STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/15/2019 through 09/17/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/15/19 through 9/17/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey. The census in this 180 certified bed facility was 164 at the time of the survey. The survey sample consisted of 32 current resident reviews and 7 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. 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. §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.	F 550		11/18/19

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

Electronically Signed | 10/09/2019

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal 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. §483.10(b) Exercise of Rights. 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. §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. §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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a dignified dining experience on one of three dining areas. During breakfast in the East unit restorative dining room, facility staff stood over residents while feeding them and fed them without initiating any conversation. The findings include: On 9/16/19 from 7:50 a.m.to 8:15 a.m., breakfast service was observed in the East unit restorative dining room. On 9/16/19 at 7:50 a.m., certified	F 550	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.	

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F 550	Continued From page 2 nurses' aide (CNA) #3 offered Resident #34 a banana. CNA #3 handed a peeled banana to the resident. Resident #34 took one bite of the banana and placed it on a napkin on the table. The resident had no plate or dish in front of her. During this meal observation, certified nurses' aide (CNA) #1 was observed feeding Residents #9, #33 and #87 seated at the same table. CNA #1 was standing and went from resident to resident feeding them the breakfast food items/drink from their trays. CNA #1 gave Resident #33 a bite of food, then went to Resident #87 and fed him several bites. CNA #1 then went to Resident #9 and fed her several bites of food. CNA #1 proceeded to go from resident to resident feeding each resident several bites before moving to the next resident. On 9/16/19 at 8:06 a.m., CNA #7 entered the dining room and started feeding Resident #9. CNA #7 stopped feeding Resident #9 after a few minutes, cleaned off dirty plates/cups/napkins from another table, then returned to feed Resident #9. CNA #1 continued to feed Residents #33 and #87, going back and forth between the residents. Both CNAs stood while feeding the three residents and had no conversation with any of the residents during the observation. On 9/16/19 at 8:14 a.m., CNA #1 sat beside Resident #33 and continued feeding her but shortly got up to feed Resident #87. On 9/16/19 at 9:18 a.m., CNA #1 was interviewed about standing and feeding multiple residents at the same time during breakfast. CNA #1 stated, "We have more feeders now." CNA #1 stated she was trying to get everyone fed so that was why she was feeding all three residents. CNA #1	F 550	F550 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Dining room and restorative dining room have been rounded on twice a day during meal times by management staff with concentration on residents needing assistance with eating, to ensure a dignified dining experience concentrating on residents #34 ,9, 33, 87. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents requiring assistance with eating their meals in the dining areas were observed. Any issues were addressed as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: ** Staff Development Coordinator or designee to educate current CNA□s on not handling dirty trays and then resume feeding without washing their hands, not standing up to feed residents, feeding one resident at a time, sitting in front of them and paying close attention to their comfort and dignity, and not handling any food items with bare hands (example a peeled banana,etc.) How the facility plans to monitor its performance to make sure that solutions are sustained: ** Unit Manager or designee will audit	

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F 550	Continued From page 3 stated CNA #7 came in to help during the meal and they probably should have been seated while feeding them. On 9/16/19 at 9:21 a.m., the licensed practical nurse unit manager (LPN #4) was interviewed about the breakfast observation. LPN #4 stated the aides "normally" sit with the residents and were supposed to feed one resident at a time. LPN #4 stated there usually were two aides in the dining room to feed those needing assistance. LPN #4 stated the aides usually sit and engage residents while feeding them. This finding was reviewed with the administrator and director of nursing during a meeting on 9/16/19 at 5:40 p.m.	F 550	dining and restorative dining room twice a week at different meals, for compliance. Audit to be conducted for 6 weeks. Date of Compliance 11/18/19 *Discrepancies will be brought to the QA meeting and addressed as needed	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		11/18/19

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F 656	Continued From page 4 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review the facility staff failed to implement the care plan (CP) for Resident # 86 for restorative services, and failed to develop a comprehensive plan of care (CCP) for Resident # 408's fluid restriction. Findings include: 1. Resident # 86 was admitted to the facility 8/3/17 with diagnoses to include, but not limited to: spinal stenosis, chronic pain, and chronic kidney disease. The most recent MDS (minimum data set) was a	F 656	F656 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident #86 has been monitored daily for proper use of splints, proper times for application, and that they were put on correctly. Care plans have been updated to reflect proper use and application of splints. Care plan has been updated so that CNA□s can see the task and document that it was completed in PCC (PointClickCare) POC (Point of Care) documentation.	

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F 656	Continued From page 5 quarterly review dated 9/5/19 and had Resident # 86 with moderate impairment in cognition with a total summary score of 10 out of 15. On 9/15/19 at 2:00 p.m. Resident # 86 was observed in her room sitting in a wheel chair. Resident # 86 was observed with splint boots to each foot. The boot on the left foot was not applied securely, and the right boot was sideways on the resident's foot. Resident # 86 stated "Yes, they are quite a sight, aren't they?" She went on to state the CNA (certified nursing assistant) applied the boots in the mornings after getting her out of bed. CNA # 3 was in the hallway across from the resident's room, and was asked to come and assist the resident to adjust the boots. CNA # 3 was asked when the boots were put on the resident and she stated, "They get put on in the morning and taken off at bedtime." The clinical record was reviewed 9/16/19 at approximately 7:45 a.m. The order for the boots was not located on the current POS (physician order summary). The care plan was then reviewed, and included the following: "Focus: The resident has limited physical mobility related to muscle weakness, difficulty walking, spinal stenosis. Created on: 7/19/17. Revision on: 4/23/19..." Goals included, "The resident will remain free of complications related to immobility...through the next review date. Created on: 8/8/17. Revision on: 7/9/19." Interventions included, "NURSING REHAB/RESTORATIVE: PASSIVE ROM (range of motion) Program # 1: Pt (patient) has excessive tone in legs but with very slow long stretch can reach full knee extension on L (left) lower extremity and full flexion on R (right) lower	F 656	*Resident # 408□s MAR and care plan updated for fluid restriction. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with splints or on fluid restrictions were reviewed. Corrections were made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: ** Staff Development Coordinator or designee will educate current nursing staff on proper use of splints and to check for proper documentation, times to be used, and for all to know reason for splints and on proper documentation of fluid restrictions. How the facility plans to monitor its performance to make sure that solutions are sustained: ** Unit Manager or designee will audit current residents with restorative splinting to ensure that they have proper documentation and proper care plans and that all staff are aware of times of use and schedule. To be done once a week for 6 weeks. **Unit Manager or designee will audit current residents on fluid restrictions in facility for proper documentation of amount consumed per shift once a week for 6 weeks. Date of Compliance: 11/18/19 *Discrepancies will be brought to the QA meeting and addressed as needed	

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F 656	Continued From page 6	F 656		

extremity for 15 minutes twice daily." The revision date for the intervention was 4/23/19. "NURSING REHAB/RESTORATIVE: ACTIVE ROM: Program # 2: Resident will maintain present muscle strength and endurance without evidence of contractures through next review. Need ROM to bilateral lower extremities in sitting working on straightening the left lower extremity and bending the right lower extremity in chair. Place pt. neuro multipodus boots on for 2 hours in chair with left leg straightened and elevated and right leg bent with leg rest lowered. Created on :9/5/19." The frequency was noted as "PRN (as needed)."

On 9/16/19 at 9:15 a.m. the DON (director of nursing) was asked if an order was needed for the multipodus boots in use by Resident #86, and was also asked for the documentation of the restorative services provided. The DON reviewed the clinical record, then stated "There is no documentation for the restorative services or an order for the boots. When there is a referral for restorative serves the unit manager should have put in definitive times for the services to be provided and notified the doctor; that wasn't done. It was entered as 'prn' so it did not trigger over to the CNA to know the resident should be picked up for restorative, so there is no documentation." The DON was advised that the resident had been observed with the boots on since the survey team entered the facility 9/15/19 at 1:00 p.m. The DON stated "I will make sure the physician is notified about the order and the specific times for the boots to be applied."

On 9/16/19 at 9:25 a.m.,. CNA # 1, who was assigned to restorative services on Resident # 86's hall, was asked if she was aware Resident #

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F 656	Continued From page 7	F 656		

86 was to be receiving restorative services. CNA # 1 stated "No. It is not on my ADL (activities of daily living) sheet; she is? I certainly did not know that...I think (name of CNA # 3) might work with her some too, you may want to ask her..." CNA # 3, who was present during the interview was then asked about the restorative services for the resident. CNA # 3 stated she was aware, and further stated "When she got the boots we had an inservice with therapy about it." CNA # 3 was asked if she was in the inservice, and she stated she was. She was then asked about the time frame for the boots as she stated the day before that Resident #86 wore the boots from morning until bedtime. CNA # 3 was also asked for her documentation of the restorative exercises. CNA # 3 stated "It's not documented in the ADL's; I thought the boots were to be on all day..."

On 9/16/19 at 9:30 a.m. the unit manager, identified as LPN (licensed practical nurse) # 4 was interviewed about the restorative referral. LPN # 3 stated "I was not aware to put it in with times or to notify the doctor..."

The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during a meeting with facility staff 9/16/19 beginning at 5:40 p.m.

No further information was provided prior to the exit conference.

2. Resident # 408 was admitted to the facility 9/3/19 with diagnoses to include, but were not limited to: left femur fracture, muscle weakness, diabetes, and congestive heart failure.

The most recent MDS (minimum data set) was

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F 656	Continued From page 8 the admission assessment. Resident # 408 was assessed as cognitively intact with a total summary score of 14 out of 15. The clinical record was reviewed 9/15/19 at approximately 3:00 p.m. The current POS (physician order summary) included an order dated 9/13/19 for "Fluid restriction 2,000 ml daily." The MAR (medication administration record) and TAR (treatment administration record) were then reviewed, but no information about the fluid restriction could be located. A review of the care plan revealed no documentation for the fluid restriction. The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during a meeting with facility staff 9/16/19 beginning at 5:40 p.m. The DON was asked if a care plan should be developed for the fluid restriction. She stated "Yes." No further information was provided prior to the exit conference.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		11/18/19

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F 657	Continued From page 9 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 39 residents in the survey sample. Resident #112's care plan was not revised to include use of fall mats and an air mattress. Resident #69's care plan was not revised regarding a healed pressure ulcer. The findings include: 1. Resident #112 was admitted to the facility on 3/20/19 with a re-admission on 4/23/19. Diagnoses for Resident #112 included respiratory failure, seizures, cerebrovascular disease, diabetes, COPD (chronic obstructive pulmonary disease), dysphagia, cognitive communication deficit, schizophrenia, glaucoma, mood disorder and high blood pressure. The minimum data set (MDS) dated 8/25/19 assessed Resident #112	F 657	F657 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident #112 has been monitored to ensure that all equipment on and around his bed is safe and in good working condition and that the fall mats are in place when resident is in bed. *Resident #69 care plan has been revised regarding a healed pressure ulcer. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with fall mats and/or an air mattress are at risk and were reviewed. Residents with a pressure ulcer who have experienced a change in the status of	

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F 657	Continued From page 10 with short and long-term memory problems and moderately impaired cognitive skills. On 9/15/19 at 5:20 p.m., Resident #112 was observed in bed. The resident's right foot was hanging off the side of the bed. The resident was on an air mattress with no floor mats in place. Resident #112 was observed again on 9/16/19 at 7:47 a.m., 10:13 a.m. and 2:15 p.m. in bed with no floor mats in place on either side of the bed. Resident #112's clinical record documented the resident had an unwitnessed fall from the bed on 8/8/19. A nursing note dated 8/8/19 at 11:37 p.m. documented, "Resident was found by CNA [certified nurses' aide] with his head and upper torso on the floor and lower extremities on the bed. Un-witnessed...No acute distress noted. No injury..." The clinical record documented a post-fall assessment dated 8/8/19 listing immediate action taken to prevent further falls/injury was, "Fall mats." Resident #112's plan of care (revised 9/5/19) listed the resident was at risk of falls. Interventions listed anticipate and meet the resident's needs, use assistive devices, call light within reach, fall education, appropriate footwear and trip-free environment. The plan of care was not updated to indicate use of the protective fall mats and made no mention of the alternating air mattress. On 9/16/19 at 2:20 p.m., the licensed practical nurse (LPN #3) caring for Resident #112 was interviewed about the protective floor mats. LPN #3 stated she was not sure if the resident required floor mats. LPN #3 reviewed the resident's plan of care and stated she did not see	F 657	their pressure ulcer were reviewed. Corrections made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: ** Staff Development Coordinator or designee will provide education to nursing staff to update care plans whenever new interventions are added for a resident. ** Staff Development Coordinator or designee will educate nursing staff on updating care plans when change of condition occurs to include healed wounds. How the facility plans to monitor its performance to make sure that solutions are sustained: ** Unit Manager or designee will audit current residents with fall mats/air mattresses 2 times a week for 6 weeks to ensure that interventions are in place and that care plans have been updated. ** Unit manager or designee will audit current pressure ulcers 2 times a week for 6 weeks to ensure proper care planning when initial incident occurs and upon its resolution. Date of compliance: 11/18/19 *Discrepancies will be brought to the QA meeting and addressed as needed	

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F 657	Continued From page 11	F 657		

the floor mats listed. LPN #3 stated, "Normally, I don't care for him [Resident #112]."

On 9/16/19 at 2:25 p.m., the unit manager (LPN #4) was interviewed about floor mats indicated on the post-fall assessment for Resident #112 and the air mattress in use. LPN #4 stated she remembered implementing the floor mats after the resident's fall on 8/8/19. LPN #4 reviewed the plan of care and stated she did not see the mats listed. LPN #4 stated she thought she added the mats to the care plan but did not see them listed.

On 9/16/19 at 3:30 p.m., the director of nursing (DON) and corporate nursing consultant were interviewed about Resident #112's post-fall assessment indicating the use of protective fall mats and the air mattress. The DON stated the resident was supposed to have fall mats in place for injury prevention. The DON stated the mats were initiated following the resident's fall from the bed on 8/8/19. The DON stated the unit manager was responsible for updating the care plan. The corporate consultant stated the air mattress was provided by hospice and was listed on the hospice plan.

This finding was reviewed with the administrator and director of nursing during a meeting on 9/16/19 at 5:40 p.m.

2. Resident #69 was admitted to the facility on 05/14/11 with diagnoses that included multiple sclerosis, left and right hand contractures, depression, chronic pain, neuromuscular bladder, anxiety and type 2 diabetes. The most recent minimum data set (MDS) dated 08/02/19 was a quarterly assessment and assessed Resident #69 as cognitively intact with a score of 14 for daily decision making.

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F 657	Continued From page 12 Resident #69's clinical record was reviewed on 09/15/19 at 5:06 p.m. A progress note documented the following: "09/06/19 11:40 Skin/Wound Note. Observed residents R (right) buttocks, pressure ulcer healed at this time. No drainage, or odor observed. No s/s (signs/symptoms) of infection observed. No open areas observed....Notified resident's dad of wound healing..." A review of Resident #69's care plan documented the following: "The resident has a stage 3 to R buttocks r/t (related to) immobility...." The care plan included goals and interventions for pressure ulcer treatment and healing. Resident #69's care plan had not been reviewed and revised to to reflect the pressure ulcer had healed. On 09/16/19 at 3:00 p.m. the unit manager (LPN #1) who was responsible updating the care plan was interviewed. LPN #1 was asked if the stage 3 pressure ulcer on Resident #69's right buttock had healed. LPN #1 stated yes the pressure ulcer had healed. LPN #1 was asked to review the care plan. LPN #1 reviewed the care plan and stated she simply overlooked updating the care plan. These findings were shared with the administrator, director of nursing and corporate nurse during a meeting on 09/16/19 at 5:00 p.m. No additional information was received prior to the exit conference on 09/17/19 at 1:00 p.m.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		11/18/19

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F 684	Continued From page 13 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and clinical record review, the facility staff failed to follow physician orders for 4 of 39 residents in the survey sample. A physician ordered knee brace for Resident # 86 was not applied per order; fluid restriction for Resident # 408 was not implemented as ordered; TED hose (compression stockings) were not applied as ordered for Resident # 143; and medications were not administered per physician's orders for Resident #355. Findings include: 1. Resident # 86 was admitted to the facility 8/3/17 with diagnoses to include, but not limited to: spinal stenosis, chronic pain, and chronic kidney disease. The most recent MDS (minimum data set) was a quarterly review dated 9/5/19 and had Resident # 86 with moderate impairment in cognition with a total summary score of 10 out of 15. On 9/15/19 at 2:00 p.m. Resident # 86 was observed in her room sitting in a wheel chair with splint boots on each foot. Resident #86 stated "I also have another brace I usually have on my	F 684	F684 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident #86 has been monitored to ensure that knee braces were discontinued appropriately and that all braces have been care planned and that restorative program is in place. *Resident #408 2000 ml per day fluid restriction order corrected on MAR and nurses are documenting amount of fluid consumed each shift. *Resident #143 was observed to ensure that he was wearing ted hoses on in am and off in pm. *Resident #355 has been discharged from facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with orders for TED hose, braces and fluid restrictions were reviewed. New admissions reviewed for timeliness of medication administration. Corrections were made as necessary.	

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F 684	Continued From page 14 knee; I think it's over there behind the door." There was not any device behind the resident's door. Resident #86 was observed randomly throughout 9/15/19, without a brace on either knee. The clinical record was reviewed 9/16/19 at approximately 7:45 a.m. The current POS (physician order summary) included an order carried forward from 4/23/19 for "Left Knee Brace to Left Knee every shift..." On 9/16/19 at 9:00 a.m. Resident # 86 was observed without the knee brace to the left knee. The regional nurse consultant was in the hallway, and came in the resident's room to inquire if assistance was needed. He was informed of the order, and the observations that the knee brace had not been observed on Resident #86 since 9/15/19 at 2:00 p.m. The nurse consultant then asked LPN (licensed practical nurse) # 3 about the brace. At that time, LPN # 3 and the nurse consultant searched the resident's room, but were unable to locate the brace. LPN # 3 asked Resident #86 if the brace was in the laundry, and the resident responded she did not know. The regional nurse consultant stated he would go look in laundry to see if it was there. On 9/16/19 at 5:40 p.m. during an end of the day meeting with facility staff the nurse consultant and DON (director of nursing) were asked if the knee brace had been located. The DON stated "No; it was discontinued today." No further information was provided prior to the exit conference. 2. Resident # 408 was admitted to the facility	F 684	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: ** Staff Development Coordinator or designee will educate nursing staff that when any kind of splints and/or braces are observed, to check if they have an active order, care plan and restorative program in place. ** Staff Development Coordinator or designee will provide education to nurses and CNA□s regarding purpose, applying ted hose, and updating care plans when ted hose are ordered. Staff Development Coordinator or designee will educate nurses on entering orders for fluid restrictions and documentation of fluid volumes on MAR/TAR. **Staff Development Coordinator or designee to educate all nursing staff on timely receiving of admission medication especially when admission is on weekends or after hours. Educated on who to contact, following up, pharmacy hours and delivery times and to ensure medications are present at the time of the resident□s admission to the facility. How the facility plans to monitor its performance to make sure that solutions are sustained: ** Unit manager or designee will audit current residents with ted hose for proper use, orders and care plans once a week for 6 weeks. ** Unit manager or designee will audit current residents with braces for proper	

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F 684	Continued From page 15 9/3/19 with diagnoses to include, but were not limited to: left femur fracture, muscle weakness, diabetes, and congestive heart failure. The most recent MDS (minimum data set) was the admission assessment. Resident # 408 was assessed as cognitively intact with a total summary score of 14 out of 15. The clinical record was reviewed 9/15/19 at approximately 3:00 p.m. The current POS (physician order summary) included an order dated 9/13/19 for "Fluid restriction 2,000 ml daily." The MAR (medication administration record) and TAR (treatment administration record) were then reviewed, but no information about the fluid restriction could be located. On 9/16/19 at 10:30 a.m. the DON (director of nursing) was asked for assistance in locating the fluid restriction documentation. The DON stated "It should be documented on the MAR." The DON then reviewed the MAR and the physician order and stated "The order was not entered correctly, so it didn't trigger on the MAR." The DON then stated the name of LPN (licensed practical nurse) # 2 as the nurse who entered the order. On 9/16/19 at 10:35 a.m. LPN # 2 was asked where Resident # 408's fluid restriction was being documented. LPN # 2 stated "Let me look in my computer; it should be on the MAR." LPN # 2 then reviewed the MAR then stated "It's not on here; she's on fluid restriction?" LPN # 2 then pulled up the orders and stated "I didn't even have this resident Friday, but my name is on there as entering the order. I have no idea how	F 684	use, orders and care plans once a week for 6 weeks. ** Unit manager or designee will audit current residents with fluid restrictions for orders, documentation and care planning once a week for 6 weeks. ** Unit Manager or designee will audit new admissions for timely delivery of meds to including weekends 3 times a week for 6 weeks. Date of Compliance: 11/18/19 Discrepancies will be brought to the QA meeting and addressed as needed	

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that happened but I have fixed it now..."

The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during a meeting with facility staff 9/16/19 beginning at 5:40 p.m.

No further information was provided prior to the exit conference.

3. Resident #143 was admitted to the facility on 8/22/19. Diagnoses for Resident #143 included; Sepsis, bladder cancer, chronic AFIB, emphysema, and chronic kidney disease. The most current MDS (minimum data set) was a 14 day assessment with an ARD (assessment reference date) of 9/5/19. Resident #143 was assessed as having moderately impaired cognitive skills.

On 9/16/19 resident #143's clinical chart was reviewed. A physician's order dated 9/4/19 documented, "Apply TED hose [compression hose] to Bilateral lower extremities in am [sic] and remove @ (at) bedtime two times a day for swelling."

On 09/16/19 at 9:15 AM, Resident #143 was observed sitting up on side of the bed without TED hose in place and both legs were edematous. When asked about the TED hose, Resident #143 stated they haven't put them on. Resident #143 was observed again at 9:45 AM sitting on the side of bed without TED hose.

On 09/16/19 at 10:02 AM, certified nursing assistant (CNA #2, assigned to Resident #143) was interviewed and also observed Resident #143 without TED hose. When asked about the TED hose, CNA #2 stated that she was aware

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that Resident #143 had an order for TED hose but hadn't got to him yet and said she had been very busy because another CNA had called off work.

09/16/19 05:39 PM the above information was presented to the administrator and director of nursing.

No other information was presented prior to exit conference on 9/17/19.

4. Resident #355 was admitted to the facility on 01/27/19 and discharged on 02/15/19. Admitting diagnoses for this resident included, but were not limited to: hip fracture (right femur), Parkinson's disease, muscle weakness, history of falls, encephalopathy, vitamin d deficiency, and constipation.

The most current full MDS (minimum data set) was an admission assessment dated 02/01/19 Resident #355 was assessed as receiving 4 injections on this MDS (not insulin).

The clinical record was reviewed and documented the resident was admitted to the facility at approximately 10:30 AM on 01/27/19. The resident was ordered medications that included, but were not limited to: Sinemet (Parkinson's medication) three times daily, celebrex (scheduled pain medication) twice daily, lovenox (anticoagulant) once daily, Lortab (as needed pain medication) every 6 hours, ramelteon (insomnia medication) every night, and senna (laxative medication) every day.

The resident's January 2019 MARs (medication administration records) were reviewed and revealed that the resident only received as

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needed pain medications on the date of admission (01/27/19) and one dose of the Sinemet (Parkinson's disease) on the day of admission (1 PM dose). All other medications were not administered as ordered by the physician. Several of the resident's medications for 01/27/19 and 01/28/19 had a code of '5' and a code of '9' documented on the MARs. The "5" indicated that the medication was not administered and documented, "Hold/See progress notes." The "9", indicated that the medication was not administered and documented, "Other/See Progress Notes."

The physician's orders and progress/nursing notes were reviewed from admission to discharge and no information was found regarding the why the resident did not have medications for administration.

The DON (director of nursing) was interviewed on 09/17/19 at 7:34 AM regarding Resident #355 and the above information. The DON stated that for a new admission, they activate the orders put in the queue, once the resident is at the facility they will confirm and then the medications are brought from pharmacy on the next run, or from the back up pharmacy. The DON stated that there is a cut off and stated that if the resident is admitted and the medications are put in before 5:00 PM, the pharmacy will deliver them by 7:00 PM. The DON was asked for any information as to why this resident did not receive her medications from the pharmacy as ordered. The DON stated that they have had problems with the pharmacy as far as getting medications. The DON stated that the pharmacy is open Monday through Friday, but they are available 24 hours a day from the backup pharmacy. The DON stated

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off hours for backup pharmacy would be after 7:00 PM and on the weekends.

A policy was presented, titled "Providing pharmacy products and services." The policy stated, "...will provide facility with the facility specific information sheet, which details how facility staff can contact pharmacy 24 hours a day, seven days a week...normal business hours set forth in the facility specific information sheet, facility staff may contact by phone...fax...by mail or hand delivery...if orders for medications are received from physician...when pharmacy is closed...contact emergency number..."

The facility specific information sheet documented, that the pharmacy hours of operation were Monday through Friday 9 AM to 9 PM and Saturday, Sunday and Holidays: 9 AM to 5 PM. This did not match what the DON stated in her interview.

On 09/18/19 at approximately 9:45 AM, the GM (General Manager) from the local pharmacy was interviewed. The GM stated that the local pharmacy closes at 7:00 PM (Monday through Friday) and closes at 5:00 PM on Saturday, the pharmacy is closed Sunday. The GM stated those hours have been in effect since early 2018 and the facility should be aware of that. The GM further stated that the facility will have to call the back up pharmacy to get medications during off hours and that the medications are typically delivered within 4 hours; there is not cut-off on that and that if the facility put that information in the computer that medications will not be delivered within the 4 hours, a phone call actually has to be made. The GM stated that he was not sure where the breakdown happened, but stated

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F 684	Continued From page 20 that if there were extenuating circumstances that information would have been documented and there was no information indicating that. The DON and administrator were made aware that the information presented did not match the interviews. The DON was asked where the breakdown occurred with Resident #355. The DON stated that she could not look the information up in the computer to see if the medications were ordered and could not determine what happened. No further information and/or documentation was presented prior to the exit conference on 09/17/19 at 1:00 PM to evidence that the facility staff ordered the physician prescribed medications for Resident #355 to ensure the medications were available upon admission to the facility for administration, without interruption. This is a complaint deficiency.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		11/18/19

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F 686	Continued From page 21 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to implement interventions for the prevention of pressure ulcers for one of 39 residents in the survey sample. Resident #121, with a recent history of pressure ulcers on both heels, did not have dressings, topical treatment and protective booties applied for 10 consecutive days as required by physician orders and the care plan for pressure ulcer prevention. The findings include: Resident #121 was admitted to the facility on 11/18/18 with a re-admission on 8/13/19. Diagnoses for Resident #121 included bladder cancer, peptic ulcer, hypertension, adult failure to thrive, depression, congestive heart failure, dementia and diabetes. The minimum data set (MDS) dated 8/27/19 assessed Resident #121 with moderately impaired cognitive skills. Resident #121's clinical record documented the resident was assessed with pressure ulcers on both heels on 5/25/19. Skin assessment sheets documented the pressure ulcers as healed on 8/30/19. The clinical record documented a physician's order dated 9/6/19 to apply skin prep treatment and an Allevyn dressing to both heels every day for pressure ulcer prevention. The resident's plan of care (revised 9/4/19) listed the resident was at risk of skin breakdown. Interventions for pressure ulcer prevention included use of "bunny boots," a heels-up cushion and an air mattress.	F 686	F686 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident #121 has been checked daily to ensure that allevyn and skin prep have been applied to both heels for prevention. Heels up and profalon boots applied to lower extremities. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with pressure ulcers were observed to ensure prevention interventions are in place. Corrections made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: ** Staff development coordinator or designee to educate nursing staff and CNA□s about following orders, updating care plans and documentation of interventions related to residents with pressure ulcers. How the facility plans to monitor its performance to make sure that solutions are sustained: ** Unit manager or designee to audit resident with pressure ulcer prevention measures being used and ensure proper implementation, orders are in place,	

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F 686	Continued From page 22 On 9/16/19 at 11:10 p.m., accompanied by licensed practical nurse (LPN) #3 and LPN #10, Resident #121's feet/heels were observed. Resident #121 was in bed with his heels positioned directly on the bed sheets. The resident's heels had no Allevyn dressings, no booties and no elevation of his feet/heels. The left heel had a scarred area with dry skin. The right heel was dry, with an area of peeling thick skin. LPN #3 was interviewed at this time about the Allevyn dressing and booties. LPN #3 stated the resident had a physician's order for the Allevyn dressing to be on each heel and the resident's heels were supposed to be elevated. LPN #3 stated she did not know why the dressings were not in place. LPN #3 looked and found the "bunny boots" in the resident's closet. Further review of Resident #121's clinical record on 9/16/19 documented no evidence the Allevyn dressings or skin prep had been applied since ordered on 9/6/19. There was no evidence indicating application of the protective booties as required on the care plan. The Allevyn, skin prep and bunny boots were not listed on the resident's treatment administration record or medication administration record. On 9/16/19 at 3:40 p.m., the director of nursing (DON) was interviewed about Resident #121 in bed without physician ordered dressings, booties or heel elevation. The DON reviewed the resident's current treatment record and stated she did not see the Allevyn, skin prep or booties listed. The DON stated the nurse entering the orders was supposed to mark the items to show on the treatment and/or medication record to ensure the interventions were implemented. The DON reviewed Resident #121's record and stated	F 686	documentation being completed and care planned once a week for 6 weeks. Date of compliance: 11/18/19 Discrepancies will be brought to the QA meeting and addressed as needed	

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LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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F 686	Continued From page 23 the orders for the Allevyn and skin prep were not marked properly in the computer and therefore were not listed on the treatment record. The DON stated the Allevyn was a padded dressing used to protect the resident's heels from further breakdown. This finding was reviewed with the administrator and director of nursing during a meeting on 9/16/19 at 5:40 p.m.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to provide restorative nursing services for one of 39 residents in the survey sample, Resident # 86.	F 688	F688 How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	11/18/19

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F 688	Continued From page 24 Findings include: Resident # 86 was admitted to the facility 8/3/17 with diagnoses to include, but not limited to: spinal stenosis, chronic pain, and chronic kidney disease. The most recent MDS (minimum data set) was a quarterly review dated 9/5/19 and had Resident # 86 with moderate impairment in cognition with a total summary score of 10 out of 15. On 9/15/19 at 2:00 p.m. Resident # 86 was observed in her room sitting in a wheel chair. Resident # 86 was observed with splint boots to each foot. The boot on the left foot was not applied securely, and the right boot was sideways on the resident's foot. Resident # 86 stated "Yes, they are quite a sight, aren't they?" She went on to state the CNA (certified nursing assistant) applied the boots in the mornings after getting her out of bed. CNA # 3 was in the hallway across from the resident's room, and was asked to come and assist the resident to adjust the boots. CNA # 3 was asked when the boots were put on the resident and she stated "They get put on in the morning and taken off at bedtime." The clinical record was reviewed 9/16/19 at approximately 7:45 a.m. The order for the boots was not located on the current POS (physician order summary). The care plan was then reviewed, and included the following: "Focus: The resident has limited physical mobility related to muscle weakness, difficulty walking, spinal stenosis. Created on: 7/19/17. Revision on: 4/23/19..." Goals included, "The resident will remain free of complications related	F 688	*Resident #86 has been monitored to ensure that a restorative ROM program is in place and being done appropriately, documented appropriately in the care plan and that an assessment has been completed by the nurse. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with Restorative interventions were reviewed. Corrections made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Development Coordinator or designee to educate nurses on entering restorative orders, care planning restorative interventions and documentation of restorative programs. CNA□s will be educated on restorative programs and documentation in the POC. Unit Manager or designee to audit residents with Restorative care plans and ensure that restorative interventions were entered into the POC correctly and are being carried out per the plan of care with documentation of the interventions. How the facility plans to monitor its performance to make sure that solutions are sustained: **Unit manager or designee will audit residents receiving restorative interventions once a day for 6 weeks for compliance and documentation of restorative program.	

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F 688	Continued From page 25 to immobility...through the next review date. Created on: 8/8/17. Revision on: 7/9/19." Interventions included, "NURSING REHAB/RESTORATIVE: PASSIVE ROM (range of motion) Program # 1: Pt (patient) has excessive tone in legs but with very slow long stretch can reach full knee extension on L (left) lower extremity and full flexion on R (right) lower extremity for 15 minutes twice daily." The revision date for the intervention was 4/23/19. "NURSING REHAB/RESTORATIVE: ACTIVE ROM: Program # 2: Resident will maintain present muscle strength and endurance without evidence of contractures through next review. Need ROM to bilateral lower extremities in sitting working on straightening the left lower extremity and bending the right lower extremity in chair. Place pt. neuro multipodus boots on for 2 hours in chair with left leg straightened and elevated and right leg bent with leg rest lowered. Created on :9/5/19." The frequency was noted as "PRN (as needed)." On 9/16/19 at 9:15 a.m. the DON (director of nursing) was asked if an order was needed for the multipodus boots in use by the resident, and also for the documentation of the restorative services provided. The DON reviewed the clinical record, then stated "There is no documentation for the restorative services or an order for the boots. When there is a referral for restorative services the unit manager should have put in definitive times for the services to be provided and notified the doctor; that wasn't done. It was entered as 'prn' so it did not trigger over to the CNA to know the resident should be picked up for restorative, so there is no documentation." The DON was advised at that time the resident had been observed with the boots on since 9/15/19 at	F 688	Date of Compliance: 11/18/19 Discrepancies will be brought to the QA meeting and addressed as needed	

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F 688	Continued From page 26	F 688		

1:00 p.m. The DON stated "I will make sure the physician is notified about the order and the specific times for the boots to be applied."

On 9/16/19 at 9:25 a.m., CNA # 1, who was assigned to restorative services on Resident # 86's hall, was asked if she was aware Resident # 86 was to be receiving restorative services. CNA # 1 stated "No. It is not on my ADL (activities of daily living) sheet; she is? I certainly did not know that...I think (name of CNA # 3) might work with her some too, you may want to ask her..." CNA # 3, who was present during the interview was then asked about the restorative services for the resident. CNA # 3 stated she was aware, and further stated "When she got the boots we had an inservice with therapy about it." CNA # 3 was asked if she was in the inservice, and she stated she was. She was then asked about the time frame for the boots as she had stated the day before the resident wore the boots from morning until bedtime. CNA # 3 was also asked for her documentation of the restorative exercises. CNA # 3 stated "It's not documented in the ADL's. I thought the boots were to be on all day..."

On 9/16/19 at 9:30 a.m. the unit manager, identified as LPN (licensed practical nurse) # 4 was interviewed about the restorative referral. LPN # 3 stated "I was not aware to put it in with times or to notify the doctor..."

The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during a meeting with facility staff 9/16/19 beginning at 5:40 p.m.

No further information was provided prior to the exit conference.

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to implement interventions for fall and injury prevention for one of 39 residents in the survey sample. Resident #112's fall mats were not implemented for over a month following an unwitnessed fall from his bed. The findings include: Resident #112 was admitted to the facility on 3/20/19 with a re-admission on 4/23/19. Diagnoses for Resident #112 included respiratory failure, seizures, cerebrovascular disease, diabetes, COPD (chronic obstructive pulmonary disease), dysphagia, cognitive communication deficit, schizophrenia, glaucoma, mood disorder and high blood pressure. The minimum data set (MDS) dated 8/25/19 assessed Resident #112 with short and long-term memory problems and moderately impaired cognitive skills. The MDS listed the resident had highly impaired vision and required the extensive assistance of two people for bed mobility. On 9/15/19 at 5:20 p.m., Resident #112 was observed in bed. The resident's right foot was hanging off the side of the bed. The resident was	F 689	F689 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #112 is being monitored to ensure that fall mats are in place and that all equipment being used is safe. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with new fall interventions were reviewed. Corrections were made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Residents experiencing a fall will be reviewed by Unit Manager or designee for new interventions and implementation of the new interventions. How the facility plans to monitor its performance to make sure that solutions are sustained:	11/18/19

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F 689	Continued From page 28 on an air mattress with no floor mats in place. Resident #112 was observed again on 9/16/19 at 7:47 a.m., 10:13 a.m. and 2:15 p.m. in bed with no floor mats in place on either side of the bed. Resident #112's clinical record documented the resident had an unwitnessed fall from the bed on 8/8/19. A nursing note dated 8/8/19 at 11:37 p.m. documented, "Resident was found by CNA [certified nurses' aide] with his head and upper torso on the floor and lower extremities on the bed. Un-witnessed...No acute distress noted. No injury..." The clinical record documented a post-fall assessment dated 8/8/19 listing immediate action taken to prevent further falls/injury was, "Fall mats." On 9/16/19 at 2:20 p.m., the licensed practical nurse (LPN #3) caring for Resident #112 was interviewed about the protective floor mats. LPN #3 stated she was not sure if the resident required floor mats. LPN #3 reviewed the resident's plan of care and stated she did not see the floor mats listed. LPN #3 stated, "Normally, I don't care for him [Resident #112]." On 9/16/19 at 2:25 p.m., the unit manager (LPN #4) was interviewed about the floor mats indicated on Resident #112's post-fall assessment. LPN #4 stated she remembered implementing the floor mats after the resident's fall on 8/8/19. LPN #4 reviewed the plan of care and stated she did not see the mats listed. LPN #4 stated she thought she added the mats to the care plan but did not see them listed. LPN #4 stated she did not know why the mats had not been implemented. On 9/16/19 at 2:40 p.m., the certified nurses' aide	F 689	Unit manager or designee to audit all residents who experience a fall for any new interventions and ensure those interventions are in place once a week for 6 weeks. Date of Compliance: 11/18/19 Discrepancies will be brought to the QA meeting and addressed as needed	

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F 689	Continued From page 29 (CNA #3) that routinely cared for Resident #112 was interviewed. CNA #3 stated she was not aware of any floor mats used with Resident #112. On 9/16/19 at 2:53 p.m., CNA #7 caring for Resident #112 was interviewed. CNA #7 stated, "To my knowledge, he [Resident #112] does not have mats." CNA #7 stated she had worked with Resident #112 since 8/12/19 and she had not been instructed to use mats for Resident #112. On 9/16/19 at 3:30 p.m., the director of nursing (DON) was interviewed about Resident #112's post-fall assessment indicating the use of protective fall mats. The DON stated the resident was supposed to have fall mats in place for injury prevention. The DON stated the mats were initiated following the resident's fall from the bed on 8/8/19. The DON stated the unit manager was responsible for adding the mats to the care plan and communicating the need for the mats to the direct-care staff. Resident #112's plan of care (revised 9/5/19) listed the resident was at risk of falls. Interventions listed were anticipate and meet needs, use assistive devices, call light within reach, fall education, appropriate footwear and trip-free environment. The plan of care was not updated to indicate use of the protective fall mats. This finding was reviewed with the administrator and director of nursing during a meeting on 9/16/19 at 5:40 p.m.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		11/18/19

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F 695	Continued From page 30 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident record review, the facility staff failed to follow physician orders for oxygen administration for 2 of 39 resdients in the survey sample, Residents #46 and #114. The Findings Include: 1. Resident #46 was admitted to the facility on 8/22/19. Diagnoses for Resident #46 included: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, and sleep apnea. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/17/19. Resident #46 was assessed as being cognitively intact. On 09/16/19 at 9:12 AM, Resident # 46 was interviewed. During the interview Resident #46 was asked if staff change out oxygen tubing and asked to observed oxygen concentrator. Resident #46 stated that staff do change the oxygen tubing. The oxygen concentrator was then observed and the rate of oxygen was set at 4 LPM (liters per minute). On 09/16/19 Resident #46's record was reviewed and included an active physician's order dated dated 5/16/19 which documented "Oxygen	F 695	F695 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Resident #46 has been monitored and checked that her concentrator or oxygen delivery system is set according to physician order. *Resident # 114 has been monitored and checked that her concentrator or oxygen delivery system is set according to physician□s order. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents receiving supplemental oxygen were reviewed to ensure accuracy of oxygen delivery per physician order. Corrections were made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: ** Staff Development Coordinator or designee will educate nursing staff to ensure that at any time a resident is changed to a different delivery method or	

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F 695	Continued From page 31 Therapy-Oxygen at 2 liters per minute via nasal cannula every shift." On 09/16/19 at 10:15 AM, Resident #46's oxygen was again observed with a rate at 4 LPM. On 09/16/19 at 10:35 AM, license practical nurse (LPN) #9, who was assigned to Resident #46, was interviewed regarding the oxygen rate. LPN #9 reviewed Resident #46's oxygen order and then observed Resident #46's oxygen rate at 4 LPM. LPN #9 turned down the oxygen and said "that's on me." On 09/16/19 at 5:39 PM, the administrator and director of nursing were informed of the above information. No other information was provided prior to exit conference. 2. Resident # 114 was admitted tot he facility 8/13/19 with diagnoses to include, but were not limited to: history of falls, acute respiratory failure, and COPD (choronic obstructive pulmonary disease). The most recent MDS (minimum data set) was the admission assessment dated 8/20/19. Resident # 114 was coded with moderate impairment in cognition with a total summary score of 10 out of 15. The clinical record was reviewed 9/16/19 at 9:00 a.m. The current POS (physician order summary) included an order dated 8/14/19 for "Oxygen Therapy- Oxygen at (1) liters per minute via nasal cannula every shift for shortness of breath."	F 695	returns to room, or from another area, oxygen delivery method should be checked for compliance to physician□s orders. How the facility plans to monitor its performance to make sure that solutions are sustained: ** Unit manager or designee will audit residents receiving oxygen to ensure that oxygen delivery rate is set per physician orders. Residents with oxygen orders will be audited 3 times a week for 6 weeks. Date of Compliance: 11/18/19 Discrepancies will be brought to the QA meeting and addressed as needed	

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F 695	Continued From page 32 On 9/16/19 at 10:45 a.m. Resident # 114 was observed in bed with his oxygen being administered at 3 lpm (liters per minute). LPN (licensed practical nurse) # 2, who was at the nurses' station, was asked about the oxygen for Resident # 114. LPN # 2 looked at the order and confirmed it was to be administered at 1 lpm. Resident #114's oxygen was observed with LPN # 2 who confirmed the oxygen was being administered at 3 lpm. She adjusted the oxygen back to 1 lpm, and stated "I don't know how that happened; there are people in and out of here all the time. Therapy comes in and works with him, and he complains a lot of feeling like he can't breathe so they may have turned it up..." LPN # 2 was asked if it was acceptable for anyone coming in the room to adjust the oxygen. LPN # 2 stated "I'm not saying that..." On 9/16/19 at 4:30 p.m. the physical therapy assistant (PTA) who worked with Resident # 114 was interviewed about what would happen if a resident complained of feeling unable to breathe during a session. The PTA stated "Well, I would check with nursing about what to do." The administrator, DON (director of nursing), and regional nurse consultant were informed of the above observations during a meeting with facility staff 9/16/19 beginning at 5:40 p.m. No further information was provided prior to the exit conference.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate	F 700		11/18/19

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F 700	Continued From page 33 alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess one of 39 residents (Resident #112) for entrapment risks prior to use of bed rails with a specialty mattress. The findings include: Resident #112 was admitted to the facility on 3/20/19 with a re-admission on 4/23/19. Diagnoses for Resident #112 included respiratory failure, seizures, cerebrovascular disease, diabetes, COPD (chronic obstructive pulmonary disease), dysphagia, cognitive communication deficit, schizophrenia, glaucoma, mood disorder and high blood pressure. The minimum data set (MDS) dated 8/25/19 assessed Resident #112	F 700	F700 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #112 has been assessed for proper use of mattress and assist bars. Bed and all additional equipment and devices have been checked in collaboration with nursing and maintenance. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with air mattresses with assist bars/bed rails on their beds were reviewed	

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F 700	Continued From page 34 with short and long-term memory problems and moderately impaired cognitive skills. The MDS listed the resident had highly impaired vision and required the extensive assistance of two people for bed mobility. On 9/15/19 at 5:20 p.m., Resident #112 was observed in bed. The resident's right foot was hanging off the side of the bed. The resident was on an alternating air mattress with short bed rails raised on both sides of the bed. The rails were near the head of the bed. Resident #112 was observed again on 9/16/19 at 7:47 a.m., 10:13 a.m. and 2:15 p.m. in bed with both bed rails in the up position. No floor mats were in place by the bed. Resident #112's clinical record documented the resident had an unwitnessed fall from the bed on 8/8/19. A nursing note dated 8/8/19 at 11:37 p.m. documented, "Resident was found by CNA [certified nurses' aide] with his head and upper torso on the floor and lower extremities on the bed. Un-witnessed...No acute distress noted. No injury..." Resident #112's clinical record documented a "Device Assessment" dated 8/6/19 listing the resident used side rails and a low bed with mats. The purpose of the side rails and concave mattress was documented as "safety." This assessment listed the responsible party was notified and the care plan was updated to include use of the side rails. The clinical record and device assessment listed no prior attempted alternatives to the bed rails, no informed consent from the resident's representative regarding bed rail use and no indication of the medical need addressed by the	F 700	for safety and risk of entrapment. Corrections were made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nursing in collaboration with maintenance will conduct an audit upon changes in bed frame, assistive device, mattress, or bed rail to ensure dimensions of bed/mattress/turn bars are appropriate. ** Staff development Coordinator or designee to educate all staff including maintenance dept, about adding a specialty mattress, even if a bed already has assist bars (side rails). How the facility plans to monitor its performance to make sure that solutions are sustained: **Unit Manager, Maintenance Director or designees will audit beds with air mattresses to assess for entrapment risk 1 time a week for 6 weeks. Date of Compliance: 11/18/19 Discrepancies will be brought to the QA meeting and addressed as needed	

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rails. There was no additional bed rail safety assessment performed after the resident's unwitnessed fall on 8/8/19 and no assessment regarding the resident's bed rail use with the alternating air mattress currently on the bed.

Resident #112's plan of care (revised 9/5/19) documented the resident was at risk of falls, had left sided weakness, a seizure disorder, impaired cognitive function and impaired vision. Interventions listed included anticipate and meet the needs, use assistive devices that included "assist bars," call light within reach, fall education, appropriate footwear and trip-free environment. There was no mention the resident had "assist bars" in use with an alternating air mattress.

On 9/16/19 at 2:30 p.m., the licensed practical nurse unit manager (LPN #4) was interviewed about Resident #112's bed rail use with the air mattress. LPN #4 stated residents were assessed upon admission for use of side rails. LPN #4 stated Resident #112 could hold the grab rails during care but he did not independently use the rails to turn or move about in bed. LPN #4 stated the resident required the assistance of two people for bed mobility. LPN #4 stated there was no re-assessment of the bed rails after the resident fell on 8/8/19. LPN #4 stated she did not know of an assessment regarding rail use with the air mattress.

On 9/16/19 at 2:40 p.m., a certified nurses' aide (CNA #3) that routinely cared for Resident #112 was interviewed. CNA #3 stated Resident #112 was "total assist" and did not use the bed rails on his own.

On 9/16/19 at 3:18 p.m., the maintenance

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director (other staff #6) was interviewed about any assessment or review of Resident #112's bed rails. The maintenance director stated his department annually reviewed beds, mattresses and bed rails for entrapment risks and safety using FDA guidelines. After reviewing his records, the maintenance director stated Resident #112's bed was last inspected for safety on 9/18/18. The maintenance director stated hospice placed the current alternating air mattress on Resident #112's bed. The maintenance director stated he had not reviewed and/or assessed Resident #112's bed or rails with the current air mattress because he was not aware the specialty mattress was in use.

On 9/16/19 at 3:30 p.m., the director of nursing (DON) and corporate nursing consultant were interviewed about Resident #112's bed rail use without an assessment for safety. The DON stated that the resident should have been re-assessed regarding bed rail use after the fall on 8/8/19. The DON stated the assessment completed on 8/6/19 was not accurate as the resident had assist bars and not side rails. The corporate consultant stated he did not think "assist bars" were considered bed rails. The DON stated she had no information about any attempted alternatives to the bed rails. The DON stated she did not realize the entrapment risk requirements applied to assist bars.

The facility's policy titled Bed Systems Audit (effective 1/1/19) documented, "...Maintenance will also conduct an intermittent audit immediately upon notification by nursing of any individual change of a bed frame, an assistive device, a mattress, or a bed rail. Maintenance and nursing will collaborate in order to identify gaps, ensure a

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F 700	Continued From page 37 tight fit of mattress to the bed system and, if appropriate, to inspect for mattress compressibility...Any bed rail and/or mattress changes implemented and/or newly purchased separately from the bed frame system, will be assessed collaboratively for compatibility in width and length and with adherence to the manufacturer's recommendation and specifications..." This finding was reviewed with the administrator and director of nursing during a meeting on 9/16/19 at 5:40 p.m.	F 700		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		11/18/19

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F 880	Continued From page 38 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 39 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to perform hand hygiene during meal assistance in one of three dining rooms (East unit restorative). The findings include: On 9/16/19, breakfast was observed in the East unit restorative dining room from 7:50 a.m. until 8:15 a.m. On 9/16/19 at 7:50 a.m., certified nurses' aide (CNA) #3 offered Resident #34 a banana. Without use of gloves, CNA #3 completely peeled the banana and directly touched the food with her bare hands before handing the banana to the resident. The resident took one bite of the banana and placed it on a napkin on the table. Certified nurses' aide (CNA) #1 was observed feeding Residents #9, #33 and #87, who were seated at the same table. CNA #1 was standing and went from resident to resident feeding them the breakfast food items/drink from their trays. CNA #1 gave Resident #33 a bite of food, then went to Resident #87 and fed him several bites. CNA #1 then went to Resident #9 and fed her several bites of food. CNA #1 proceeded to go from resident to resident feeding each resident several bites before moving to the next resident. CNA touched the residents' utensils, drink cups, milk cartons, wheelchair backs and patted one resident on the shoulder during the meal assistance. CNA #1 performed no hand hygiene between any of the residents while assisting and feeding them.	F 880	F880 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Nursing staff are using appropriate hand hygiene while serving and feeding meals in the dining room. How the facility will identify other residents having the potential to be affected by the same deficient practice: Resident in dining rooms were observed to ensure hand hygiene occurring appropriately during meals. Corrections were made as necessary. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: ** Staff development Coordinator or designee to provide education to all staff about hand hygiene before and after eating or handling food and before and after assisting a patient with meals. How the facility plans to monitor its performance to make sure that solutions are sustained: **Unit Manager, Staff Development Coordinator or designee to audit staff for knowledge of this education in dining rooms and units once a week for 6 weeks, alternating between day and evening shift.	

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F 880	Continued From page 40 On 9/16/19 at 8:06 a.m., CNA #7 entered the dining room and started feeding Resident #9. CNA #7 stopped feeding Resident #9 after a few minutes, cleaned off dirty plates/cups/napkins from another table. Without performing hand hygiene, CNA #7 then returned to feeding Resident #9. CNA #1 continued to feed Residents #33 and #87, going back and forth between the residents. There was no hand hygiene performed by either CNA during the meal observation. On 9/16/19 at 9:18 a.m., CNA #1 was interviewed about hand hygiene during the breakfast observation. CNA #1 stated hand sanitizer was available. CNA #1 stated hand sanitizer was used when passing out meal trays. When asked about hand hygiene between residents, CNA #1 had no response. On 9/16/19 at 9:21 a.m., the licensed practical nurse unit manager (LPN #4) was interviewed about the breakfast observation. LPN #4 stated staff members were supposed to use hand sanitizer between contacts with residents or their items. The facility's policy titled Handwashing Requirements (effective 12/26/17) documented, "...Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections...Hand hygiene can consist of handwashing with soap and water or use of an alcohol based hand rub...The following is a list of some situations that require hand hygiene...Before and after eating or handling food (hand washing with soap and water)...Before and after assisting a patient with meals (hand washing with soap and water)..."	F 880	Date of Compliance: 11/18/19 Discrepancies will be brought to the QA meeting and addressed as needed	

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F 880	Continued From page 41 This finding was reviewed with the administrator and director of nursing during a meeting on 9/16/19 at 5:40 p.m.	F 880		