ACCORDIUS

HEALTH

AT HARRISONBURG

December 27, 2019

Ms. Nicole Keeney
Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

RE: Accordius at Harrisonburg , Provider #495146

Ms. Keeney,

Attached, please find a copy of our Plan of Correction for the Complaint Licensure Survey ending on December 5, 2019. We allege compliance by January 10, 2020. Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with federal regulations.

If you have any questions or concerns, please feel free to contact me at 540-433-2791 or via email at meturner@accordiushealth-harrisonburg.com

Sincerely,

Meredith Turner, LNHA MBA
Executive Director

UPS Copy sent 12/27/19
Faxed copy sent 12/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HARRISONBURG LLC	94 SOUTH AVENUE HARRISONBURG, VA 22801

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/03/2019 through 12/05/2019. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey: VA00046811 substantiated with a related deficiency; VA00047203 was substantiated with a related deficiency; VA00045506 was unsubstantiated, but with related deficiencies; VA00047937 was substantiated with a related deficiency; VA00046099 was substantiated with a related deficiency. The census in this 117 certified bed facility was 102 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #4 through #9, #11 through #17, and #24 through #29) and 10 closed record reviews (Residents #1 through #3, #10, and #18 through #23).	F 000		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, facility staff failed to ensure current CPR (cardiopulmonary resuscitation) certification for two of 19 staff.	F 678	**1. Immediate action was taken upon identification of this deficiency. The two nurses that had CPR certifications that expired on December 4, 2019 have been identified and we have contacted a local educator that teaches the American Heart Association BLS certification.** **2. An audit of all CNA, LPN and RNs was completed to see who else would need to take the certification to create CPR teams, per our policy, for each shift.** **3. A Staffing Development Coordinator has been hired to insure all training is completed in a timely manner under the supervision of the Director of Nursing and employee files will be audited for CPR certification. A chart of compliance is in place to insure training schedule in the event SDC is out of the building.** **4. Review of all staff certification will be reviewed monthly staff notified of renewals upcoming to insure it is scheduled and completed prior to expiration date.** **5. We will be in compliance with this requirement by 1/10/20**	

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

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

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F 678	Continued From page 1 Findings included: During the survey conducted 12/03/2019 through 12/05/2019 staff certified in CPR was reviewed. A list of current staff certified in CPR was requested and received from the DON (director of nursing) on 12/05/2019 at approximately 2:00 p.m. Included on the list were seven (7) RN's (registered nurses), nine (9) LPN's (licensed practical nurses) and three (3) other facility employees. Of the nineteen (19) employees, two certifications, one RN and one LPN, were expired. A copy of the CPR policy was requested and documented, "Emergency Procedure - Cardiopulmonary Resuscitation (Revised April 2016)" included, "General Guidelines...6. If an individual...is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS [basic life support] shall initiate CPR unless: ...Preparation for Cardiopulmonary Resuscitation - 1. Obtain and/or maintain American Red Cross or American Heart Association certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel...4. Select and identify a CPR Team for each shift in the case of an actual cardiac arrest. To the extent possible, designate a team leader on each shift who is responsible for coordinating the rescue effort and directing other team members during the rescue effort. 5. The CPR Team in this facility shall include at least one nurse, one LPN/LVN [licensed vocational nurse] and two CNAs [certified nursing assistants], all of whom have received training and certification in	F 678		

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F 678	Continued From page 2 CPR/BLS..." On 12/05/2019 LPN #1 and LPN #2 were interviewed. They both stated that they keep up with their own CPR training. They were asked who trained the rest of the staff. LPN #1 stated, "I think the DON is doing all that now. Not everyone has access to the online trainings, I don't know who is keeping up with it. That's a really good question." The survey team met with the Administrator, DON, and Vice President Clinical Services at 3:45 p.m. They were informed during this meeting that two employees had expired certifications. The DON stated, "Yes, I have to get those. All of our nurses are certified. There is always other nurses here and our 11-7 nurses are not expired." When asked why no CNAs were CPR certified, the DON stated, "[Name] previous company, did not want CNA's trained in CPR. They did not want CNAs initiating CPR." Regarding the facility policy, the Administrator stated, "No, we do not have a CPR team." Regarding who is responsible for employee training in the absence of a Staff Development Coordinator (SDC), the Administrator stated, "The DON and unit managers are taking over that until a new SDC is hired. The SDC left the first week of November." No further information was received prior to the exit conference on 12/05/2019.	F 678		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

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F 684	Continued From page 3 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to follow physician orders for obtaining weights, for one (1) of 29 residents in the survey sample, Resident #4. Findings included: Resident #4 was admitted to the facility on 11/07/2019 with diagnoses including, but not limited to: Congestive Heart Failure (CHF), Cellulitis, Venous Insufficiency, and Dementia. Her most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 11/14/2019. Resident #4 was assessed as severely impaired in her cognitive status with a total cognitive score of three (3) out 15. Resident #4's electronic medical record (EMR) was reviewed on 12/04/2019 at approximately 8:40 a.m. The physician order sheet (POS) dated 11/01/2019 - 12/04/2019 included: "Weights every day shift every Mon, Wed, Fri for CHF," Order Date: 11/11/2019. A second order included: "Weights/ Notify MD [medical doctor] if patient gains 5 lbs. [pounds] [Physician Name and phone number] every day shift every Mon, Wed, Fri for CHF," Order Date: 11/18/2019.	F 684	**1. Immediate action was taken upon identification of this deficiency to prevent further occurrences. To insure compliance in the future the following steps have been put in place:** **2. Daily audits of weights and vitals by each unit manager and Director of Nursing to insure all are done or documented if refused.** **3. Weekly weight meetings with all clinical staff, Dietician, Director of Nursing and the Administrator to identify any potential problems that need to be addressed.** **4. Results from weight meetings will be discussed monthly in the Quality Assurance meeting with the Medical Director.** **5. We will be in compliance of this regulation by 1/3/20**	

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F 684	Continued From page 4 Subsequent review of Resident #4's weight record, recorded on the TAR (treatment administration record) included weights for 11/15/2019, 11/20/2019, 12/02/2019, and 12/04/2019. The following dates were coded with a "9" meaning "Other / See Nurse Notes," 11/13/2019, 11/27/2019, and 11/29/2019 and two dates 11/22/2019 and 11/25/2019 were left blank. No notes were included with the TAR's . Nursing progress notes for 11/13/2019, 11/22/2019, 11/25/2019, 11/27/2019, and 11/29/2019 were reviewed at approximately 9:00 a.m. The only documentation regarding weights was in a note dated 11/27/2019 at 0139 (1:39 a.m.). The note included, "...Uncooperative with care, refuses medications and treatments frequently..." The unit manager, LPN #1 (licensed practical nurse) was interviewed on 12/04/2019 at 11:35 a.m. regarding Resident #4's weight orders. LPN #1 stated, "I don't believe he was ever on QD [everyday] weights. He is the one from [Physician Name]. If he was it would show up on the nurse's TAR." At 11:50 a.m., LPN #1 stated, "She was never on QD weights. When they come from the hospital we always change to Monday, Wednesday, Friday if on frequent weights. That is our norm." (Note: LPN #1 referred to Resident #4 as "he" but the resident was female) RN #1 (registered nurse) was interviewed on 12/04/2019 at 11:55 a.m. regarding dates marked with a "9" on the TAR. RN #1 stated, "We just mark "9-other see nurse's note," But I don't always document in the nursing note. She always refuses meds [medications], treatments, dressing changes, to eat, is hard to redirect. I	F 684		

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F 684	Continued From page 5 chart on her everyday, but I don't write the same thing consistently everyday." The nurse who left 11/22/2019 and 11/25/2019 blank on the TAR for weights was unavailable for interview. The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 12/04/2019 at approximately 4:25 p.m. No further information was received by the survey team prior to the exit conference on 12/05/2019. This is a complaint deficiency.	F 684		
F 711 SS=F	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 711	**1.Immediate action was taken upon identification of this deficiency. All open orders and progress notes were printed and reviewed by the Medical Director, who then signed all and had them scanned into residents' medical records.** **2. 100% audit was completed and all residents were affected.** **3.All nursing staff is instructed on procedure of taking orders and have them signed off on appropriately.** **4.Director of Nursing will check all orders daily to insure that they have been signed off by the physician and that they are given to Medical Records to scan into patient records.** **5. We are currently in compliance of this deficiency immediately following survey.**	

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F 711	Continued From page 6 a complaint investigation, the facility staff failed to ensure physician orders were dated and signed in the electronic record from July 1, 2019 through December 5, 2019 for all residents in the facility. Findings were: On 12/05/2019 at approximately 11:30 a.m., during the course of a complaint investigation, the DON (director of nursing) was asked for information/evidence regarding the date and time of physician signatures on orders observed in the electronic medical record. At approximately 11:55 the DON and the administrator came to the conference room to speak with the survey team. The administrator stated, "We just discovered the physicians have not been signing the orders...when [name of current company] bought the facility, they didn't purchase the electronic signature piece from [name of electronic record company]...I spoke with [name of medical director] and asked him how they were signing the orders and he said he wondered why nothing was prompting him to do that...this is the first we were aware of this...we are checking on it now." At approximately 1:40 p.m., the DON and the administrator were interviewed. They were asked why no one knew the orders were not being signed and what the protocol was for signing the orders. They were also asked if orders signed prior to the change of ownership had transferred over to the current system. At approximately 1:50 p.m., the DON stated that she had spoken with the medical director and one of the nurse practitioners regarding signatures on	F 711		

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F 711	Continued From page 7 their orders. She stated, "[Name of medical director] said he wondered why it wasn't coming up for him to sign and when I spoke with the nurse practitioner and asked her how she was signing orders she asked 'What did you mean? No, I'm not signing the orders.'...no one said a word to anyone until we asked them today that they couldn't sign the orders." At approximately 2:00 p.m a telephone interview was conducted with the medical director. He stated that he had been aware that the electronic orders were not being signed but had not thought to bring it up to the facility staff. He stated, "We all made assumptions...the process was broken." At approximately 2:20 p.m., the Corporate Vice President, the DON, and the administrator were interviewed regarding the lack of physician signatures on the electronic records. The Corporate VP stated, "Orders go in the system one of three ways...verbal orders, telephone orders and presciber written orders...there is really more to it than just pushing a button [with the electronic record company]...apparently this has to be built from the ground up and is going to take a while to do...we learned about all of this at 10:00 this morning." The administrator stated, "All of the orders have been printed out today and signed by the medical director, we will continue to do that until the problem is fixed." The DON stated, "All of the care for the residents has been provided as ordered." She also stated that they physician and the nurse practitioners were in during the week to see the residents. The DON, the administrator and the VP were asked why no one had noticed the orders had not been signed and if anything looked different when reviewing the orders. The VP and the DON stated, "Nothing	F 711		

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F 711	Continued From page 8 looks different unless you go into each individual order and look at the auditing trail like we have done today, otherwise you wouldn't know...we do see that the orders signed prior to the change of ownership are still showing in the system as signed." No further information was obtained prior to the exit conference on 12/05/2019.	F 711		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		

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F 725	Continued From page 9 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on group interview, resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, facility staff failed to provide sufficient staff to provide showers and baths for 3 of 28 residents (Residents #8, #9 and #27) in group interview, and failed to answer call bells timely for 5 of 28 residents (Residents #7, #8, #24, #26, #28) in group interview. Findings were: On 12/03/2019 the Resident Council meeting minutes for the last three months obtained. Review of the meeting minutes dated 09/17/2019 contained the following information: "A special meeting was called by Resident Council President [Resident #28], to address concerns with the shower schedule not being followed on both wings. [Names of unit managers] stated the reason the shower schedule was not being followed was due to being short staffed. Both managers addressed the staffing issue and assured the residents they are trying to increase staff. [LPN (licensed practical nurse) #1] said she understood the impact the lack of staffing is having on the residents and the showers are being given to all residents to catch up the schedule. [Name of Resident #24] asked why on the weekend only one CNA [certified nursing assistant] was on the night shift on the B wing. [Name of LPN #1] assured [Resident name] that would never happen again, and she was looking into the incident. [Name of Resident #26] asked the staff if there could be more supervision in the dining room during the evening meal to address	F 725		

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F 725	Continued From page 10 residents being rude to one another and to staff..." Group meeting minutes from 11/12/2019 contained the following: "[Name of Resident #7] stated she rang her call bell on 11/12/19 at 6am for 1 hour before it was answered...[Name of Resident #24] added the aids are not working together...[Name of Resident 29] stated when she raises her hand during meals she needs something. ([Staff name] explained that the staff are very busy because many people are asking for things and they will get to her.)". A group meeting was held on 12/03/2019 at 3:30 p.m., with 28 cognitively intact residents. The resident council meeting from 09/17/2019 was addressed and the residents were asked if staffing/personnel care had improved. Multiple residents laughed and other residents responded "No...Are you kidding?...It's worse." Residents were asked for specifics regarding staffing as related to call bell response, baths/showers, and bathroom assistance (areas addressed in complaint allegations under investigation). Residents #8, #9 and #27 reported they were not receiving showers or baths on a regular basis. Resident #8 stated, "I got a shower yesterday and that's the first one I have gotten in a week." He was asked when his showers were scheduled. He stated, "I'm supposed to get a shower every Monday and Thursday in the evening." He was asked if he knew why he wasn't getting his showers as scheduled. He stated, "There aren't enough staff here to do it." Resident #9 also stated, "I'm supposed to get a shower on Wednesday and Saturday during the day shift. They don't have enough people working here to do it." Resident #27 stated, "My showers are on	F 725		

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F 725	Continued From page 11 Mondays and Fridays; I'm not getting mine either." Residents were asked about call bell response. Resident #7 stated, "There aren't enough here on any day, but weekends are worse...you sometimes have to wait 30 minutes or more to get help...then if they take you to the bathroom they leave you sitting there and go off to help somebody else...you might be in there an hour waiting to go back to bed..." Resident #24 stated, "I live on the B wing...you have to watch them. They will come in and turn your bell off and say they'll be back, but they don't come back. I tell them now, don't you touch my button to turn that off until you are gonna stay in here and help me." Resident #26 stated, "They aren't organized and the aids don't work together...if I need help and ring my bell they walk by and wave their hand and say, I'm not your aid....I have watched them put my roommate to bed at night, they might change her and they might not...they never even wipe her face off with a washcloth when she gets in the bed." Resident #28 stated, "This hasn't happened to me, but I've heard other residents ask to go the bathroom and the aid say, 'Just go in your pants and I'll change you', that's not right, they shouldn't say that." The residents were asked if the facility had improved anything since the meeting in September when the concerns were voiced to the staff. Resident #8 stated, "For about two weeks they came in the dining room to supervise, but that's over." One resident requested to remain anonymous and stated, "Since this company took over this place has gone from bad to worse...there aren't enough staff here. If you complain they will tell you that you don't need to be here anymore and they want you out...They have cut costs at our	F 725		

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expense...our briefs are cheap, they leak and pee runs down on the floor, they took away our soft drinks. Families can bring them in but if you don't have family to that it's just too bad for you. They are working the staff to death, they aren't showing up for work, and they can't get anybody to work here. As much as we pay to be here we ought to have better care." Resident #8 stated, "The aids go outside on their breaks and smoke...they don't let us smoke, but they come back in when we've been waiting on help, smelling like a cigarette."

LPN #1 was interviewed on 12/03/2019 at approximately 5:05 p.m. regarding staffing on the A wing unit. She stated, "I would say it is minimal for the most part." She was asked to elaborate and stated, "On day shift we have 3 aids, that's about 20 residents per aid and we have a shower aid. All our showers are on day shift. It's hard for them to get everything done with the amount of care that the residents need." Information regarding call bell response that was obtained from the resident council meeting was discussed. She was asked if call bell response time was monitored. She stated, "No, not in the last 6 months." She was asked how many aids she felt were needed to provide the level of care needed by they residents on the unit. She stated, "If we had six aids it would run much smoother, five on the floor and one giving showers."

LPN #2 was interviewed on 12/03/2019 at approximately 5:35 p.m. regarding staffing on the B wing unit. She stated, "It could be better...we have 3 aids and one shower aid on day shift, 3 aids on evening and 2 aids on 11-7." She was asked about showers. She stated, "We do showers on day shift and evening shift...there is a shower aid during the day, but the aid assigned to

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the residents that are on an evening schedule do their own." She was asked she knew how often showers were missed. She stated, "They get missed on days if we don't have a shower aid...that happens if someone calls in or doesn't show up, we have to pull the shower aid to the floor...a couple of months back that was happening more frequently especially on Mondays but it has gotten a little better." Information from the resident council meeting was discussed. LPN #2 was asked about residents being left in the bathroom while toileting and needing to wait for extended times for the CNA to return. She stated, "They don't have time to wait...the CNAs go and do something else and come back when they can...sometimes they get tied up in another room." She was asked how many aids she felt were needed to provide the level of care needed by the residents. She stated, "It would be nice if we had five, four on the floor and one for showers." She was asked if she felt the residents needs were currently being met. She stated, "Since July the staffing has declined, there have been a lot of changes...we don't use agency aids any more due to budgeting, so our staffing is down...little things that the residents need are not getting done. We noticed that residents were not getting nail care in the shower because the aids just don't have enough time, so we had to address that." She was asked if call bell response had been monitored. She stated, "No, not since I've been here, but I work on the floor a lot and I stay over too. I think we all try to get to the lights as soon as we can."

On 12/04/2019 at approximately 11:40 a.m., CNA #2 was interviewed regarding showers. She stated, she does showers every day that she works, she was occasionally pulled to the floor to

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F 725	Continued From page 14 provide care if a staff member called in or was a no show. She was asked how she knew who needed a bath on which day. She stated, "I have a list in the shower room...I try to get to everybody on my list every day...if the resident refuses I try to go back and ask them again to see if they changed their mind...I stay late a lot of days to make sure they get bathed." She was asked how late she stayed, she stated, "I'm supposed to get off at 3:00 but a lot of days it's 4-4:30." Shower records for Resident #8 were requested. Resident #8 had voiced in the group interview that he was not receiving regular showers. His clinical record was reviewed. Resident #8's cognitive status on a quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/12/2019, indicated he was cognitively intact with a summary score of "15". Resident #8's shower record was reviewed from 07/01/2019 - 12/03/2019. During August 2019, Resident #8 received 7 showers, September 2019 he received 5 showers. In October 2019, he received 8 showers (3 documented in one week) and in November 13 showers were documented (one week had 4 showers documented, the others each had 3). Resident #8 was interviewed on 12/04/2019 at approximately 1:00 p.m., regarding the shower documentation of 3-4 showers in one week. He stated, "That's a lie...I've never gotten that many showers in a week here." He was asked about this shower schedule. He stated, "My showers are in the evening on Monday and Thursday...I go to dialysis on Tuesday, Thursday, and Saturday...I leave at 6:30 in the morning and get back around noon. I have a paracentesis every Friday...I got a shower this week on Monday night. That's the	F 725		

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F 725	Continued From page 15 first one I got since the Monday before. I'll be honest with you they did come in there at 10:30 on Thursday night and offer me one and I refused...it was too late and I was tired...but I've never had four showers in a week, not even at home. That's a lie." The above information was discussed with the administrator and the DON (director of nursing) during an end of the day meeting on 12/04/2019. No further information was obtained prior to the exit conference on 12/05/2019. THIS IS A COMPLAINT DEFICIENCY. 2. Resident #9 was admitted to the facility originally on 02/05/08. The resident had diagnoses of anemia, high blood pressure, neurogenic bladder, history of a stroke with right side hemiplegia, depression, and aphasia. The resident's most recent MDS (minimum data set) was a quarterly assessment dated 11/19/19. This MDS assessed the resident as having a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed on this MDS as requiring extensive assistance of one staff person for transfers, dressing and hygiene and total assistance of one staff member for actual bathing. Resident #9 attended the group meeting conducted on 12/03/2019 at 3:30 p.m. The resident expressed concerns over not getting bathed. Resident #9's clinical records were reviewed. The resident's CCP documented, "...Bathing:	F 725	**1.Immediate action was taken upon identification of this deficiency. The Administrator and the Director of Nursing have set the position of Shower Aide on each unit to insure that every resident receives his or her shower when they are supposed to receive them.** **2.100% audit completed following identification of deficiency.** **3.Shower logs will be in place to insure they days and times each resident is to get his/her shower.** **4.Director of Nursing will review the POC (charting by CNAs) daily to insure all were given or charted if refused.** **5.Facility will be in compliance of this deficiency by 1/10/20.**	

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F 725	Continued From page 16 Provide a sponge bath when a full bath or shower cannot be tolerated PRN [as needed]...Resident prefers showers...Personal Hygiene...requires assistance...re-approach and redirect if resistive to care...keep routine consistent and try to provide consistent care givers as much as possible..." Resident #9 was interviewed in private on 12/04/19 11:15 AM. The resident stated that she prefers a shower and that her baths/showers are scheduled for Wednesday and Saturday during the day. The resident stated that she is only getting one shower per week and prefers two showers a week on the days set. The resident stated that staff do not come to inform you that you aren't getting a bath or shower, that you just don't get it. The resident also stated that she cannot go to the bathroom herself and is incontinent of urine and stool at times. The resident stated that staff will clean/wash her 'down' there when that happens, but that isn't enough and they don't wash her anywhere else. The resident was asked if she ever refuses a bath or shower. The resident stated, "No." The resident also stated that her hair has only been getting washed once a week. The resident stated that she did not think that the facility had enough staff to give baths and showers like they are supposed to. The resident's progress notes were reviewed and there was no documentation found that indicated the resident refused any baths/showers or that the resident was unable to tolerate a shower or bath for any reason. The resident's bathing records were reviewed from August 2019 to present (December 2019).	F 725		

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During the month of August 2019 the resident only had five showers for the entire month. The resident had a total of five showers for the month of October 2019. The resident had a total of seven showers for the entire month of November 2019. The resident had two documented showers on 11-7 shift on a Sunday and a Monday during the month of December 2019. These are not the resident's bath days and baths/showers are not given on 11-7 shift.

On 12/04/19 at 12:00 noon, CNA (certified nursing assistant) # 1 (assigned to the wing where Resident #9 lives) was interviewed. This CNA stated that there is not a set person to do baths/showers. The CNA stated that this task is usually rotated amongst the CNAs and that before it's assigned they (nursing) will usually ask (CNAs) who wants to do showers and it can be assigned that way. This CNA stated that on this wing of the facility, showers are only given on day shift, not on 3-11 shift and not on 11-7 shift. The CNA was asked about documentation for a resident on this unit getting a bath on 11-7 shift. The CNA stated that would be wrong, they (staff) only give baths and showers on day shift.

The CNA stated that normally they have three CNAs on the floor (each wing) to do care for the whole unit and one person to do all the showers scheduled for that day. The CNA stated it's hard to get it all done and that they (staff) are rushed. The CNA stated that she will stay past her shift, if needed to ensure all showers are done, but doesn't know if everyone does that. The CNA stated that if someone calls out or just doesn't show up, then the shower aide will be pulled to the floor and baths and showers don't get done. The CNA stated that, that doesn't happen on a

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F 725	Continued From page 18 regular basis, but it has happened. The CNA stated that it's rough when it does happen and you are rushed trying to make sure everyone is done, clean and happy. The CNA stated that for whatever reason Wednesdays and Saturdays are the days that seem to be the worst. The CNA stated that staff will call out or not show up. On 12/04/19 at approximately 3:00 PM, the DON (director of nursing) and administrator were made aware of the above concerns. The DON and administrator stated that they (facility) were hiring and had openings listed on a specified hiring website online. No further information was provided. No further information and/or documentation was presented prior to the exit conference on 12/05/19 at 5:00 PM.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		

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F 732	Continued From page 19 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure nurse staffing information was posted on a daily basis, at the beginning of each shift in prominent place, and readily accessible to residents and visitors. Findings include: During a complaint survey on 12/03/19 through 12/05/19 the nursing facility and nursing units were observed for nurse staff posting. No nurse staff posting could be located on A wing or B wing of the facility. No nurse staff posting was found in the facility on 12/03/19. On 12/03/19 at 10:45 AM, LPN (Licensed Practical Nurse) #2 was interviewed on B wing	F 732		

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F 732	Continued From page 20 about nurse staff posting. LPN #2 stated, "It's right here." The LPN then retrieved a clipboard from behind the nurse's station. LPN #2 was asked if this was posted on this unit where it's accessible and visible to residents and/or visitors. The LPN stated this is where we keep it (on the clipboard) on the unit and stated that she thought it was also posted by the DON's (director of nursing) office. The DON's office was then observed. No nurse staff posting was observed outside of the DON's office. The DON's office had a small alcove area where the nurse staff sheet was posted. This sheet was not readily accessible or visible to residents and/or visitors. The A wing was then observed at 10:50 AM and LPN #1 was asked where the nurse staff posting was located. LPN #1 pointed to a clipboard that was turned over on top of the nurse's station. The LPN picked it up and turned it over. LPN #1 stated that they keep it on the clip board, turned over. LPN #1 stated that they normally don't post it. The LPN was asked about the staff listed for A wing on the sheet and it was confirmed that the staffing was incorrect for 12/03/19. On 12/03/19 at 11:00 AM, the DON was interviewed regarding nurse staff posting. The DON stated that it is posted up near the receptionist's desk. The DON then pointed out the nurse staff posting, which was behind the receptionist's desk on the wall. The posting was not in a clear and readable format, was not in a prominent place, and was not readily accessible or visible to residents and visitors.	F 732	**1. Immediate action was taken upon identification of this deficiency. A whiteboard in the hallway on each unit.** **2. All residents were affected equally with this defiency.** **3. Boards updated daily and every shift with the names of the CNAs on duty and what rooms they are assigned to, as well as the names of nurses on duty and what rooms are assigned to them.** **4. Unit managers will audit the boards daily for completion under direction of DON.** **5. Facility will be in compliance of this deficiency by 1/3/20.**	

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F 732	Continued From page 21 The sheet listed the projected staffing for each shift for the entire 24 hours, it was not unit specific and was not actual. The nurse staff posting was not completed prior to each shift, for each shift and was not posted in a manner that was specific to each unit/wing. On 12/03/19 at 11:30 AM, the DON did not provide any information as to why the nurse staff posting was not on each unit and easily and readily accessible to residents and visitors. No further information and/or documentation was presented prior to the exit conference on 12/05/19 at 5:00 p.m.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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F 758	Continued From page 22 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to ensure one of 29 residents, Resident #2, was free from an unnecessary medication, Ativan/Lorazepam. Findings were: Resident #2 was admitted to the facility on 02/19/2019 with the following diagnoses including	F 758	**1.Upon identification of this deficiency, process was put in place for assessing patient's prior to giving psychotropic medications regardless of if Hospice or not to insure we aren't giving unneeded medications - if staff does the assessment and resident doesn't meet criteria for medication they are to notify the physician on call and the Director of Nursing.** **2. Facility completed a 100% audit following the identification of this deficiency and identified all residents affected.** **3. Facility has implemented weekly risk assessment meetings to review all residents on psychotropic medications to review stop dates and review dates.** **4.Weekly audits of psychotropic medications will be completed and reviewed by DON.** **5. Facility will be in compliance with this deficiency by 1/3/20.**	

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but not limited to: Chronic diastolic (congestive) heart failure, AFTT (adult failure to thrive), dementia with behaviors, anxiety disorder and Type II diabetes mellitus.

Resident #2 died at the facility on 03/03/2019. A complete MDS (minimum data set) had not yet been completed. Per the admission nursing note dated 02/19/2019, "Resident's functional status on admission was as follows: Transfers performed by staff; Ambulation Non-ambulatory, Mobility bedbound...Oral hygiene performed by staff...Eating totally fed by staff (NO participation at all)....behavior noted on Admission is, Anxious/Restless. Psychotropic medication review history is as follows:...antianxiety: Ativan...Level of consciousness is Alert & oriented to person with the following observations hearing impaired...Neurological symptoms are Memory Loss and Musculoskeletal symptoms are Positioning problems Impaired Coordination Weakness...hospice patient."

A physician progress note dated 02/22/2019 contained the following information: "...followed by....hospice was admitted to the hospital after becoming overwhelmed by her behaviors at home as sole caregiver. Her daughter has lived with her at her house over the last 16 months approximately. She tells me that the patient [Resident #2] has had a sharp decline over the last 2 weeks and has been more confused with the inability to be mobile around the house like she normally was with increased agitation and minor injuries, She [care giver] is unable to take care of the patient anymore and they revoked hospice care and brought her to the hospital. She had been falling at home more and the daughter is [sic] been having to catch her...the confusion

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has significantly worsened and there were some reports of more agitation over the last few nights...her pain has been minimal and well controlled. Daughter is grateful for care and support and very involved in her care. She would like to avoid any further trips to hospital and expects her to pass peacefully here...Continue hospice care."

The physician orders were reviewed. Resident #2 was ordered: "02/25/2019 Ativan 2 mg/ml (Lorazepam) Give 0.5 mg sublingually three times a day for Agitation; Anxiety ***in addition to Q4 hour PRN*** [every four hours as needed]; 02/23/2019 Lorazepam Intensol Concentrate 2 mg/ml ...Give 0.5 mg by mouth every 4 hours as needed for anxiety; 02/23/2019 Lorazepam Intensol Concentrate 2 mg/ml...give 1 mg by mouth every 4 hours as needed for severe anxiety."

The general nursing notes for Resident #2 were reviewed. On 02/21/2019 a note was written documenting Resident #2 was up in the hallway pushing a wheelchair and walking into other resident rooms. She had pulled out her Foley. On 02/23/2019 a note documented that she was admitted to hospice. There were no additional nursing notes in the clinical record for Resident #2 until her death on 03/03/2019.

The notes from the hospice agency were reviewed (these notes contained dates only, not times of the visits) and contained the following:

"03/01/2019 HN [hospice nurse] visits with [name]. She is restless and calling out when I try to place her leg back in bed. Otherwise she is quiet. She begins mumbling something over and

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over and is difficult to understand. She never opens her eyes for me...disoriented and unable to answer if she were having any discomfort. She cries out again as I place her on her left side before I leave. The discomfort seen, goes away when she is still...not trying to get out of bed. Inquiry with nurse for [name] for recent medications, comfort. I ask that nurse ask for scheduled lorazepam be stopped and only given PRN..."

"03/02/2019 Visit to establish lethargy/end of life status since scheduled lorazepam has been stopped. [name] doesn't respond when I move her leg further in the bed. She does not respond to sternal rub. Breathing at 20 even and unlabored...HN goes to nurse on floor taking care of [name]. [Nurses name] states that the medication of lorazepam is still scheduled on her med list. I ask whom is the dr on call for the weekend. I then call Dr. [name] and received a VO [verbal order] to stop scheduled lorazepam r/t [related to] unresponsiveness. HN thought this was arranged to be stopped days ago. I fill out a paper sheet that goes in a slot to be placed in the computer and also write a sticky note to be placed in chart where medications are listed, as to not be overlooked and thus over medicated. I also call back at 9pm to make sure that med change has been communicated in report..."

The facility MAR (medication administration record) and coinciding notes were reviewed. Resident #2 received Ativan as scheduled three times a day from 02/26/2019 through 02/28/2019. On 03/01/2019, she did not receive her scheduled medications including her Ativan at 9:00 a.m., or 1:00 p.m. Per the MAR notes the medications were not given because she was "to

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F 758	Continued From page 26 [sic] lethargic" Ativan was administered at 5:00 p.m. on 03/01/2019 and at 9:00 a.m. and 1:00 p.m. on 03/02/2019. An EMAR note dated 03/03/2019 at 1:25 a.m., contained the following: "Res was very lethargic all shift. Hospice nurse received v/o [voice order] to hold lorazepam. Res did not take any meds this shift..." On 12/04/2019 at approximately 9:10 a.m., the hospice nurse that had cared for Resident #2 was interviewed regarding the scheduled Ativan that Resident #2 received. She stated, "[Name of Resident #2] had been our [hospice] patient before she went to the facility. Her daughter had gotten sick and couldn't take care of her at home so she went into the hospital and was then sent to [name of facility]. [Resident name] had been restless and we had the scheduled Ativan on board for her, but when I went in on March 1 she was very sleepy. I thought we needed to stop the scheduled Ativan and just go with the PRN dosage. I spoke with the nurse taking care of her. [The hospice nurse did not remember the nurse's name]. She said she would take care of it...when I went back in the next day to followup [Resident #2] was unresponsive. I did a sternal rub and got nothing. I talked to her nurse about her medications and asked if the Ativan had been stopped as requested. She told me that it was still scheduled and she was giving it. I told her it was supposed to have been stopped. I asked her what I needed to do to get it taken care of. She told me and I wrote the order and contacted the physician...there was definitely an increase in [Resident #2]'s lethargy and unresponsiveness from the time I was there from one day until the next...I don't know why they kept giving her the scheduled Ativan after I asked them to stop but she didn't need it...I called back that night to	F 758		

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F 758	Continued From page 27 make sure they had stopped it and they had." The unit manager was interviewed on 12/04/2019 at approximately 9:30 a.m. The nurse's names in the clinical record and on the MAR were reviewed. The unit manager stated that those nurses were no longer at the facility. She was asked about the documentation. She stated, "There should be more documentation. I don't know why they were still giving her the scheduled Ativan if she was that sleepy, I really can't tell from the record what was going on or why she got it after the hospice nurse asked them to stop." The above information was discussed during an end of the day meeting with the facility administrator and DON on 12/04/2019. No further information was obtained prior to the exit conference on 12/05/2019.	F 758		
F 841 SS=F	THIS IS A COMPLAINT DEFICIENCY. Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility failed to ensure resident orders were signed off by the	F 841		

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F 841	Continued From page 28 physician and/or alternate provider for all 102 residents in the facility; the Medical Director was aware that there was not a system in place for approximately 6 months and failed to implement care policies to address the problem. Findings include: During the complaint survey process, twenty eight residents were added to the survey sample. Medical records for all twenty eight resident were reviewed and found that the residents' physician's orders were not being signed off. On 12/04/19 at approximately 1:50 PM, a meeting was held with the DON (director of nursing) and the administrator. The aboveconcerns were shared regarding the lack of physician signatures on the residents' orders. The DON and administrator were asked to provide the physician's orders of the sampled residents to verify the physician and/or providers had signed off on the residents' orders. On 12/05/19 at approximately 11:00 AM, the administrator, DON and the VPCS (vice president of clinical services) stated that while attempting to provide the requested information to the survey team, they became aware that none of the resident orders had been signed off by the physician or provider. The DON and administrator stated that they were not aware of this until 10:00 AM this morning (12/05/19). The DON and administrator both stated that no one had reported this to them and they were unaware that the physician had not been signing the resident orders. On 12/05/19 at approximately 11:30 AM, the DON	F 841		

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F 841	Continued From page 29 stated that the Medical Director was on his way into the facility to sign all resident orders. The Medical Director was interviewed via phone on 12/05/19 at 2:00 PM with the survey team. The Medical Director stated that the company took new ownership in July (07/01/19) and apparently that is when the orders were no longer being able to be signed. The Medical Director stated that he was aware of it, but didn't bring it up and that the facility didn't bring it up. The Medical Director was made told that the DON and administrator were not aware until today. The Medical Director stated that he just didn't think to bring it up. The Medical Director stated that every order has now been signed and that they were doing triplicate orders (paper) and that the DON should have that information. The Medical Director stated that the staff and himself included, had all made assumptions, and that the process was broken. The Medical Director stated that the facility's company decided not to purchase that feature of the electronic record (for physician's to sign). The DON, administrator and VPCS were interviewed with the survey team at 2:30 PM. The facility staff were asked to present any evidence physician signatures as stated above by the physician. A policy was requested at this time on attending physician responsibilities. The policy, "Attending Physician Responsibilities" was presented and reviewed. The policy documented, "....Providing appropriate, timely medical records...Providing appropriate, timely, and pertinent documentation...the physician will guide staff, and help document, the basis for decisions and orders...the physician will provide	F 841	**1.Immediate action was taken upon identification of this deficiency. All open orders and progress notes were printed and reviewed by the Medical Director, who then signed all and had them scanned into residents' medical records.** **2. 100% audit was completed and all residents were affected.** **3.All nursing staff is instructed on procedure of taking orders and have them signed off on appropriately.** **4.Director of Nursing will check all orders daily to insure that they have been signed off by the physician and that they are given to Medical Records to scan into patient records.** **5. We are currently in compliance of this deficiency immediately following survey.**	

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F 841	Continued From page 30 orders to ensure that individuals have appropriate comfort and supportive measures...will provide timely and appropriate medical records...the physician will verify the accuracy of verbal orders when they are then given and will authenticate, co-sign, and date them in a timely manner no later than the next visit to the resident..." No further information and/or documentation was presented prior to the exit conference on 12/05/19 at 5:00 PM to evidence that the attending physician, Medical Director and/or provider had been signing off on all resident orders.	F 841		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		

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

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 32 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure electronic medical records were complete and accurate for all 102 residents in the facility. The facility staff failed to ensure all resident's physician's orders were signed off by the physician in their electronic medical record. Findings include: During the survey process, a total of 28 record (current and closed) reviews were conducted. Resident #10 was admitted to the facility on 04/02/19 and expired on 05/18/19. Diagnoses for Resident #10 included, but were not limited to: Chronic atrial fibrillation, anemia, pulmonary hypertension, depression, chronic kidney disease, mitral valve insufficiency, history of DVT (deep vein thrombosis), and left AKA (above knee amputation). The resident's most current MDS (minimum data set) was a 5 day admission assessment dated 04/09/19. This MDS assessed the resident with a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident required extensive to total assistance with assistance of at least one staff person for all ADL's (activities of daily living). The resident was a full code upon admission to the facility on 04/02/19. It was documented in the	F 842		

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physician's progress note dated 04/04/19 that the resident requested to be a DNR (Do Not Resuscitate)/no CPR (Cardio-Pulmonary Resuscitation). The physician continued to document the above in the physician progress notes.

On 05/17/19 the resident's son signed a DDNR (Durable Do Not Resuscitate) order. The physician did not sign this form.

During the clinical record review, the resident's electronic medical records were reviewed. The resident had a DNR order. This order was not signed by the physician until 05/27/19 via password via phone.

Additional residents within the facility were added to the survey sample for verification of physician signatures on all resident physician orders. During the review of 28 sampled residents it was found that all residents had physician's orders, but all of the physician's orders were not signed by the physician or provider.

On 12/04/19 at approximately 1:50 PM, a meeting was held with the DON (director of nursing) and the administrator. The above concerns were shared regarding the lack of physician signatures on the residents' orders. The DON and administrator were asked to provide the physician's orders of the sampled residents to verify the physician and/or providers had signed off on the residents' orders.

On 12/05/19 at approximately 11:00 AM, the administrator, DON and the VPCS (vice president of clinical services) stated that while attempting to provide the requested information to the survey

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team, they became aware that none of the resident orders had been signed off by the physician or provider. The DON and administrator stated that they were not aware of this until 10:00 AM this morning (12/05/19). The DON and administrator both stated that no one had reported this to them and they were unaware that the physician had not been signing the resident orders.

On 12/05/19 at approximately 11:30 AM, the DON stated that the Medical Director was on his way into the facility to sign all resident orders.

At approximately 12:00 PM, the UM (unit manager) on A wing was interviewed. The UM stated that she did not notice that resident orders were not signed by the physician. The UM stated that when the facility used a paper chart, the nurses would "red line" order and that this was done when the 24 hour chart checks were done. The UM was asked how they do chart checks now with an electronic record. The UM stated that she really didn't know. The UM stated that she is the one on the unit who usually puts orders into the computer and that it was assumed that the physician goes in behind and signs. The UM stated that nothing looks different in the computer system. The UM was asked how she would be able to verify that all of the orders were signed by the physician. The UM stated, "I wouldn't unless I go in [computer] and open each individual order for each resident." The UM was asked if she does a 24 hour check or some type of check to ensure that orders are signed. The UM stated that she usually goes into the computer every couple of days and does checks. The UM stated, "I'd like to say that I do it everyday, but I don't." The UM stated that nothing looked any different

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F 842	Continued From page 35 to her. A policy was presented on telephone orders. The policy documented, "...verbal orders may only be received by licensed personnel...recorded in the medical record...must be countersigned by the physician during his or her next visit..." A policy was presented on electronic medical records. The policy documented, "...the administrator...quality assurance...shall review requests for and the implementation of our electronic medical records system...the facility permits the use of electronic signatures and orders in accordance with recognized standards and laws...health care providers wishing to use an electronic signature and/or place electronic orders must have a signature card on record with the facility. The Medical Director was interviewed via phone on 12/05/19 at 2:00 PM with the survey team. The Medical Director stated that the company took new ownership in July (07/01/19) and apparently that is when the orders were no longer being able to be signed. The Medical Director stated that he was aware of it, but didn't bring it up and that the facility didn't bring it up. The Medical Director was made told that the DON and administrator were not aware until today. The Medical Director stated that he just didn't think to bring it up. The Medical Director stated that every order has now been signed and that they were doing triplicate orders (paper) and that the DON should have that information. The Medical Director stated that the staff and himself included, had all made assumptions, and that the process was broken. The Medical Director stated that the facility's company decided not to purchase that	F 842	**1.Immediate action was taken upon identification of this deficiency. All verbal orders were printed and reviewed by the Medical Director, who then signed all and had them scanned into residents' medical records.** **2. 100% audit was completed and all residents were affected.** **3.All nursing staff is instructed on procedure of taking orders and have them signed off on appropriately.** **4.Director of Nursing will check all orders daily to insure that they have been signed off by the physician and that they are given to Medical Records to scan into patient records.** **5. We are currently in compliance of this deficiency immediately following survey.**	

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	495146	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HARRISONBURG LLC	94 SOUTH AVENUE HARRISONBURG, VA 22801

(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
F 842	Continued From page 36 feature of the electronic record (for physician's to sign). The DON, administrator and VPCS were interviewed with the survey team at 2:30 PM. The facility staff were asked to present any evidence physician signatures as stated above by the physician. No further information and/or documentation was presented prior to the exit conference on 12/05/19 at 5:00 PM to evidence that the physician and/or provider had been signing off on all resident orders.	F 842		