining room while coaching him to eat his breakfast on 07/10/2019.<br><br>Resident #97, an 83-year old male, was admitted to the facility on 07/02/2019. Diagnoses included but not limited to cerebral infarction, generalized | F 550 | 1. Employee C was provided 1:1 education on demonstrating dignity while assisting with resident meals by the Director of Rehab Services on 7/10/19. Resident #97 expressed no concerns from this event.<br>2. The DON/designee will observe each household dining room for staff standing while cueing or feeding residents by 8/2/19. Any noted variances will be immediately addressed with staff.<br>3. Clinical Educator will provide education to all departments that assist with serving or feeding on respect and | |

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| F 550 | Continued From page 2<br>muscle weakness, dysphagia, and mild cognitive impairment.<br><br>The Minimum Data Set was in progress.<br><br>On 07/10/19 at 08:07 AM, Resident #97 was observed sitting in his wheelchair in the dining room receiving assistance to eat breakfast. Employee C, a speech therapist, was standing to the left of Resident #97 and coaching him throughout the mealtime.<br><br>On 07/10/19 at 08:22 AM, an interview with Employee C was conducted. When asked if it was her routine process to stand next to residents when assisting them through mealtimes, she stated. "Sometimes." Employee C stated she didn't know it was a dignity issue to stand over him while giving assistance at mealtime.<br><br>On 07/10/19 at 10:47 AM, the DON was notified of findings and stated that staff should sit when assisting residents with meals to maintain resident dignity. A policy on assisting residents with meals was requested.<br><br>On 07/10/19 at 04:14 PM, Employee E from Quality Assurance stated the facility did not have a policy regarding assisting residents with meals.<br><br>On 07/11/2019 at approximately 4:30 PM, the administrator and DON had no further information or documentation to offer. | F 550 | dignity with dining by 8/9/19.<br>4. DON/designee will audit dining in each household twice per week for 4 weeks and once per week in each household for 8 weeks. The results of the audits will be reported at the QA meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as | F 554 | | 8/18/19 |

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| F 554 | Continued From page 3<br>defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure safety and clinical appropriateness for self-administration of medication for 1 resident (Resident #297) in a survey sample of 21.<br><br>The findings included:<br><br>For Resident #297, the facility staff failed to properly determine the safety and clinical appropriateness for self-administration of an Albuterol inhaler.<br><br>Resident #297, an 80 year old male, was admitted to the facility on 07/03/2019.<br><br>On 07/09/19 at approximately 12:35 PM, during the course of an interview, an Albuterol inhaler with a spacer was observed in Resident #297's dresser drawer. Resident #297 stated, "my wife brought that up here to me yesterday from home for me to start using" and further stated, "the nurse saw it out on my bed yesterday when my wife brought it up here and told me just to stick it in my dresser drawer, I only use it if I feel like I need to".<br><br>On 07/09/19 at approximately 1:05 PM, the Director of Nursing (Employee B) stated, that Resident #297 "is not approved for self-administration, we were getting ready to do that, it was brought to my attention this morning" and when asked if she expected the inhaler to be stored in the Resident's dresser drawer, she | F 554 | 1. On 7/9/19 the unit nurse discussed with resident # 297 about securing his medications in a safe container. He decided to let the nurse maintain the inhaler in the med cart. A new self-administration assessment was completed on 7/26/19 and approved by the IDT on 7/26/19 for him to hold and administer the inhaler. The medication will be stored in the medication cart per resident's choice. His Care Plan has been updated.<br>2. DON/designee will round and interview on all current residents for self-administration of meds by 8/2/19. Any resident requesting self-administration will have the process completed to determine appropriate action.<br>3. Clinical Educator/designee will educate nursing staff on Policy and Procedure for Self-Administration of Medications by 8/9/19.<br>4. DON/Designee will round on 2 residents in each household for 4 weeks and 1 resident in each household per week for 8 weeks. The results of the audits will be reported at the QA meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 554 | Continued From page 4 | F 554 | | |

stated, "no, it shouldn't be there". LPN B approached the nursing station during this interview and stated that she had assessed Resident #297 for self-administration of his inhaler and she had "approved" it.

On 07/09/19, review of the clinical record revealed an "Assessment for Self Administration of Medications" form completed by LPN B at 10:46 AM. Documentation of that assessment indicates that Resident #297 "correctly verbalizes medication purpose--able with cueing, correctly documents administration of medication--unable, and can demonstrate correct ability to store medications in room--able with cueing".

On 07/10/19, review of the facility's policy entitled "Resident Care: Self-Administration of Medications" (last review date 2/2019), the purpose states, "If a resident requests to self-administer medications, it is the responsibility of the interdisciplinary team to determine that it is safe for the resident to self-administer the medications, before the resident may exercise that right....The attending physician must approve a recommendation from the interdisciplinary team prior to the resident being permitted to self-administer medications. The physician's order must identify that self-administration of medications is authorized, the physician must specifically identify each medication that is to be self-administered". At approximately 5:20 PM, the DON (Employee B) was interviewed and stated, "the IDT [interdisciplinary team] is made up of leadership in different departments and I represent clinical nursing, IDT has not met since he [Resident #297] has been admitted, I am not familiar with the facility policy [regarding self-administration of medication], can you give

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| F 554 | Continued From page 5<br>me an education?". | F 554 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§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.<br><br>§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.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(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.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(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.<br>(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.<br>(v) The facility is not relieved of its obligation to | F 578 | | 8/18/19 |

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| F 578 | Continued From page 6<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review the facility staff failed to uphold a Resident's desire to formulate an Advance directive for one Resident (Resident #27) in a survey sample of 21 Residents.<br><br>The findings include:<br><br>For Resident #27 the facility staff failed to notify the physician of the Resident's desire to execute a Do Not Resuscitate (DNR) and indicate in the Resident's record, this wish.<br><br>Resident #27 was admitted to the facility on 8/28/15 with a recent readmission date of 3/13/19.<br><br>On 7/10/19 at 9:43am review of Resident #27's clinical chart revealed a signed DNR (do not resuscitate) signed on 4/29/19 by both of Resident #27's daughters, who are Medical Power of Attorney. The physician had not signed the form.<br><br>On 7/10/19 at 9:43am, it was observed that on the spine of Resident #27's chart there were colored dots, yellow and red. During a staff interview to explain the dots the staff indicated that a purple dot indicates the person is a DNR (which was not present), yellow means a fall risk and red indicates allergies. | F 578 | 1. The DDNR on resident #27 was retrieved from the MD office on 7/11/19 and the DNR order was entered into EMR. The purple dot for DNR was verified as present on the chart and doorway.<br>2. The DON/designee will audit all current residents' medical records by 8/2/19 to assure all DDNR forms are signed by the provider. Any unsigned DDNR's will be immediately communicated to the provider and sent to provider for signature. All DDNR orders will be audited for purple dots added to the chart and doorway.<br>3. Clinical educator will educate licensed nursing staff on DDNR process and direct care staff on "Color Coded Alert Policy" by 8/9/19.<br>4. The DON/designee will audit 2 residents per household for 4 weeks and then 1 per week per household for 8 weeks. The results of the audits will be reported at the QA meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 578 | Continued From page 7 | F 578 | | |

Review of Resident #27's physician orders for April, May, June and July reveal a Full Code status (meaning CPR would be performed in the event of cardio-pulmonary arrest).

On 07/10/19 01:10 PM outside of Resident #27's room, the name plate was observed to have a purple dot, indicating Resident #27 has a DNR.

On 7/11/19 at 12:39 an interview was conducted with LPN C regarding Resident #27's CPR/Code status. LPN C stated "she is a full code". LPN C looked in the computer at Resident #27's electronic medical record and noted that it read "Full Code".

LPN C went to Resident #27's room and agreed that the purple dot on her name tag indicated she was a DNR and stated, "oh, I don't know who put that there."

LPN C went to Resident #27's chart and on the spine there was now a purple dot. LPN C looked in the chart and saw the signed DNR form. LPN C stated, "the physician never signed it, so it's not valid. I know she is a full code I guess it is my fault for not looking at the stickers. I am very upset by this. This is a copy." When LPN C was asked if a copy is valid, LPN C stated, "no."

LPN C was asked if Resident #27 was to go into cardiac arrest would she perform CPR, LPN C was unable to answer.

Review of the facility policy titled, "Color-Coded Wristbands" with an effective date of 8/9/09 read, "To adopt the following risk reduction strategies: color-coded circles on identification cards clarifying the intent." Page 2 of this document

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| F 578 | Continued From page 8<br>under definitions the policy read, "purple- Do Not Resuscitate".<br><br>No further information was provided. | F 578 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to prevent Resident #19 from abusing one resident (Resident #148) in a sample of 21 residents. This is harm.<br><br>The Findings included:<br><br>For Resident #148, the facility staff failed to protect him from abuse. Resident #148 was assaulted by Resident #19 resulting in a hip fracture.<br><br>Resident #148 was a 100 year old who was | F 600 | 1. Resident # 148 was treated immediately following this incident. His care plan was updated to prevent any further contact with resident #19, which was implemented with no further incidents noted. The following interventions were implemented regarding resident # 19: An initial Geriatric Psychiatric evaluation was completed on 2/25/19 and 3/4/19 with ongoing follow up as needed. He had not exhibited these behaviors previously and has had no incidents since 2/17/19. His care plan was updated on 2/27/19 for Behavioral Symptoms. | 8/18/19 |

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| F 600 | Continued From page 9<br>admitted to the facility on 10/4/18. Resident #148's diagnoses included Cardiomyopathy and Alzheimer's Disease.<br><br>The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 2/5/19 was reviewed. Resident #148 had a Brief Interview of Mental Status Score of 00, indicating severe cognitive impairment.<br><br>On 7/10/19, a review of Resident #148's clinical record was conducted, revealing nurses notes. According to the notes, Resident #148 was pushed by Resident #19 and he sustained a fall. Resident #148 was sent to the hospital on 2/17/19 at 6:30 P.M., where he was diagnosed with a left hip fracture. He returned to the facility on 2/18/19 at 2:00 A.M. with new orders for pain medication.<br><br>Resident #19 was an 86 year old who was admitted to the facility on 7/22/15. Resident #19's diagnoses included Major Depressive Disorder, and Generalized Anxiety Disorder.<br><br>The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 11/28/18 coded Resident # 19 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.<br><br>On 7/9/19 a review was conducted of facility documentation, revealing a Facility Reported Incident follow-up report dated 2/25/19. In summary, on 2/17/19 at approximately 4:00 P.M., Resident #19 went into the dining room and noticed another resident (Resident #148) sitting at the dining table in the location that Resident #19 preferred to sit in. Resident #19 demanded | F 600 | 2. All residents will be free from abuse and all residents will be interviewed by Household Mentor/designee by 8/9/2019 for concerns of abuse. Any concerns noted will be reported and investigated.<br>3. Clinical Educator will provide all department staff education on the following: reporting abuse, reporting abuse to DON, Abuse Coordinator and/or Administrator, monitoring/documenting of escalating resident behaviors and immediate resident de-escalation interventions that can be implemented by 8/9/19. All resident behavior concerns will be addressed at the daily Huddle Meetings in each household and new interventions will be added to the care plan.<br>4. The Household Mentor/designee will interview 2 residents and 2 staff per week for 4 weeks per household and 1 resident and 1 staff per household for 8 weeks to ensure no inappropriate resident to resident contact has occurred. The results of the audits will be reported at the QA meeting by the Household Mentor/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 600 | Continued From page 10 | F 600 | | |

that Resident #148 move away from the table, when Resident #148 stood up from his wheelchair, and used the table to brace himself, Resident #19 pushed on Resident #148's knees, causing him to fall and sustain a hip fracture. Resident #148 was hospitalized, then returned to the facility, where he expired on 02/21/2019. A Certified Nursing Assistant (CNA K) was present and witnessed the incident.

An excerpt from CNA K's written statement dated 2/17/19 read, "I saw [Resident #19] leave his usual spot in the dining room. Quickly after [Resident #148] approached his spot. [Resident #19] returned and was agitated that [Resident #148] was there, he asked him to move but [Resident #148] was hard of hearing. [Resident #19] grabbed onto his knees and pushed backward as [Resident #148] was holding onto the table trying not to be pushed and he fell onto the floor. Before I could get up to interfere [Resident #148] was already on the floor."

On 7/9/19 at 11:30 A.M. an interview was conducted with Resident #19 in the dining room. He denied pushing Resident #148, and stated, "That guy didn't belong here. I learned to defend myself when I was young. I know how to fight."

On 7/11/19 a review was conducted to Resident #19's clinical record, revealing his care plan, and nursing notes. Prior to the incident on 2/17/19, there was no documentation of previous incidents of physical or verbal aggression toward others.

On 7/11/19 at 12:34 P.M., an interview was conducted with the MDS Coordinator (RN B), who was responsible for writing Resident #19's care plan. When asked what types of interventions

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| FRANCIS N SANDERS NURSING HOME, INC | 7385 WALKER AVE GLOUCESTER, VA 23061 |

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| F 600 | Continued From page 11<br>should have been included in Resident #19's care plan that was created on 7/2/19, she stated, "Psych. consults, counseling by a psychiatric nurse practitioner, or psychiatrist, we should have looked for triggers and the medical team should have done an investigation."<br><br>No further information was received. | F 600 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of | F 623 | | 8/18/19 |

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| F 623 | Continued From page 12 | F 623 | | |

this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,

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| F 623 | Continued From page 13<br>codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and clinical record review, the facility staff failed to notify the Resident and Resident's representative of the reason for and location of transfer, and failed to notify the ombudsman for one Resident (Resident #14) in a survey sample of 21 Residents.<br><br>The findings included:<br><br>For Resident #14 the facility staff failed to provide written notification of transfer/discharge to the | F 623 | 1. The discharge notice for resident #14 was completed and faxed to the Ombudsman on 7/29/19. Resident #14 is a current resident in the facility.<br>2. The Household Mentors/designee will complete an audit of all discharges since 7/1/19 to ensure required discharge notifications were provided to the resident on discharge and faxed to the ombudsman by 8/2/19. Variances will be corrected with prompt notification to the | |

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| F 623 | Continued From page 14<br>Resident and/or Resident Representative; and failed to notify the ombudsman of the discharge.<br><br>Resident #14 was admitted to the facility on 1/26/11 with a readmission date of 4/24/19.<br><br>On 7/11/19 a review of Resident #14's clinical record revealed that Resident #14 was sent to the hospital on 4/22/19. Review of the entire clinical record revealed no indication that the Resident or Resident Representative had been provided a notice of transfer in writing. There was no indication that the ombudsman being notified of the transfer.<br><br>On 7/11/19 at 12:34PM an interview was conducted with LPN C. When asked about transferring a resident to the hospital she indicated that the Resident and Resident representative is told of the transfer but no written information is provided to either party other than the bed hold information. When LPN C was asked who notifies the ombudsman of transfers and discharges, LPN C was unaware of who an ombudsman is.<br><br>On 7/11/19 at 12:55pm an interview was conducted with the Director of Nursing (DON). When asked what is done when a Resident is transferred and/or discharged to the hospital she indicated that only the bed hold information was provided to Resident #14's family.<br><br>On 7/11/19 at 2:01pm the DON provided a "Transfer/Discharge Notice" dated 4/22/19, which had been partially filled out, date of discharge was blank." The DON stated, "the day [Resident #14] discharged, they didn't do the process. The nurse filled this out but she didn't know what to do | F 623 | state ombudsman.<br>3. The Clinical Educator will educate nursing staff on completion of the admission process to include the discharge notice by 8/9/19. Administrator/designee will educate the Household Mentors by 7/29/19 on the requirement to provide discharge notification to the state long term care ombudsman. As of 7/29/19 the Household Mentors are reviewing all facility-initiated discharges and transfers from the facility at the morning meeting to ensure the discharge notice has been issued at transfer. Notices to the ombudsman will be faxed at a minimum of monthly by the household mentors.<br>4. The DON/designee will audit 2 facility initiated discharges per household for 4 weeks and then 1 per household weekly for 8 weeks to ensure that the immediate discharge was provided to resident by nursing. The Administrator will audit 2 facility initiated discharges per household for 4 weeks and then 1 per household weekly for 8 weeks for confirmation that discharge notices were faxed to the ombudsman. The results of the audit will be reported to the QA Committee by the Administrator for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 623 | Continued From page 15<br>with it." The DON also stated, "when we send residents to the hospital we do not notify the Ombudsman, we classify this as a leave of absence because we plan for them to come back. We need to be educated on this for our plan of correction."<br><br>Review of the facility policy titled "Nursing Home Discharge/Transfer Policy" with a date of origin: 4/8/19 with a revision date of 6/5/19 read on page 2: "The resident/representative will be provided with all applicable state and federal notices at the time of discharge to include: discharge notice. A copy of this notice will also be forwarded to the State Ombudsman."<br><br>No further information was provided. | F 623 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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 | F 656 | | 8/18/19 |

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| F 656 | Continued From page 16<br>under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to develop a comprehensive care plan for one Resident (Resident #19) in a sample size of 21 residents.<br><br>The findings included:<br><br>For Resident # 19, the facility staff failed to develop a comprehensive Behavioral Care Plan to include mental health and psychosocial services after Resident #19 assaulted another resident, resulting in a hip fracture.<br><br>Resident #19 was an 86 year old who was | F 656 | 1. Resident #19 had a Behavioral Care Plan developed on 2/27/19 by the MDS Coordinator as part of the comprehensive care plan. Care Plan was reviewed and updated on 7/29/2019.<br>2. All residents who have had a resident to resident occurrence or who have received psychiatry services since 7/1/19 will have their care plan audited by the MDS Coordinator/Designee for updates to the comprehensive care plan.<br>3. The MDS Coordinator/designee will educate the IDT on updating comprehensive care plan to include all behaviors by 8/9/19. | |

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| F 656 | Continued From page 17<br>admitted to the facility on 7/22/15. Resident #19's diagnoses included Major Depressive Disorder, and Generalized Anxiety Disorder.<br><br>The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 11/28/18 coded Resident # 19 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.<br><br>On 7/9/19 a review was conducted of facility documentation, revealing a Facility Reported Incident follow-up report dated 2/25/19. In summary, on 2/17/19 at approximately 4:00 P.M., Resident #19 went into the dining room and noticed another resident (Resident #148) sitting at the dining table in the location that Resident #19 preferred to sit in. Resident #19 demanded that Resident #148 move away from the table, when Resident #148 stood up from his wheelchair, and used the table to brace himself, Resident #19 pushed on Resident #148's knees, causing him to fall and sustain a hip fracture.<br><br>On 7/9/19 a review was conducted of Resident #19's clinical record, revealing his care plan initiated 2/27/19. It read, "Behavioral symptoms. Physical and verbal symptoms directed at others." The care plan did not contain any mental health and psychosocial interventions. The identified interventions were limited to nursing staff giving him medication, reminding him after the fact that his behavior is inappropriate and removing him from the situation.<br><br>On 7/9/19 at 11:30 A.M. an interview was conducted with Resident #19 in the dining room. He denied pushing Resident #148, and stated, "That guy didn't belong here. I learned to defend | F 656 | 4. The DON/Designee will audit 2 residents per household for 4 weeks and then 1 per household per week for 8 weeks for updates to the comprehensive care plans for noted behaviors. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 656 | Continued From page 18<br>myself when I was young. I know how to fight."<br><br>On 7/11/19 at 12:34 P.M. an interview was conducted with the MDS Coordinator (RN B), who was responsible for writing Resident #19's care plan. When asked what types of interventions should have been included in Resident #19's care plan that was created on 7/2/19, she stated, "Psych consults, counseling by a psychiatric nurse practitioner, or psychiatrist, we should have looked for triggers and the medical team should have done an investigation."<br><br>No further information was received. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in | F 657 | | 8/18/19 |

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| F 657 | Continued From page 19<br>disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to develop a careplan to include the respiratory diagnosis and use of respiratory equipment for one Resident (Resident #31) in a survey sample of 21 Residents.<br><br>The findings included:<br><br>1. For Resident #31 the facility staff failed to revise the careplan to include the diagnoses of Chronic Respiratory Failure and use of a Bi-Pap with oxygen. The care plan status was marked "completed."<br><br>Resident #31 was admitted to the facility on 9/11/13.<br><br>Resident #31's diagnoses included but were not limited to: Chronic Respiratory Failure.<br><br>Observations on 7/9/19 and 7/10/19 revealed the following:<br><br>On 07/09/19 at 12:39 PM Resident #31's bi-pap was on the bedside table and an oxygen concentrator was at the bedside.<br><br>On 07/09/19 at 04:33 PM the bi-pap was on the bedside table and an oxygen concentrator was at the bedside. | F 657 | 1. On 1/15/19 resident #31 had a care plan of Ineffective lower airway gas exchange/difficulty breathing R/T her dx of asthma, COPD with respiratory interventions. On 7/22/19 the care plan was updated to include Chronic Respiratory Failure and use of BiPAP.<br>2. The DON/designee will complete an audit for those residents with respiratory diagnosis and use of BiPAP since 7/1/19 to ensure required care planning and interventions are complete and accurate.<br>3. The MDS Coordinator/designee will educate IDT on updating comprehensive care plans to include respiratory diagnosis and BiPAP by 8/9/19.<br>4. The DON/Designee will audit 2 residents per household for 4 weeks and then 1 per week for 8 weeks for respiratory diagnosis and intervention for use of BiPAP to comprehensive care plans. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 657 | Continued From page 20<br><br>On 07/10/19 at 09:23 AM the bi-pap was on the bedside table and an oxygen concentrator was at the bedside.<br><br>On 07/10/19 at 01:13 PM the bi-pap was on the bedside table and an oxygen concentrator was at the bedside.<br><br>Review of Resident #31's physician orders for July 2019 revealed the diagnosis of Chronic Respiratory Failure and contained an order, which had an origination date of 12/15/17, and read: "Apply Bi-Pap with 2L O2 at 21:00 every day."<br><br>Review of Resident #31's careplan revealed a careplan created 2/21/17 which included the diagnoses of asthma and COPD. The careplan did have an intervention that indicated "apply bipap as ordered." The entire careplan, including problem statement, goals and interventions related to respiratory was discontinued on 1/15/19<br><br>Review of Resident #31's careplan revealed a new careplan developed 1/15/19 which stated, [Resident #31's name] is at risk for ineffective lower airway gas exchange/difficulty in breathing r/t [related to] her dx [diagnosis] of asthma, COPD." The use of oxygen and the BiPAP were not listed on the careplan.<br><br>On 7/10/19 at 5:28pm the DON (Director of Nursing) was asked if she would expect the use of oxygen or a bi-pap to be care planned, the DON said, "yes".<br><br>No further information was provided. | F 657 | | |
| F 658 | Services Provided Meet Professional Standards | F 658 | | 8/18/19 |

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| F 658 SS=D | Continued From page 21<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional practice standards for medication and treatment administration for three Residents (Residents #16 #97, and #297) in a survey sample of 21 Residents.<br><br>The staff stated their professional standard for nursing was "Mosby."<br><br>The findings included:<br><br>1. For Resident #16, the facility staff failed to ensure medications and treatments were not left at bedside unattended.<br><br>Resident #16, was initially admitted to the facility on 7-26-13. Diagnoses included; Alzheimer's type dementia, dysphagia, fractured humerus, and hand contracture.<br><br>Resident #16's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5-14-19 was coded as an annual full assessment. Resident #16 was coded as having severe cognitive impairment, and was not able to make her own daily life decisions. The Resident was coded as requiring extensive to total assistance of one to two staff members to perform all | F 658 | 1. Resident #16 meds at bedside were removed by Nurse Mentor on 7/9/19. Nurse was provided 1:1 education by Nurse Mentor on 7/9/19. Resident # 97 has no negative outcomes from omission of neuro checks. He had planned DC home on 7/23/19. Nurses who omitted neuro checks have received 1:1 education by DON/designee. Resident # 297 decided on 7/9/19 to secure his inhaler in the med cart and the medication was secured by the nurse. The Albuterol order was clarified in the medical record on 7/25/2019.<br>2. On 7/29/19 room rounds were made on all households by Nurse Mentor/designee to observe for meds at bedside or meds unattended. Any medications noted were immediately addressed. All falls since 7/1/19 will be audited for completion of neuro checks by DON/designee by 8/2/19. All omissions will have 1:1 education provided to nursing staff by DON/designee.<br>3. Clinical Educator will educate all departments on process for medications at bedside, storage of medications being self-administered and Post Fall Process by 8/9/19<br>4. The DON/Designee will audit for | |

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| F 658 | Continued From page 22<br>activities of daily living.<br><br>During initial tour of the facility alone on 7-9-19, at 11:15 a.m., it was noted on the overbed table in Resident #16's room, 2 clear 30 milliliter medication cups, each having a different color of medicated cream in them. One was white with a silvery sheen, and the other was a yellow matte color.<br><br>Resident #16's room was returned to by surveyors 3 times and after the final and third time, at 1:00 p.m., the nurse for that room was sought by surveyors. The Nurse manager was taken to the room and asked what the medication cups contained, and she responded she would have to get the nurse to explain. The surveyor followed the unit manager to find the nurse. LPN C was found in the supply room and the nurse stated that the medicated creams were "Nystatin, for under the Resident's breasts, and a house barrier cream for incontinence." She was asked why the creams were left at bedside, and she replied "the Resident was at lunch, and so she was waiting for her to finish to apply the medicated ointments." She was asked if it was a facility standard to leave medicated ointments at the bedside, and she replied "no." The nurse manager also replied no medications or treatments should be left at bedside.<br><br>Review of Resident #16's clinical record revealed a physician's order for the following medication/treatment:<br><br>Nystatin cream ordered 3-30-18 under breast as needed for redness. The "house Barrier cream" according to the unit manager needs no order and is used for all residents with incontinence to | F 658 | medications at bedside in 2 resident rooms per household for 4 weeks and then 1 per household weekly for 8 weeks. DON/Designee will audit for completion of post fall neuro checks on 2 residents per household for 4 weeks and then 1 resident per household weekly for 8 weeks. The DON/Designee will audit for self-administration process followed on 2 residents per household for 4 weeks and then 1 resident per household weekly for 8 week. The results of the audit will be reported to the QA Committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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protect their skin from moisture contact.

When interviewed, the DON (director of nursing) stated the staff should never leave medication and treatments at the bedside unattended.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:
1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation

The documents also described the act of patient self administration of medication, and instruct that medications are never left unattended.

The administrator, DON and corporate consultant were informed on 7-10-19 at 5:00 p.m. of the failure of the staff to ensure medications were not left unattended at bedside for Resident #16.

2. For Resident #97, the facility staff failed to complete neuro checks after a fall on 07/06/2019.

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Resident #97, an 83-year old male, was admitted to the facility on 07/02/2019. Diagnoses included but not limited to cerebral infarction, generalized muscle weakness, dysphagia, and mild cognitive impairment.

Resident #97's admission Minimum Data Set was in progress.

On 07/10/19 at approximately 09:30 AM, Resident #97's clinical record was reviewed. The baseline care plan dated 07/02/2019 had an entry under the header "Safety" that selected "Risk for Falls." Under the sub-header, "Interventions", it documented, "call bell in reach at all times, bed in lowest position, personal items in reach." An undated entry below that documented, "[Resident #97] has had an actual fall 7/6/19 and he is at risk for future falls secondary to weakness. Our goal is no major injuries from a fall for [Resident #97] by next review. We will provide skilled therapy for strengthening. Perform frequent rounding. Keep his call light within reach and remind him to use call light."

A clinical note dated 7/7/2019 at 3:05 p.m. documented, "Night nurse reported resident found on the floor bending down on his knees in front of his bed on last night.. [sic] Spoke to resident about this. Resident said he think [sic] he had a fall by trying to get up out of bed unassisted. Assessment completed on resident [sic] with no findings of bruises or active bleeding observed. Nothing out of the norms. Resident denies having any pain. Resident is able to move all extremities without any difficulty. Right side is weaker than the left from primary dx [diagnosis] of having a stroke. this [sic] weakness is normal. V/s/ [sic] [vital signs] BP [blood pressure] 96/57

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temp [temperature] 98.5 pulse-96 - resp/18 [respirations 18] o2 sats 99% r/a [on room air]. BP has been running low notified the physicians [sic] Resident denies h/a [headache] or blurry vision. Notified the RR [resident representative] in reference to this. Notified the provider. Resident is without any complaints. Call bell and personal belongings are within reach. Staff continue to monitor, educate and remind resident to ring the call bell for assistance. He is easily redirected. Resident acknowledge [sic] verbal understanding to this and has been ringing his call bell for assistance. Neuro checks are in place."

On 07/11/2019 at approximately 10:30 AM, a copy of the neuro checks and their policy on fall protocols were requested.

On 07/11/2019 at 12:55 PM, the DON provided a copy of a flowsheet entitled, "Post Fall Assessment." the neuro check documented post-fall. The column for frequency indicated neuro checks were to be done every 30 minutes x 4, then every hour x 4, then every 2 hours x 4, then every 4 hours x 4, then every 8 hours x 6. The neuro checks were completed beginning 07/06/2019 at 9:50 PM through 07/08/2019 at 7:00 PM. The final 8 opportunities (every 4 hours x 2 and every 8 hours x 6) were not completed. When asked about expectations for performing neuro checks as indicated following a fall, the DON stated that they should've been completed.

The facility provided a copy of their policy entitled, "Falls Prevention and Management." In Section C entitled, "Fall Documentation Standards", in part (2), item (c), it was documented, "Neuro Assessment for all unwitnessed fall or witnessed falls involving the head." The policy did not

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address frequency of neuro checks following a fall.

According to the Code of Ethics for Nurses with Interpretive Statements by the American Nurses Association (2015), Provision 4 documented, "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care."

On 07/11/2019 at approximately 4:30 PM, the administrator and DON had no further information or documentation to offer.

3. Resident #297 was told by a nurse to keep his Albuterol in his drawer. In addition, LPN B did not enter a complete order.

Resident #297, an 80 year old male, was admitted to the facility on 07/03/2019.

On 07/09/19 at approximately 12:35 PM, during the course of an interview, an Albuterol inhaler with a spacer was observed in Resident #297's dresser drawer. Resident #297 stated, "my wife brought that up here to me yesterday from home for me to start using" and further stated, "the nurse saw it out on my bed yesterday when my wife brought it up here and told me just to stick it in my dresser drawer, I only use it if I feel like I need to, I used it once or twice yesterday and once so far today".

On 07/09/19 at approximately 1:05 PM, LPN B stated that she would be "putting in an order for it [Albuterol]" and was aware that the Albuterol

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| F 658 | Continued From page 27<br>inhaler was located in Resident #297's dresser drawer.<br><br>The clinical record review also revealed a verbal order entered by LPN B at 1:48 PM that read: "Write In...Resident may self-administer Inhaler and notify nurse to access when he uses it...Ordering Prescriber: [attending physician name redacted]...Order Date 7/9/2019". There was no physician's order specifically authorizing the medication, "Albuterol", including strength, dosage, frequency, route or indication for use.<br><br>Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:<br>1. The right medication<br>2. The right dose<br>3. The right client<br>4. The right route<br>5. The right time<br>6. The right documentation<br><br>The documents also described the act of patient self administration of medication, and instruct that medications are never left unattended. | F 658 | | |
| F 679 SS=D | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1) | F 679 | | 8/18/19 |

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| F 679 | Continued From page 28<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to provide an activity program for two Residents (Resident #27, Resident #97) in a survey sample of 21 Residents.<br><br>The findings included:<br><br>1. For Resident #27 the facility staff failed to provide a program to support the Resident's interests.<br><br>Resident #27 was admitted to the facility 8/28/15.<br><br>On 7/9/19 at 11:50am Resident #27 was observed in her room, in bed, with no stimulation being provided such as a radio or television on. No supplies for independent activities was observed in the room of Resident #27.<br><br>On 07/09/19 at 03:18 PM Resident #27 was observed in her room, in bed with no stimulation provided. No supplies for independent activities was observed. | F 679 | 1. Resident #27 on 7/24/19 had new Life Enrichment Evaluation completed for activity preferences by Household Mentor. Care Plans for residents # 27 were updated on 7/24/19. Resident # 97 was discharged home on 7/23/19. An activity calendar for Facility Unit #1 was created on 7/24/19 for the remainder of July.<br>2. Household Mentors/designee will audit current residents to ensure life enrichment assessments with activity preferences are accurate and individualized activity plans are in place by 8/2/19.<br>3. Household Mentors have been educated by Administration on 7/24/19 regarding evaluation of the residents to identify individual preferences and completing a plan of care to meet their needs. A monthly Activity Committee was established on 7/26/19 and coordinated by Household Mentor – Activities who is Activity Director Certified (ADC). Monthly calendars for each household will be established at this meeting. Starting on | |

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| F 679 | Continued From page 29<br>On 7/10/19 during multiple observations throughout the day, from 9am-5pm, Resident #27 was observed in her room, in bed looking up at the ceiling. No form of stimulation was provided, such as a radio, television or any supplies for independent activities was observed.<br><br>On 7/10/19 a request was made to receive copies of activity attendance for Resident #27 for the past year. No documents were provided by the facility staff.<br><br>On 7/11/19 at 9:15am another request was made to receive copies of Resident #27's activity attendance. Upon exit of the survey team on 7/11/19 at 5pm no documents were received.<br><br>On 07/11/19 at 09:24 AM an interview was conducted with Employee G, the certified activity director. When the activity director was asked where activity attendance is recorded, the activity director stated, "I just came up with a form to start doing that." When asked if attendance has been recorded, the activity director stated, "I started here the end of January and there has been no logging of who attends activities since I have been here."<br><br>On 7/11/19 a request was made to the activities director, employee G, for the activity calendars for the past year. Group activity calendars were provided for March, April, May, June and July 2019. When the activity director was asked for activity calendars/programing prior to March, the activity director stated, "I don't have any."<br><br>Review of Resident #27's careplan revealed, "[Resident #27] is at risk for social/diversional activity deficit related to Bipolar Disorder | F 679 | 7/25/29 the household coordinator for each household is recording activities on the Activity log for all residents in each household.<br>4. Administrator/designee will audit on 2 residents per household for 4 weeks and then 1 resident per household weekly for 8 week to assure individualized activities are being done and documented. All monthly calendars will be approved by the Administrator prior to posting. The results of the audit will be reported to the QA Committee by the Household Mentors/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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Mood/behavioral disturbance and loss of interest in socialization/diversion." Interventions included: "invite to/engage resident in activities of known interest. Past/current interests include, but are not limited to: gardening, painting."

Review of the March, April, May, June and July 2019 activity calendar revealed one scheduled gardening activity and one painting activity for the entire 5 month period.

A request was made for activity related policies and the activity director and corporate staff stated there were no activity related policies.

No further information was provided .

2. For Resident #97, the facility staff failed to assess, develop, and plan an individualized activities program.

Resident #97, an 83-year old male, was admitted to the facility on 07/02/2019. Diagnoses included but not limited to cerebral infarction, generalized muscle weakness, dysphagia, and mild cognitive impairment.

Resident #97's Minimum Data Set was in progress.

On 07/09/2019 at approximately 1:15 PM, Resident #97 was observed in his room, fully dressed, awake, lying on his bed.

On 07/10/19 at 08:07 AM, Resident #97 was observed eating his breakfast in the dining room.

07/11/19 at 08:33 AM, Resident #97 was observed self-propelling himself back to his room

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after breakfast. Resident #97 positioned his wheelchair next to bathroom with his back to his room door. There was a TV in the room but it was off. When asked if he liked to watch TV, Resident #97 stated, "Not really" but added that sometimes he likes to watch cowboy movies. When asked what other things he liked to do, Resident #97 stated, "I don't know." When asked if he liked to paint, Resident #97 shook his head no. When asked if he liked working with tools, Resident #97 nodded and stated he likes building things and "putting things together."

On 07/11/2019 at approximately 9:20 AM, an interview with Employee G, the Activities Director, was conducted. When asked about Resident #97's activity preferences, Employee G stated that Resident #97 lives in the other building [Facility Unit #1]. She went on to say that she oversees activities for only for [Facility Unit #2].

On 07/11/2019 at approximately 9:35 AM, an interview with Employee K was conducted. When asked about her role, Employee K stated she was a social worker but also planned activities for residents living in [Facility Unit #1]. When asked about activity preferences for Resident #97, Employee K stated that [Resident #97] likes to read. When asked what other activities Resident #97 preferred, Employee K stated she would need to look at her notes. This surveyor and Employee K went to retrieve her notebook. Employee K looked through her notes and stated she didn't have notes about Resident #97 and his activity preferences. When asked about her process for setting up an activities program for each resident, Employee K stated she learns about new admissions in the morning meetings and she will then schedule a time to meet with the

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| F 679 | Continued From page 32<br>resident and/or the family. Employee K stated she attempts to meet with residents as soon as possible. When asked if she met with Resident #97, she stated yes but did not meet with his family. When asked about the documentation for Resident #97's activities assessment and activities plan, Employee K stated there was no assessment documentation, no activity plan, no activity log, and no activity schedule for Resident #97. When asked for Facility Unit #1 Activities Calendar, Employee K stated there was no Activity Calendar for Facility Unit #1.<br><br>On 07/11/19 at 01:04 PM, Resident #97 was observed in his room sitting in his wheelchair. When asked if he liked to read, Resident #97 stated, "Depends on the topic." When asked about what he likes to read, Resident #97 stated, "I don't know, I can't think."<br><br>On 07/11/19 at 01:07 PM, Employee K verified her credentials as social worker and also stated she has not received any training in activities.<br><br>On 07/11/2019 at 2:50 PM, the DON was notified of findings and asked about her expectations. The DON stated she expects there should be an activities calendar, an activities assessment for each resident, activities plan, activities schedule, and for all of it to be documented in the clinical record. A copy of the Activities Department policy was requested and the DON verified there was no Activities policy.<br><br>On 07/11/2019 at approximately 4:30 PM, the administrator and DON had no further information or documentation to offer. | F 679 | | |
| F 680 | Qualifications of Activity Professional | F 680 | | 8/18/19 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| FRANCIS N SANDERS NURSING HOME, INC | 7385 WALKER AVE GLOUCESTER, VA 23061 |

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| F 680 SS=E | Continued From page 33<br>CFR(s): 483.24(c)(2)(i)(ii)(A)-(D)<br><br>§483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-<br>(i) Is licensed or registered, if applicable, by the State in which practicing; and<br>(ii) Is:<br>(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or<br>(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or<br>(C) Is a qualified occupational therapist or occupational therapy assistant; or<br>(D) Has completed a training course approved by the State.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to provide a qualified activities director for one of three units.<br><br>The findings included:<br><br>1. For Facility Unit #1, the facility staff failed to provide a qualified activities director and develop an activities program.<br><br>On 07/11/2019 at approximately 9:35 AM, an interview with Employee K was conducted. When asked about her role, Employee K stated she was a social worker but also planned activities for residents living in Facility Unit #1. | F 680 | 1. An Activities Committee, coordinated by the Household Mentor – Activities, Activities Director Certified (ADC) was established and met on 7/26/19 to coordinate activities in all households.<br>2. Starting on July 26, 2019 the ADC will provide leadership oversight for activities in all households.<br>3. A monthly Activity Committee was established on 7/26/19 and coordinated by Household Mentor – Activities who is an Activities Director Certified (ADC) Review of activity options for the month and individual monthly calendars for each household will be established.<br>4. The Administrator/designee will audit | |

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| F 680 | Continued From page 34<br><br>On 07/11/19 at 01:07 PM, Employee K verified her credentials as social worker and also stated she has not received any training in activities.<br><br>A copy of the Activities Department policy was requested and the DON verified there was no Activities policy.<br><br>On 07/11/2019 at approximately 4:30 PM, the administrator and DON had no further information or documentation to offer. | F 680 | for compliance of the Activities Committee monthly for 3 months. The results of the audits will be reported at the QA meeting by the Administrator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, and staff interview, the facility staff failed to mitigate an accident hazard for 1 (Resident #297) of 21 sampled residents.<br><br>The findings include:<br><br>For Resident #297, the facility staff failed to properly repair the handles on 3 dresser drawers that are located in his room and being accessed by him for storage of personal belongings.<br><br>Resident #297, an 80 year old male was admitted | F 689 | 1. Maintenance Director repaired the dresser drawer in resident # 97 room on 7/9/19.<br>2. Maintenance Director/designee will audit furniture handles in all resident rooms by 8/2/19 and will address any findings.<br>3. Clinical Educator/ designee will educate all departments on work order process and ability to escalate immediate safety concerns to leadership by 8/9/2019.<br>4. Administrator/designee will audit 2 residents' rooms furniture handles per | 8/18/19 |

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| F 689 | Continued From page 35<br>to the facility on 07/03/2019.<br><br>On 07/09/19 at approximately 12:35 PM, during initial tour of the facility, Resident #297 shared concerns regarding sharp objects in his dresser drawers and stated, "I am afraid my hand may catch on the screw that is sticking out and scratch me, I have asked numerous times for them to come look at it and fix it".<br><br>Three drawers in his dresser revealed the heads of screws protruding approximately 2 centimeters on the inside of the drawer. Sharp edges existed around the circumference of the screw heads. The screws were holding the outside dresser drawer handles in place.<br><br>The Maintenance Director (Employee F) was interviewed and confirmed that maintenance had been performed on Resident #297's dresser recently with an open work order waiting for parts to help the drawers slide easier. | F 689 | household for 4 weeks and then 1 resident room per household weekly for 8 week. The results of the audit will be reported to the QA Committee by the Maintenance/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |
| F 690<br>SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an | F 690 | | 8/18/19 |

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| F 690 | Continued From page 36<br>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide appropriate treatment and services for 1 resident (Resident #39) with a clinically-justified indwelling urinary catheter in a survey sample of 21 residents.<br><br>The findings included:<br><br>For Resident #39, the facility staff failed to secure the tubing of the indwelling urinary catheter in a manner that would reduce the risk for a traumatic dislodgement from the Resident's bladder.<br><br>Resident #39, a 90 year old female, was admitted to the facility on 06/14/2019 with diagnoses | F 690 | 1. Unit nurse immediately applied a foley leg strap to resident # 39 on 7/10/19. The DON completed an observation of all Foley's with securement devices on 7/10/19.<br>2. All residents with Foley catheters will be audited for placement of securement straps by 8/2/19 and any variances will be corrected.<br>3. Clinical Educator/designee will educate nursing staff on appropriate application of securement devices for Foley Catheters by 8/9/19.<br>4. DON/designee will audit current residents with catheters for application of securement devices on 2 residents per | |

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| F 690 | Continued From page 37<br>including but not limited to stroke and urinary retention.<br><br>On 7/10/19 at approximately 1:20pm, RN C was observed changing an incontinence brief for Resident #39 who has a clinically-justified indwelling urinary catheter which was unsecured. RN C responded, "it [urinary catheter tubing] should be secured to her leg, otherwise it can catch on stuff and be pulled out accidentally, that can cause trauma to her urethra".<br><br>Review of the facility's policy entitled "Resident Care: Urinary Catheterization", under subheading "C. Care Practices Related to Catheterization", revealed item 1e: "Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter (for female, on anterior thigh...)". | F 690 | household for 4 weeks and then 1 resident per household weekly for 8 weeks. The results of the audit will be reported to the QA Committee by the Maintenance Director/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to | F 692 | | 8/18/19 |

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| F 692 | Continued From page 38<br>maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review the facility staff failed to ensure one Resident, Resident #27, was served the correct therapeutic diet in a survey sample of 21 Residents.<br><br>The findings include:<br><br>Resident #27 was admitted to the facility on 8/28/15 with a recent readmission date of 3/13/19. Resident #27 has diagnoses of bipolar disorder, muscle weakness, impaired gait, stiffness of left hand, paresthesia, carpal tunnel syndrome left upper limb, Lewy body dementia, anxiety, multiple sclerosis, mild cognitive impairment, and hypertension.<br><br>On 7/9/19 at 12:47pm Resident #27 was observed in bed being fed by staff. She had one bowl containing of pureed chicken, one single serving of applesauce and 120cc of juice.<br><br>On 07/11/19 at 08:55 AM, Resident # 27 received a bowl of eggs, a single serving container of yogurt and 120cc of cranberry juice.<br><br>Note: The facility does not use meal tickets. The resident diet listing read, "puree, nectar liquids, allergic to lemon per resident, needs assistance eating"<br><br>Review of Resident #27's physician orders for | F 692 | 1. As of lunch meal on 7/11/2019 a full therapeutic diet has been served to resident # 27. Resident #27 was observed on 7/25/19 by RD being served a full, therapeutic pureed diet with nectar thick liquids (Entrée, Mashed potato, Pureed Fruit, Pudding, Nectar Thickened Juice.) All residents on therapeutic diets will be served well-balanced meals. Resident will maintain the right to refuse selections or request substitutions.<br>2. Registered Dietitian/designee will observe all current residents' meal service to verify therapeutic dietary requirements are being met, allowing for food preferences. DON/designee will review all orders for supplements to ensure the order includes directions to record amount consumed and licensed nursing is documenting amount consumed. Both audits will be completed by 8/9/2019.<br>3. Food Service Director/designee will provide education to homemakers to regarding verification of serving of ordered/correct diets, follow RD recommendations and utilize Interact, Stop and Watch process to notify Dietitian of changes in serving sizes or food preferences by 8/9/2019. Clinical educator/designee will provide education to nurses on how to write complete orders for supplements to include amount | |

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| F 692 | Continued From page 39<br>April-July of 2019 revealed an order that read, "diet: pureed" dated 3/14/19.<br><br>Review of Resident #27's Clinical notes reveals an entry dated 4/2/19 at 11:47 by Employee H, Registered Dietician that read, "She has lost 12 lbs in the past week. RN states that supplement consumption is zero, as it thickens inappropriately. Will offer Hormel NTL [nectar thick liquid] shakes TID [three times a day] to help with caloric intake."<br><br>Review of Resident #27's physician orders for April, May, June and July 2019, under the Treatment heading there was an order with a date of 4/3/19 that read, "give 120ml between breakfast and lunch and 120 ml between lunch and dinner, nectar consistency shake." The TAR revealed that staff initialed that the supplement was administered but made no indication regarding if the Resident consumed the supplement and how much was consumed.<br><br>Review of physician progress notes for April-July 2019 did not indicate Resident #27 received Hormel NTL shakes three times a day as recommended by the registered dietician.<br><br>Review of Resident #27's careplan states "nutritional supplements offed [sic] to help meet dietary needs. Diet as ordered by MD and in conjunction with resident choice- pureed."<br><br>On 07/11/19 at 09:35 AM an interview was conducted with the Registered Dietician (RD), Employee H. Employee H acknowledged that Resident #27 has had a decline and "they offer assistance when she needs it." | F 692 | consumed by 8/9/2019.<br>4. Food Services Director/designee will audit for therapeutic servings on meal trays on 2 residents per household for 4 weeks and then 1 resident per household weekly for 8 weeks. DON/designee will audit supplement documentation on TAR on 2 residents per household for 4 weeks and then 1 resident per household weekly for 8 week. The results of the audit will be reported to the QA Committee by the Food Service/Designee for diet audit and the DON/designee for TAR Audit for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 692 | Continued From page 40 | F 692 | | |

When the RD was asked what is an appropriate meal serving for a pureed diet, the RD stated, "a protein, vegetable and starch. They puree what is on the menu, typically they thin it with broth or gravy and puree the same food that is served to everyone else."

When the RD was told what Resident #27 received for lunch on 7/9/19 and breakfast on 7/11/19, the RD stated "generally that is not an adequate offering. They give her what she likes and eats, an adequate pureed diet would be all of that on the menu, like a cereal, a drink, some sort of protein."

Resident #27's "Simple Pleasures, Resident Food Information" for preferences, likes and dislikes was reviewed and indicated no items that Resident #27 dislikes other than being allergic to Lemons and Fish.

On 7/11/19 at 10:40am an interview was conducted with CNA D, who fed Resident #27 breakfast and CNA D stated "she ate all of her pureed eggs." On 7/11/19 at 10:56am an interview was conducted with Employee J, homemaker who served Resident #27's plate for breakfast. Employee J stated that she provided the Resident 2 scoops of eggs. Employee J then measured 2 scoops which equaled 1/2 a cup. CNA D stated she would record Resident #27 as consuming 100% of her meal, despite that she wasn't served a full meal.

On 7/11/19 the Dietary Manager was asked to provide verification of dining staff having received education on meal service to include portion size. At the time of the survey team's exit at 5:00pm on 7/11/19 no education on these topics was

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| F 692 | Continued From page 41<br>provided.<br><br>No further information was provided. | F 692 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure that a multi dose vial of TB (tuberculosis) Test medication was dated after being accessed via needle puncture for 1 of 2 sampled units and | F 761 | 1. The TB test medication was removed from the refrigerator on 7/11/19. Resident #297's inhaler was removed by the unit nurse and placed on the medication cart on 7/9/19. | 8/18/19 |

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| F 761 | Continued From page 42<br>failed to safely secure an Albuterol inhaler for 1 of 21 sampled residents.<br><br>The Findings included:<br><br>On 7/9/19 at 12 Noon, an observation was conducted of the Rehabilitation Unit's medication storage room. Licensed Practical Nurse G (LPN G) was present. She unlocked the refrigerator, and handed the surveyor a 50% empty bottle of Aplisol 10 Test (TB Test with 10 doses).<br><br>When asked why the bottle had not been dated when opened, LPN G stated, "They should have dated it when it was opened. It looks like two doses are missing."<br><br>On 7/11/19 at 9:45 A.M. an interview was conducted with the corporate nurse (Employee E). She stated that when the bottle is unopened, it contains 10 doses.<br><br>On 7/12/19 a review of facility documentation was conducted. The Medication Ordering and Receipt Policy dated 10/15/18 was reviewed. An excerpt read, "was once a bulk item is opened, the beyond use date should default to one year or the manufacturer's expiration date on the item, whichever is shorter."<br><br>No further information was received.<br><br>2. For Resident #297, the facility staff failed to safely secure storage of an Albuterol inhaler.<br><br>Resident #297, an 80 year old male, was admitted to the facility on 07/03/2019. | F 761 | 2. On 7/29/19 all medication refrigerators were audited by DON/designee for open undated multi dose vials. Any noted open and/or unlabeled vials were removed. On 7/29/19 room rounds were made on all households by Nurse Mentor/designee to observe for meds at bedside or meds unattended. Any medications noted were immediately addressed.<br>3. Clinical Educator/designee will educate the nursing staff on proper storage and labeling of open multi-dose vials, medications at bedside and medications unattended by 8/9/19.<br>4. The DON/designee will audit each medication refrigerator twice weekly for 4 weeks then weekly for 8 weeks. The DON/Designee will audit for medications at bedside in 2 resident rooms per household for 4 weeks and then 1 resident room per household weekly for 8 weeks. The results of the audit will be reported to the QA Committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 761 | Continued From page 43<br>On 07/09/19 at approximately 12:35 PM, during the course of an interview, an Albuterol inhaler with a spacer was observed in Resident #297's dresser drawer. Resident #297 stated, "My wife brought that up here to me yesterday from home for me to start using" and further stated, "the nurse saw it out on my bed yesterday when my wife brought it up here and told me just to stick it in my dresser drawer, I only use it if I feel like I need to".<br><br>On 07/09/19 at approximately 1:05 PM, the Director of Nursing (Employee B) was asked if she expected an Albuterol inhaler to be stored in Resident #297's dresser drawer, she stated, "No, it shouldn't be there". The DON confirmed that medication should be stored in a secure location to limit access to authorized staff and if the Resident was approved for self-administration of his medication, "a lock box should be provided for him to keep the medicine secured in his room". | F 761 | | |
| F 842 SS=E | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident | F 842 | | 8/18/19 |

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| F 842 | Continued From page 44 | F 842 | | |

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

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

§483.70(i)(5) The medical record must contain-

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| F 842 | Continued From page 45<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for four residents (Resident #97, Resident #27, Resident #31, Resident #297) in a sample size of 21 residents.<br><br>The findings included:<br><br>1. For Resident #97, there was an active physician's order for Do not Resuscitate but the code status was listed as Full Code on the baseline care plan and on the Patient Summary page in the electronic health record.<br><br>Resident #97, an 83-year old male, was admitted to the facility on 07/02/2019. Diagnoses included but not limited to cerebral infarction, generalized muscle weakness, dysphagia, and mild cognitive impairment.<br><br>Resident #97's admission Minimum Data Set was in progress.<br><br>On 07/10/19 at approximately 09:30 AM, Resident #97's clinical record was reviewed. A | F 842 | 1. Resident #97's patient summary page (profile) was update by MDS for DNR on 7/9/19. The baseline care plan was updated by the Nurse Mentor for DNR on 7/10/19. Resident #27 order was received on 7/11/19 for DNR. Resident #31's TAR indicates frequent BiPaP refusals in July, 9 refusals of 29 days in July. MD notified on 7/29/19 of frequent refusals and MD advised to continue to offer BiPaP. As of 7/9/19 resident #297 discussed with his nurse the plan for securing his medications in a safe container and he decided to let the nurse secure the inhaler in the medication cart.<br>2. DON/Designee will review 100% of current residents to verify signed DDNR forms with updated code status orders that match the baseline/comprehensive care plan and the resident summary by 8/2/19. DON/designee will complete an audit of current BiPAP orders with appropriate follow up/documentation by 8/2/2019. DON/Designee will audit all self-administration orders for appropriate documentation of the process by 8/2/19. | |

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| F 842 | Continued From page 46<br>physician's order dated 07/02/2019 documented, "Do Not Attempt Resuscitation. Ensure DNR [do not resuscitate] on file." A Durable Do Not Resuscitate Order form dated 07/01/2019 and signed by physician and Resident Representative was in the hard chart. The baseline care plan in the electronic health record listed the code status as "Full code."<br><br>On 07/10/2019 at 4:48 PM, Certified Nursing Assistant A [CNA A] was asked how she determined a resident's code status. CNA A stated she looks on her 'Patient Summary' page in the electronic health record. This surveyor and CNA A observed the Patient Summary page for Resident #97 on the electronic health record and CNA A stated, "[Resident #97] is a full code."<br><br>Licensed Practical Nurse A [LPN A] was asked how the information gets populated to the Patient Summary page and LPN A stated the nurse should update this from the orders. When asked about the importance of having the correct code status on the CNA Patient Summary page, LPN A stated, "So everyone can be on same page and know what's going with [Resident #97's] code status."<br><br>On 07/10/19 at approximately 5:15 PM, the DON was notified of findings and stated she expects the code status information to match throughout the clinical record.<br><br>On 07/11/2019 at approximately 4:30 PM, the administrator and DON had no further information or documentation to offer.<br><br>2. For Resident #27 the facility staff failed to | F 842 | 3. Clinical educator/Designee will provide education to licensed nursing staff on updating baseline/comprehensive care plans and resident summary to match code status, documenting refusals, provider notification of refusal of BiPAP and Policy and Procedure for Self-Administration of Medication by 8/9/19.<br>4. The DON/Designee will audit DNR/Full code orders to ensure they match baseline care plan and resident summary, BiPAP documentation with appropriate notification to provider if refusing and residents requesting self-administration for proper documentation of self-administered doses for 2 residents per household for 4 weeks and then 1 resident per household weekly for 8 week. The results of the audits will be reported to the QA Committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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maintain an accurate medical record to indicate the CPR/code status.

Resident #27 was admitted to the facility on 8/28/15 with a recent readmission date of 3/13/19.

Review of Resident #27's careplan revealed an Advance Directive status of Do Not Resuscitate with an effective date of 2/2/17.

On 7/10/19 at 9:43am review of Resident #27's clinical chart revealed a signed DNR (do not resuscitate) signed on 4/29/19 by both of Resident #27's daughters, who are Medical Power of Attorney. The physician had not signed the form.

A progress note from the Psychiatric Nurse Practitioner dated 6/10/19 indicated Resident #27 "is now a DNR."

However a review of Resident #27's physician orders for April, May, June and July reveal a Full Code status (meaning CPR would be performed in the event of cardio-pulmonary arrest).

On 7/11/19 at 12:39 an interview was conducted with LPN C regarding Resident #27's CPR/Code status. LPN C stated "she is a full code". LPN C looked in the computer at Resident #27's electronic medical record and noted that it read "Full Code".

LPN C went to Resident #27's room and agreed that the purple dot on her name tag indicated she was a DNR and stated, "oh, I don't know who put that there."

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LPN C went to Resident #27's chart and on the spine there was now a purple dot. LPN C looked in the chart and saw the signed DNR form. LPN C stated, "the physician never signed it, so it's not valid. I know she is a full code I guess it is my fault for not looking at the stickers. I am very upset by this. This is a copy." When LPN C was asked if a copy is valid, LPN C stated, "no."

LPN C was asked if Resident #27 was to go into cardiac arrest would she perform CPR, LPN C was unable to answer.

Review of the facility policy titled, "Color-Coded Wristbands" with an effective date of 8/9/09 read, "To adopt the following risk reduction strategies: color-coded circles on identification cards clarifying the intent." Page 2 of this document under definitions the policy read, "purple- Do Not Resuscitate".

No further information was provided.

3. For Resident #31 the facility failed to maintain an accurate clinical record regarding the use of and refusal of a bi-pap machine.

Resident #31 was admitted to the facility on 9/11/13.

Resident #31's diagnoses included but were not limited to: Chronic Respiratory Failure.

Observations on 7/9/19, 7/10/19 and 7/11/19 of Resident #31's private room revealed an oxygen concentrator at bedside and a bi-pap machine, which was on the bedside table.

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| F 842 | Continued From page 49 | F 842 | | |

Review of Resident #31's physician orders for June and July 2019 revealed an order, which had an origination date of 12/15/17, and read: "Apply Bi-Pap with 2L O2 at 21:00 every day."

Review of Resident #31's Treatment Administration Record (TAR) for June 2019, revealed an entry that read, "Apply Bi-pap with 2L O2 (2 liters of oxygen) at 2100 every day." There was only one note, which was dated 6/8/19 and indicated not administered due to refusal.

Review of Resident #31's TAR for July 2019 indicated the bi-pap had been discontinued 10/12/16 and there was no record of it being applied as ordered by the physician or refused by the Resident for the entire month of July.

On 7/10/19 at 5:20pm an interview was conducted with LPN D. LPN D accompanied the surveyor to Resident #31's room and LPN D was questioned regarding the bi-pap machine located at the bedside. LPN D did indicated "yes" when asked if they have an order to use it. LPN D stated, "she refuses it all the time." When asked if they put it on Resident #31, LPN D stated, "yes but she may keep it on 5 minutes and remove the mask."

No further information was provided.

4. For Resident #297, the facility staff failed to document the self administration of Albuterol.

Resident #297, an 80 year old male, was admitted to the facility on 07/03/2019.

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| F 842 | Continued From page 50<br><br>On 07/09/19 at approximately 12:35 PM, during the course of an interview, an Albuterol inhaler with a spacer was observed in Resident #297's dresser drawer. Resident #297 stated, "my wife brought that up here to me yesterday from home for me to start using" and further stated, "the nurse saw it out on my bed yesterday when my wife brought it up here and told me just to stick it in my dresser drawer, I only use it if I feel like I need to, I used it once or twice yesterday and once so far today".<br><br>Clinical record review on 07/09/19 at approximately 3:00 PM. There was no documentation of the 3-4 self-administered doses of Albuterol previously taken by Resident #297 located within the clinical record. | F 842 | | |
| F 868 SS=E | QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)<br><br>§483.75(g) Quality assessment and assurance.<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. | F 868 | | 8/18/19 |

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| F 868 | Continued From page 51<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility documentation review, the facility staff failed to have quarterly QAA/QAPI (Quality Assessment and Assurance/ Quality Assurance/Performance Improvement) meetings for 3 of a possible 4 quarters<br><br>The findings include:<br><br>On 07/11/19 at 12:06 PM, a review of the facility's QAA/QAPI program was conducted. When asked for the attendance logs of QAPI meetings since the last survey, the administrator presented two attendance records. One document was dated 05/30/2019 and the other was dated 06/26/2019. The administrator verified he did not have attendance logs or meeting minutes as evidence QAA/QAPI meetings were held quarterly. Also, the attendance log dated 05/30/2019 did not have the Medical Director in attendance.<br><br>The facility provided a copy of their policy entitled, "Quality Management Systems." In Section III, Part (a), under the header, "Facility" on page 5, it was documented, "Conduct quarterly facility-specific Quality and Performance Improvement meetings."<br><br>On 07/11/2019 at approximately 4:30 PM, the administrator and the DON had no further documentation or information to offer. | F 868 | 1. A QAA meeting was held 6/26/19 and the medical director was present.<br>2. QAA meetings are scheduled quarterly with next meeting scheduled 7/31/19.<br>3. The Director of Clinical Reimbursement/Education provided education on 7/25/19 to the Administrator and DON regarding the regulation of quarterly QAA meeting requirements.<br>4. The Corporate Clinical Manager will audit for proof of QAA meetings with appropriate attendees quarterly. The results of the audits will be reported to the QA Committee by the Administrator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an | F 880 | | 8/18/19 |

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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

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| F 880 | Continued From page 53<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to maintain respiratory equipment in a manner to prevent infections for one Resident (Resident #31) in a survey sample of 21 Residents.<br><br>The findings included:<br><br>For Resident #31 the facility staff failed to store the Bi-Pap tubing in a manner to prevent the development of infection.<br><br>Resident #31 was admitted to the facility on | F 880 | 1. Resident #31's BiPAP tubing was cleaned 7/25/19 by Household Mentor.<br>2. All residents with a BiPAP will have the tubing secured in a manner to prevent infection.<br>3. Clinical Educator/Designee will educate by 8/9/19 the all departments on nursing staff on maintaining BiPAP equipment in a manner to prevent infection.<br>4. The DON/Designee will audit for BiPAP's proper storage to prevent infection in 2 resident's rooms per household for 4 weeks and then 1 per | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495383 | A. BUILDING _____ B. WING _____ | 07/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FRANCIS N SANDERS NURSING HOME, INC | 7385 WALKER AVE GLOUCESTER, VA 23061 |

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|---|---|---|---|---|
| F 880 | Continued From page 54<br>9/11/13.<br><br>Resident #31's diagnoses included but were not limited to: Chronic Respiratory Failure.<br><br>Observations on 7/9/19 and 7/10/19 revealed the following:<br>On 07/09/19 at 12:39 PM Resident #31's bi-pap tubing was noted in floor behind the oxygen concentrator.<br><br>On 07/09/19 at 04:33 PM the bi-pap tubing was noted in floor behind the oxygen concentrator.<br><br>On 07/10/19 at 09:23 AM the bi-pap tubing was noted in floor behind the oxygen concentrator.<br><br>On 07/10/19 at 01:13 PM the bi-pap tubing was noted in floor behind the oxygen concentrator.<br><br>Review of Resident #31's physician orders for July 2019 revealed an order, which had an origination date of 12/15/17, and read: "Apply Bi-Pap with 2L O2 at 21:00 every day."<br><br>On 7/10/19 at 5:20pm an interview was conducted with LPN D. When LPN D was asked how they store the tubing and mask she stated, "in here" and opened the top drawer of the bedside table and the mask was in a bag in the drawer. When LPN D was asked where the tubing is, she said "I don't know why it is down there [as she reached to the floor to retrieve it], it's not supposed to be there."<br><br>On 7/10/19 at 5:28pm the DON (Director of Nursing) was asked how bi-pap's are to be stored, she responded, "they are to rinse out the mask every morning, allow it to dry, then put it in | F 880 | household weekly for 8 weeks. The results of the audit will be reported to the QA Committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.<br>5. August 18, 2019 | |

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| F 880 | Continued From page 55 | F 880 | | |

a bag." When asked if tubing should be on the floor, the DON stated, "nothing should be on the floor."

Review of the facility policy titled, "Infection Control: Respiratory Therapy" with a revision date of 11/08, it read; "to provide guidelines to help prevent nosocomial infections associated with respiratory therapy equipment and to prevent transmission of infections to residents." It also read, "keep tubing used prn in a plastic bag when not in use."

No further information was provided.