DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL VIRGINIA BEACH	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/19/2019 through 11/22/2019. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	1. The Facility's Emergency Preparedness Plan has been revised and updated to ensure that an annual review of the EOP's Communication Plan was completed and the EOP was updated to reflect the Communication Plan's impact. 2. The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. 3. The Administrator has reviewed the Emergency Preparedness Planand reviewed the required items and training to be completed for compliance. All staff will be in-serviced by the administrator/designee on the Emergency Preparedness Plan. 4. The Administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance meeting for three months with a subsequent Plan of Correction as needed.	01/03/2020
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's Emergency Preparedness Program the facility failed to conduct an annual review of the Communication Plan. The findings included: A review of the Facility's Emergency Preparedness Program conducted on 11/21/2019 at 3:00 p.m., with the Facility Administrator revealed, the Facility Communication Plan was not reviewed annually. Upon inquiry, the Administrator stated, "We have not reviewed the Communication Plan since June of 2018." No additional information to support compliance with the requirement was provided prior to exit.	E 029		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emilie Bettencourt | TITLE: Administrator | (X6) DATE: 12/11/2019

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

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F 000	Continued From page 1 survey was conducted 11/19/2019 through 11/22/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 90 bed certified bed facility was 82 at the time of survey. The survey sample consisted of 31 current Resident reviews and 6 closed record reviews.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625	1. Residents #42 their RP have been notified that the facility failed to review and offer notice of bed-hold when Residents #42 was discharged to the hospital. An Incident and Accident form has been completed for this incident. 2. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers performed a one-time audit with current resident population to validate that each resident received the bed hold policy upon transfer to a hospital or the resident goes on therapeutic leave. 3. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will in-service Licensed Nurses to the facility's policy and procedures in regards to providing the resident and/or resident representative written notice which specifies the duration of the bed hold policy. 4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Manager will audit transferred residents 2 times a week for 4 weeks, then once a week for 4 weeks and once a month for 3 months to ensure each resident received the bed hold policy upon transfer to a hospital or the resident goes on therapeutic leave. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance meeting for three months with a subsequent Plan of Correction as needed.	01/03/2020

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F 625	Continued From page 2	F 625		

hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written bed hold notification at the time of an acute transfer to the hospital for one of 37 residents in the survey sample, Resident #42.

The findings included:

Resident #42 was admitted to the facility on 1/17/19 and readmitted on 9/9/19 with diagnoses that included but were not limited to Type 2 diabetes mellitus, and hemiplegia (left side paralysis following stroke). Resident #42's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 9/19/19. Resident #42 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #42's clinical record revealed that she had been sent out to the hospital on 5/23/19. There was no evidence in the clinical record that written bed hold notification was sent with Resident #42 at the time of transfer. Further review of Resident #42's clinical record revealed that she returned to the facility on 5/28/19 and was admitted to the same room.

On 11/21/19 at 1:11 p.m., an interview was conducted with OSM (Other Staff Member) #9, in

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F 625	Continued From page 3 admissions. When asked at the time of an acute care transfer, who was responsible for sending written bed hold notification with the resident, OSM #9 stated that the nurses were responsible for sending the notice. OSM #9 stated that she will follow up the next day with the resident and/or responsible party regarding the bed hold. OSM #9 stated a lot of the times she will visit the resident the following day at the hospital. OSM #9 stated that she could not find a copy of the signed bed hold notice for Resident #42 for her 5/23/19 transfer. On 11/21/19 at 1:30 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the unit manager. When asked what documents nurses were supposed to send with the resident at the time of an acute care transfer to the hospital, LPN #1 stated that nurses were supposed to send the face sheet, list of medications/treatments, and the discharge summary. When asked if bed hold notification should be sent, LPN #1 stated that bed hold notification was usually attached to the discharge summary. When asked how to determine if the bed hold notice was sent if it was not attached to the discharge summary, LPN #1 stated that a nursing note should be documented reflecting the paperwork that was sent at the time of transfer. On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. Facility policy titled, "Bed hold Prior to Transfer, " documents in part, the following: "Prior to	F 625		

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F 625	Continued From page 4 transferring a resident to the hospital, the facility will provide written information to the resident and/or the resident representative regarding bed hold." No further information was presented prior to exit.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640	1. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance meeting for three months with a subsequent Plan of Correction as needed. 2. The Resident Care Coordinator and/or designee performed a one-time audit with current resident population to ensure all residents current Minimum Data Set assessments were completed and discharge assessments have been transmitted as required. 3. The facility's Policy and Procedure have been reviewed and no changes are warranted at this time. The facility's Minimum Data Set department has been in-serviced by the Regional Nurse Consultant on the requirements for discharge assessment transmittal found in the Resident Assessment Instrument manual. All discharges will now be reviewed each week to assure transmission has been completed as required. 4. The Resident Care Coordinator will audit all discharge assessments 3 times a week for 4 weeks, then once a week for 4 weeks and once a month for three months to ensure all discharge assessments are transmitted within the required time frame. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	01/03/2020

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F 640	Continued From page 5 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to transmit a discharge assessment within the required time frame for two of 37 residents in the survey sample, Residents #1 and #2. The findings included: 1. Resident #1 was admitted to the facility on 5/30/19 and discharged on 6/21/19 with diagnoses that included but were not limited to Hemiplegia (paralysis on left side). Resident #1's most recent MDS (Minimum Data Set) assessment was a discharge assessment with an ARD (assessment reference date) of 6/21/19. Resident #1 was coded as being severely impaired in cognitive function scoring 00 out of possible 15 on the BIMS (Brief Interview for	F 640		

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F 640	Continued From page 6 Mental Status) exam. Review of Resident #1's clinical record revealed that she was transferred to the hospital on 6/21/19 due to altered mental status. Resident #1 did not return to the facility. Further review of Section Z (assessment administration) of her discharge MDS assessment revealed that her discharge MDS was not completed until 11-7-19 (over 4 months after discharge). Review of "Transmission Results Summary" revealed that her MDS was not transmitted to CMS (Centers for Medicaid/Medicare) until 11/15/19. On 11/22/19 at 2:05 p.m., an interview was conducted with OSM (other staff member) #1, the MDS coordinator. When asked when a discharge assessment should be completed for a discharged resident, OSM #1 stated that a discharge assessment should be completed 14 days after the discharge date. When asked why Resident #1's discharge assessment was not completed until 11/7/19, OSM #1 stated that the facility did not have an MDS coordinator back in June and staff from corporate were coming in and helping out with MDS assessments. OSM #1 stated that her MDS was missed. When asked when the MDS should be transmitted to CMS, OSM #1 stated that the MDS should be transmitted 14 days after the assessment completion date. OSM #1 stated that since the MDS assessment was late than the transmit date was also be late. OSM #1 stated that she used the RAI (resident assessment instrument) manual as a reference when completing the MDS.	F 640		

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F 640	Continued From page 7 On 11/22/19 at approximately 2:30 p.m., OSM #1 brought documentation from the RAI 3.0 MDS manual. The following was documented: "P 2-17: Assessment Type/Item set: Discharge Assessment; MDS completion Date: No later than Discharge date + (plus) 14 calendar days...Transmission date no later than MDS completion date + 14 calendar days." On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. No further information was presented prior to exit. 2. Resident #2 was admitted to the facility on 06/28/2019. Diagnosis included but were not limited to, Compression of Brain and Aphasia. Resident #2's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 07/05/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #2 as requiring supervision with set up help only with bed mobility, transfer, dressing, eating and toilet use, supervision with 1 person assist with personal hygiene and physical help of 1 in part of bathing activity. On 11/22/2019 review of Resident #2's clinical record revealed that the last MDS completed was an Admission Assessment dated 07/05/2019. Review of Resident #2's Face Sheet revealed that he was discharged from the facility on	F 640		

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F 640	Continued From page 8 07/30/2019. An interview was conducted with the MDS Coordinator on 11/22/2019 at 2:00 p.m., and she stated, "(Residents Name) was discharged and a Discharge Assessment was not completed until 10/03/2019." The MDS Coordinator provided a copy of the Discharge Assessment with a completion date of 10/03/2019. The MDS Coordinator explained that during this time period the facility did not have a MDS Coordinator and the corporate staff were coming in and assisting and the resident had been missed. The MDS Coordinator stated that she was new to the position and facility. The MDS Coordinator was asked, "What is the process for completing the discharge assessment?" MDS Coordinator stated, "The facility must complete a discharge assessment within 14 days after the discharge date. It must be transmitted within 14 days after completing the MDS Discharge Assessment." The MDS Coordinator was asked to provide evidence that the Discharge Assessment was sent to CMS (Centers for Medicare and Medicaid Services). On 11/22/2019 at 2:40 p.m., the MDS Coordinator stated, "I checked and the Discharge Assessment completed on 10/03/2019 was not submitted to CMS, I submitted it today." The MDS Coordinator provided the Surveyor a copy of the Final Validation Report with a submission date of 11/22/2019. The Administrator, Assistant Director of Nursing, Vice President of Operations and Corporate Nurse Consultant were informed of the findings at the exit meeting on 11/22/2019 at approximately 3:45 p.m. The facility did not present any further	F 640		

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F 640	Continued From page 9 information about the findings.	F 640		
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 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	F 656	1. Resident #5's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include their diagnosis of Diabetes Mellitus and their smoking habit. 2. The Director of Nursing, Assistant Director of Nursing, and/or Unit Manager performed a one-time audit with current resident population to identify residents with inaccurate or incomplete comprehensive care plans. 3. The Regional Nurse Consultant in-serviced the Director of Nursing, Resident Care Coordinator, and Interdisciplinary Team on the development, revision and implementation process of individualized care plans. 4. The Director of Nursing and/or Resident Care Coordinator will audit 5 residents 3 times a week for 4 weeks, then once a week for 4 weeks, and once a month for 3 months to ensure residents comprehensive care plans are accurate. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	01/03/2020

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F 656	Continued From page 10	F 656		

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 observation, resident interview, staff interview, facility documentation review and clinical record review the facility staff failed to develop a complete comprehensive care plan to include Diabetes Mellitus and that the resident was a smoker, for 1 of 37 residents in the survey sample, Resident #5.

The findings included:

1a. Resident #5 was admitted to the facility on 11/06/2019. Resident #5 was discharged from the facility on 07/26/2019 and readmitted to the facility on 07/30/2019. Diagnoses included but were not limited to, Diabetes Mellitus and Hypertension.

Resident #5's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 08/06/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment.

On 11/21/2019 review of Resident #5's clinical record revealed the following:

The Face Sheet listed "Type 2 Diabetes Mellitus without complications" under Additional Current Diagnosis.

Review of Resident #5's Physician Orders

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F 656	Continued From page 11 revealed an order for "Lantus 100 Unit/ML (Milliliter) vial - Administer 5u (Units) SQ (Subcutaneous) Q (Every) HS (Hour of Sleep)." DX (Diagnosis) - DM2 (Diabetes Mellitus Type 2). Order Date: 07/30/2019. Review of Resident #5's comprehensive care plan on 11/21/2019 did not reveal a care plan for Diabetes Mellitus. On 11/22/2019 at 3:30 p.m., an interview was conducted with the MDS Coordinator. When asked if the resident received insulin, MDS Coordinator stated, "Yes." When asked if Resident #5 had a diagnosis of Diabetes, MDS Coordinator stated, "Yes." When asked if Diabetes Mellitus was addressed in the residents care plan, MDS Coordinator stated, "No." When asked if Diabetes Mellitus should be included in the residents care plan, MDS Coordinator stated, "Yes." When asked what the purpose of the care plan was, MDS Coordinator stated, "The care plan is a summary of what we are doing for the resident." The Administrator, Assistant Director of Nursing, Corporate Nurse Consultant and Vice President of Operations was informed of the findings at the pre-exit meeting on 11/22/2019 at 12:30 p.m. The facility did not present any further information about the findings. 1b. On 11/19/2019 at approximately 6:45 p.m., a list of residents in the facility that smoke was requested. During the initial tour of the facility on 11/19/2019 at approximately 7:15 p.m., Resident #5 was sitting in his wheel chair and he stated, "I just	F 656		

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F 656	Continued From page 12 came back inside, I've been outside smoking." On 11/20/2019 at approximately 9:00 a.m., a list of the residents in the facility who smoke was received along with the facility Smoking Policy and Smoking Schedule. Review of the list revealed Resident #5 was on the list. On 11/22/2019 review of Resident #5's comprehensive care plan revealed a problem that read as follows: "Res. (Resident) continues to use code to exit building to smoke - Family provides code; Res. watches staff." The care plan did not include a goal or approaches for smoking. On 11/22/2019 at approximately 3:00 p.m., an interview was conducted with Resident #5. When asked if he kept cigarettes in his room, Resident #5 stated, "No, the staff keep the cigarettes and lighter at the nurses desk." When asked if he went outside and smoked by himself, Resident #5 stated, "No, they have set smoking times and the staff supervise." The Administrator, Assistant Director of Nursing, Corporate Nurse Consultant and Vice President of Operations were informed of the findings on 11/22/2019 at approximately 3:45 p.m. The facility did not present any further information about the findings. On 11/22/2019 at approximately 4:00 p.m., an interview was conducted with the MDS Coordinator. When asked if the resident smoked, MDS Coordinator stated, "Yes." When asked where the resident gets his cigarettes from, MDS Coordinator stated, "He gets cigarettes from his friends that visit and uses the code to exit the	F 656		

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F 656	Continued From page 13 building to smoke." When asked if the resident's care plan problem addressing smoking was complete, MDS Coordinator stated, "No, it needs interventions."	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. (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, facility document review and clinical record review, it	F 657	1. Resident #4's comprehensive care plan has been reviewed and revised to accurately reflect the resident's fall interventions. 2. The Resident Care Coordinator or designee will perform a one-time audit with current resident population to ensure care plans have been updated appropriately. 3. The Regional Nurse Consultant will in-service Licensed Nurses on care plan revision for fall interventions. The Director of Nursing and Interdisciplinary Team will review falls in clinical morning meeting and will be reviewed in the facility's weekly Risk meeting to validate compliance. 4. The Director of Nursing and/or Resident Care Coordinator will audit all residents with falls once a week for 3 months to ensure care plans are revised and reflects current fall interventions. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	01/03/2020

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F 657	Continued From page 14 was determined that facility staff failed to revise the care plan for one of 37 residents in the survey sample, Resident #4. The findings included: Resident #4 was admitted to the facility on 5/12/15 with diagnoses that included but were not limited to Alzheimer's disease, Delusional disorders, lack of coordination. Resident #4's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/2/19. Resident #4 was coded as being severely impaired in cognitive function scoring 09 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #4's fall risk care plan dated 11/1/19 documented the following intervention: "Wear clip alarms as ordered." On 11/19/19 through 11/20/19 several observations were made of Resident #4; she did not have a clip alarm in place. Review of Resident #4's November 2019 POS (physician order summary) revealed that she did not have a current order for a clip alarm. Further review of Resident #4's POS revealed an order for a clip alarm that was discontinued on 11/6/19. On 11/21/19 at 1:40 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the unit manager. When asked who was responsible for revising the care plan, LPN #1 stated that any nurse could revise the care plan with any new changes in the resident's care and with new orders. When asked the purpose of the	F 657		

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F 657	Continued From page 15 care plan, LPN #1 stated that the purpose of the care plan was to serve as a guide of care for each resident. LPN #1 confirmed that Resident #4's clip alarm was discontinued and should have been removed from the care plan. On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. Facility policy titled, "Care Plan- Comprehensive" documents in part, the following: "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans..."	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice and document the amount of insulin actually given for three of 37 residents in the survey sample, Resident #42, #19 and #53. The findings included: For Resident #42, #19 and #53, Licensed	F 658	Resident # 42's physician has been notified that facility staff failed to document the amount of insulin actually given on 11/2/19,11/6/19, 11/15/19, 11/17/19, 11/18/19 and 11/20/19. An incident and accident form has been completed for these incidents. Resident # 19's physician has been notified that facility staff failed to document the amount of insulin actually given on 11/1/19 and 11/2/19. An incident and accident form has been completed for these incidents. Resident # 53's physician has been notified that facility staff failed to document the amount of insulin actually given on 11/3/19, 11/8/19, and 11/19/19. An incident and accident form has been completed for these incidents.	01/03/2020

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F 658	Continued From page 16 Practical Nurse (LPN) #3 was identified as the nurse who inaccurately documented insulin administration. On 11/21/19 at 5:22 p.m., an interview was conducted with LPN #3. When asked if she had ever experienced glitches when documenting in the eMAR (electronic medication record), LPN #3 stated that she was a new nurse to the facility and has only been working at the facility for approximately 2.5 weeks. LPN #3 stated that she was still adjusting to the new computer system. LPN #3 stated that she requested an additional nine more days of training due to the computer system. LPN #3 stated at first when documenting blood sugars; she was entering in the blood sugar amount/reading underneath the section for the amount of units of insulin administered. LPN #3 stated that she was re-educated by administration. LPN #3 stated that she had started employment on 10/29/19 and thought was evaluated on 11/4/19. LPN #3 stated that she had requested 9 more days of additional training on the computer system shortly after that. This writer showed LPN #3 the November MAR for Resident #42. LPN #3 stated that she has never administered the wrong amount of insulin and was always double checking the order with the amount if insulin prepared and administered. LPN # 3 stated she was always "verifying the right dose." When asked if it was important that the MAR reflected the amount of insulin actually administered, LPN #3 stated that it was. LPN #3 stated that it sometimes gets hectic on the nursing floor and that sometimes she will forgot to sign off the medications after they were administered. LPN #3 stated that sometimes she will have to go back later and sign off that the medications were given.	F 658	2. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager performed a one-time audit of all resident's insulin administration documentation. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding. 3. The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced documentation in the medical record/electronic medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licensed staff will be in-serviced by the Director of Nursing, Assistant Director of Nursing, and/or Unit Manager on the policy & procedure for medication administration to include giving at ordered time and physician notification if a medication is held or refused. 4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Manager will audit medication orders 5 times a week for 4 weeks, twice a week for 4 weeks, and once a month for three months to monitor compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting with a subsequent Plan of Correction as needed.	

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F 658	Continued From page 17 On 11/21/19 at 5:42 p.m., an interview was conducted with ASM (Administrative Staff Member) #2 , the ADON (Assistant Director of Nursing). When asked if LPN #3 had any recent medication errors with insulin, ASM #2 stated, "Not that I am aware of." ASM #2 stated that LPN #3 was a brand new nurse to their facility and that she had recently got off orientation. When asked how the facility monitors for medication errors, ASM #2 stated that in morning meetings facility staff will go over new orders and make sure MARS/TARS match the orders but that they did not check all MARS and TARS for medication errors. ASM #2 stated that she thought there was a way to see if a medication was given too early, or the wrong dose administered. ASM #2 stated that she would find out what had happened. When asked if LPN #3 had requested additional training, ASM #2 stated that LPN #3 at first thought she could take on more; but then started to feel overwhelmed with the computer system that she requested additional training with documentation. ASM #2 stated that LPN #3 was evaluated by nursing staff for medication pass before she took on an assignment on her own. On 11/22/19 at 10:45 a.m., further interview was conducted with ASM #2. ASM #2 stated that she looked into the above dates of insulin administration, as well as interviewed LPN #3 and determined that LPN #3 was not signing off her medication right after administration. ASM #2 stated that by the time LPN #3 was ready to sign off on her medications, she had forgot how much insulin was administered to her residents and would just enter in any number to "just get it signed off." ASM #2 stated that LPN #3 was even called at home on a few occasions to come back into the facility to sign off her medications that	F 658		

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F 658	Continued From page 18	F 658		

were showing up late. ASM #2 stated that on 11/21/19 LPN #3 was removed from the medication cart until this situation was investigated and she was in-serviced on documentation that you must "sign off at that moment." ASM #2 stated that medications should be signed off immediately after administration. ASM #2 stated that she had also started education for the rest of her nurses on documentation after medication administration.

Review of LPN #3's annual competency skill review, revealed that she was signed off on medication administration; including subcutaneous injections and the use of the glucometer on 11/5/19.

A witness statement documented by LPN #3 dated 11-21-19 documented the following: "I (Name of LPN #3) LPN new hire on October 29, 2019 currently on our state survey review. There was /are some discrepancies found on many patient's MAR record for incorrect data entry for insulin administration. Moreover, for the patients that incorrect documentation of insulin presented this writer provided and administered the correct dose of insulin per sliding scale as directed. However the patient's MAR was in fact signed off yet not confirmed by my signature as the nurse. On the other hand, due to not being familiar with this current computer format in the beginning of usage with data entry, failure to confirm all medications given provided with lock signature of this writer presented with many data entry errors of patients insulin administration. So late entry of data with confirmation of my signature presented as incorrect documentation. Lastly, I want to take full responsibility for my incorrect documentation and from this day forward it will be my duty to

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F 658	Continued From page 19 review, verify, and confirm all insulin/all medication data entry. " Specific documentation errors are as follows: 1. Resident #42 was admitted to the facility on 1/17/19 and readmitted on 9/9/19 with diagnoses that included but were not limited to Type 2 diabetes mellitus. Resident #42's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 9/19/19. Resident #42 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #42 was coded in section N (Medications) as receiving insulin injections. Review of Resident #42's November POS (physician order summary) revealed the following order for insulin: "Accucheck AC/HS (before meals)/at bedtime) W/ (with) humalog (1) 100 units/mL (milliliters) vial SSI (sliding scale insulin) BS (blood sugar) 0-60, notify provider (physician) BS 61-200 = 0 units BS 201-250 = 2 units BS 251-300 = 4 units BS 301-350 = 6 units BS 351- 400 = 8 units BS > (greater than) 401, give 10 units and notify provider. Review of Resident #42's November 2019 MAR (Medication Administration Record) revealed that incorrect amount of insulin was documented as administered on 11/2/19, 11/6/19, 11/15/19, 11/17/19, 11/18/19, and 11/20/19. The following	F 658		

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F 658	Continued From page 20 was documented: 11/2/19 11:30 AM Bld_Glu (blood glucose): 334; SubQ (subcutaneous) inj (injection): LLQ (left lower quadrant) (abdomen); Units: 10. 11/6/19 11:30 AM Bld_Glu: 410; SubQ inj: LLQ; Units: 6. 11/15/19 4:30 PM Bld_Glu: 451; SubQ inj: RLQ (right lower quadrant) (abdomen); Units: 6. 11/17/19 11:30 AM Bld_Glu: 322; SubQ inj: RLQ; Units: 8. 11/18/19 8:30 PM Bld_Glu: 402; SubQ inj: LLQ; Units: 6. 11/20/19 4:30 PM Bld_Glu: 392; SubQ inj: LLQ; Units: 6." There was no evidence in Resident #42's clinical record of any adverse outcomes related to the incorrect amount of insulin administered. Further review of Resident #42's November 2019 MAR revealed that one nurse (LPN (Licensed Practical Nurse) #3), was responsible for documenting the incorrect dose of insulin administered on all six occasions. On 11/21/19 at 3:40 p.m., an observation was conducted of LPN #3 obtaining blood sugars and administering insulin on five residents. There were no concerns related to the above findings. Review of the medication administration reports to Resident #42's November MAR revealed that on multiple occasions, there was no evidence of	F 658		

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F 658	Continued From page 21 when LPN #3 had administered insulin to Resident #42. Further review of these reports revealed late administration times of the above insulin. On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. ASM #2 at approximately 1 p.m., presented evidence that LPN #3 was re-educated on the "Administering Medications" policy on 11/21/19. Facility policy titled, "Administering Medications" documents in part, the following: "The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones." No further information was presented prior to exit. 2. Resident #19 was admitted to the facility on 5/22/17 with diagnoses that included but were not limited to Type two diabetes mellitus. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Resident #19 was coded as moderately impaired in cognitive function scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #19 was coded in section N (Medications) as receiving insulin injections. Review of Resident #19's November POS (physician order summary) revealed the following	F 658		

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F 658	Continued From page 22 order for insulin: "Novolog 100 units/mL (milliliters) Flexpen AC/HS (before meals)/at bedtime) Novolog per sliding scale FBG (fasting blood sugar) less then 90 = 0U (units) 91-120 = 20U 121-130 = 30U 131-180 = 35U 181-220 = 40U 221- 300 = 50U 301 OR> (greater) = 60" Review of Resident #19's November 2019 MAR (Medication Administration Record) revealed that incorrect amount of insulin was documented as administered on 11/1/19 at 430 p.m. and 8:30 p.m., and 11/2/19 at 11:30 a.m.. The following was documented: 11/1/19 4:30 PM Bld_Glu (blood glucose): 181; SubQ (subcutaneous) inj (injection): LLQ (left lower quadrant) (abdomen); Units: 165. 11/1/19 8:30 PM Bld_Glu: 165; SubQ inj: LLQ; Units: 181. 11/2/19 11:30 AM Bld_Glu: 352; SubQ inj: LLQ; Units: 35." There was no evidence in Resident #19's clinical record of any adverse outcomes related to the incorrect amount of insulin administered. Further review of Resident #19's November 2019 MAR revealed that one nurse (LPN (Licensed Practical Nurse) #3), was responsible for documenting the incorrect dose of insulin administered on all three occasions.	F 658		

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F 658	Continued From page 23 On 11/21/19 at 3:40 p.m., an observation was conducted of LPN #3 obtaining blood sugars and administering insulin on five residents. There were no concerns related to the above findings. Review of the medication administration reports to Resident #19's November MAR revealed that on multiple occasions, there was no evidence of when LPN #3 had administered insulin to Resident #19. On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. ASM #2 at approximately 1 p.m., presented evidence that LPN #3 was re-educated on the "Administering Medications" policy on 11/21/19. No further information was presented prior to exit. 3. Resident #53 was admitted to the facility on 3/6/19 with diagnoses that included but were not limited to Type 2 diabetes mellitus. Resident #53's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/29/19. Resident #53 was coded as being severely impaired in cognitive function scoring 07 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #53 was coded in section N (Medications) as receiving insulin injections.	F 658		

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F 658	Continued From page 24 Review of Resident #53's November POS (physician order summary) revealed the following order for insulin: "Novolog 100 units/mL (milliliters) Flexpen Accuchecks before meals with SSI (sliding scale insulin): 200-249 = 1U (unit) 250- 299 = 2U 300- 349 = 3U 350- 399 = 4U 400-449 = 5U 450-499 = 6U 500-549 = 7U Dx (diagnosis) DM2 (Diabetes Mellitus type 2)." Review of Resident #53's November 2019 MAR (Medication Administration Record) revealed that incorrect amount of insulin was documented as administered on 11/3/19 at 11:30 a.m., 11/8/19 at 11:30 a.m. and 11/19/19 at 4:30 p.m. and 8:30 p.m. The following was documented: 11/3/19 11:30 AM Bld_Glu (blood glucose): 411; SubQ (subcutaneous) inj (injection): LLQ (left lower quadrant) (abdomen); Units: 2. 11/8/19 11:30 AM Bld_Glu: 281; SubQ inj: LLQ; Units: 6. 11/19/19 4:30 PM Bld_Glu: 402; SubQ inj: LLQ; Units: 6. 11/19/19 8:30 PM Bld_Glu: 427; SubQ inj: LLQ; Units: 1." Further review of Resident #53's November 2019 MAR revealed that one nurse (LPN (Licensed Practical Nurse) #3), was responsible for	F 658		

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F 658	Continued From page 25 documenting the incorrect dose of insulin administered on all four occasions. On 11/21/19 at 3:40 p.m., an observation was conducted of LPN #3 obtaining blood sugars and administering insulin on five residents. There were no concerns related to the above findings. Review of the medication administration reports to Resident #53's November MAR revealed that on multiple occasions, there was no evidence of when LPN #3 had administered insulin to Resident #53. On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. ASM #2 at approximately 1 p.m., presented evidence that LPN #3 was re-educated on the "Administering Medications" policy on 11/21/19. No further information was presented prior to exit.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690	1. Resident #83's Foley catheter orders have been updated by the physician and the resident's comprehensive plan of care has been reviewed and revised to accurately reflect physician ordered interventions. A facility Incident & Accident form was completed for this incident. 2. All other residents with a Foley catheter may have been potentially affected. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager performed a .one-time audit of all residents with a Foley catheter to identify residents at risk. Residents identified will be corrected at time of discovery and a Facility Incident & AccidentForm will be completed for each negative finding.	01/03/2020

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F 690	Continued From page 26 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to obtain orders for the use of a catheter for one of 37 residents in the survey sample, Resident #83. The findings included: Resident #83 was admitted to the facility on 10/28/19 and readmitted on 11/15/19 with diagnoses that included but were not limited to Hydronephrosis with renal and ureteral	F 690	3. The facility Policy and Procedure for Foley/Suprapubic Catheter insertion, usage and care has been reviewed and no changes are warranted at this time. The nursing staff will be in-serviced by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager on the policy and procedures for ensuring that physician orders are in place for the use of Foley catheters. 4. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager will perform audits all residents with Foley Catheters once a week for 3 months to monitor for compliance. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 690	Continued From page 27	F 690		

obstruction. Resident #83's most recent MDS (Minimum Data Set) assessment was an admission assessment with an ARD (assessment reference date) of 10/28/19. Resident #83 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #83 was coded in section H (Bowel and Bladder) as having an indwelling catheter.

Review of Resident #83's elimination care plan dated 10/21/19 documented the following: "Alteration in elimination Indwelling catheter and ileostomy related to: Dx (diagnosis) of Hydrourterinephrosis (1), wounds, rectal/colon cancer...change catheter and drainage bag as per order."

Review of Resident #83's October 2019 POS (physician order summary) revealed the following orders for her urinary catheter:
"- 16 Fr (french) foley catheter. Dx: Hydrourterinephrosis
- Change 16" french foley catheter PRN (as needed)
- Change foley catheter bag the 1st and 15th of every month.
- Foley catheter care Q (every) shift
-Flush foley catheter PRN."

All the above orders were discontinued on 11/11/19 when Resident #83 was sent to the hospital.

Review of a nursing note dated 11/15/19 revealed that Resident #83 was admitted back to the facility with a foley catheter. The following in part, was documented: "Foley cath intact and patient draining 50 ml (milliliters) amber colored urine no

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F 690	Continued From page 28 sediments or foul odor present..." An order for the use of Resident #83's Foley catheter could not be found on her November 2019 POS. The only catheter order that was re-instated on the November 2019 POS was the following: "Change foley catheter bag the 1st and 15th of every month." On 11/21/19 at 1:37 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the unit manager. When asked what orders she would expect to see for a resident with a Foley catheter, LPN #1 stated that there should first be an order for the catheter documenting size, how often to change the bag, how often to replace the catheter (once a month), an irrigation order and orders for foley catheter care every shift. When asked who was responsible for providing catheter care every shift, LPN #1 stated that the nurses provide catheter care every shift. When asked if nurses would know to provide catheter care if there was not a current order for a urinary catheter or to provide care every shift; LPN #1 stated that catheter care was a nursing standard of practice and should be performed on every resident with a catheter. When asked how staff would know how often to change the catheter and provide flushes, LPN #1 stated that those instructions would have to be on the TAR (treatment administration record) and that orders would have to be in place in order for it to show up on the TAR. LPN #1 reviewed Resident #83's November 2019 orders and confirmed that not all of her catheter orders were reinstated when she arrived back to the facility on 11/15/19. LPN #1 stated that she was going to re-activate all of Resident #83's catheter orders.	F 690		

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F 690	Continued From page 29 On 11/21/19 at 1:53 p.m., an interview was conducted with Resident #83. Resident #83 stated that staff performed catheter care a few times a day along with Hospice staff. Resident #83 stated that she had no concerns related to her catheter. On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. Facility policy titled, "Catheter Care" did not address the above concerns. No further information was presented prior to exit.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761	1. The expired bottle of house stock calcium tablets found in the medication cart was removed and destroyed upon discovery. 2. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager performed a one-time audit of the medication rooms, medication carts, and medication refrigerators to identify any expired medication. 3. All licensed nurses will be in-serviced by the Director of Nursing, Assistant Director of Nursing, and/or Unit Manager on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be in-serviced on the Medication Administration Policy and Procedure to include weekly review of all Medication rooms, medication refrigerators and medication carts for expired medications.	01/03/2020

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F 761	Continued From page 30 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, the facility staff failed to ensure that 1 opened bottle of house stock calcium tablets 500 mcg (micrograms) with the expiration date of 09/2019 was discarded. The findings included: On 11/22/19 at approximately 10:15 AM, an inspection of the medication cart on the Rose unit was conducted with Licensed Practical Nurse (LPN) #1. An opened bottle of Calcium tablets was stored on a medication cart with an expiration of 09/19. LPN #1 was asked what should have been done with the expired bottle of medication; she stated, "They should have discarded and replaced the medication." The Facility Policy titled, "Storage of Medications" Reads as follows: The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. The above findings were shared with the Administrator, the Acting Director of Nursing and the Corporate Nurse Consultant during the pre-exit meeting conducted on 11/22/19 at 12:30 PM. No further information was presented by the	F 761	4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Manager will audit the Medication rooms and Medication carts twice a week for 4 weeks, then once a week for 4 weeks and monthly for 3 months to monitor compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 761	Continued From page 31 facility staff.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to apply hair restraints before entering the food preparation area in the facility kitchen. On 11/19/19 at 6:20 PM during the initial tour of the kitchen there were no hair restraints available upon entrance into the kitchen and food prep area. On the floor before entering into the kitchen and food prep area was a yellow and black strip with unreadable lettering. There were staff observed throughout the survey crossing the unreadable yellow and black line on the floor	F 812	1. Signage warning that personnel entering the dietary department may not cross the yellow line without a hairnet was placed between the dietary entrance door and the yellow caution line. A box of hairnets was also placed below the sign. 2. The Dietary Manager and/or Dietary Assistant will monitor all persons entering the dietary department area for compliance. 3. Current facility policy & procedure has been reviewed and no changes are warranted at this time. The Dietary Manager will in-service all staff on the proper use of hairnets while in the dietary department. 4. The Dietary Manager and/or Dietary Assistant will complete 3 random audits twice a week for 4 weeks, then once a week for 4 weeks, and once a month for three months to monitor for compliance. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance meeting for three months with a subsequent Plan of Correction as needed.	01/03/2020

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F 812	Continued From page 32 entering the kitchen without hair restraints. In order to get a hairnet you had to enter the kitchen, turn right and go past the food prep area to open a drawer that housed the hair restraints. On 11/20/19 at approximately 11:15 AM a tour of the kitchen was made with the Dietary Director. She was asked how would someone entering the kitchen obtain a hairnet? She stated, "They would stop at this line and someone would bring them a hairnet. She was then asked how would someone know to stop at this yellow line. She stated, "The yellow line has caution written on it." She was then asked how would someone make out the wording of these letters because it's hard reading the lettering; no comment was made. On 11/21/19 at approximately, 9:35 AM a sign was observed placed between the entrance doors reading: PLEASE DO NOT CROSS THE YELLOW LINE WITHOUT A HAIRNET, THANKS. Located below the sign were hair restraints. The Dietary Manager stated, "The sign was put up yesterday." The above findings were shared with the Administrator, the Acting Director of Nursing and the Corporate Nurse Consultant during the pre-exit meeting conducted on 11/22/19 at 12:30 PM. No further information was presented by the facility staff.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 814	1. The area around the dumpsters was cleaned of the trash on the ground and it was properly disposed of inside the dumpsters. 2. All other garbage disposal areas have the potential to be affected. The Maintenance Director and/or Maintenance Assistant will inspect all garbage storage areas to identify risk.	01/03/2020

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F 814	Continued From page 33 Based on observation and staff interview the facility staff failed to ensure the garbage storage area was maintained in a sanitary condition. The findings included: On 11/21/19 at approximately 9:40 AM the garbage and refuse containers were observed with the Dietary Director. The ground area surrounding the two trash dumpsters were observed to have a small amount of scattered debris of glass fragments, cigarette butts, coffee filter grounds and two small trash bags located in front of the dumpsters on the ground. A cat was seen walking away from the dumpsters. The Dietary Director stated that the garbage disposal truck was here earlier and left debris on the ground. The Dietary Director was asked what should have been done concerning the debris left on the ground; she stated, "We should keep the gate closed and check the dumpster after the garbage truck comes to pick up trash." The above findings was shared with the Administrator, the Acting Director of Nursing and the Corporate Nurse Consultant during the pre-exit meeting conducted on 11/22/19 at 12:30 PM. No further information was provided by facility staff.	F 814	3. The facility policy & procedure for the storage and disposal of refuse was reviewed and no changes are warranted at this time. The Maintenance Director and/or Maintenance Assistant will provide an in-service to all staff on the proper techniques for the disposal of all refuse inside supplied dumpsters and keeping lids closed at all times. 4. The Maintenance Director and/or Maintenance Assistant will complete rounds of dumpster areas twice a week for 4 weeks, then once a week for 4 weeks, and once a month for three months to monitor and maintain compliance. Any refuse on the ground surrounding the dumpsters will be corrected immediately. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842	1. Resident #19's attending physician has been notified that the resident's clinical record does not indicate the correct amount of insulin given on 11/13/19, 11/14/19, 11/15/19, 11/18/19, 11/19/19 and 11/20/19. A facility incident and accident form has been completed for this incident.	01/03/2020

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F 842	Continued From page 34 (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 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	F 842	2. All other residents may have been potentially affected. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager performed a one-time audit of all resident's insulin administration documentation. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding. 3. All licensed nursing staff will be in-serviced by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager on the clinical documentation standards regarding sliding scale insulin administration per facility policy and procedure. 4. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager will audit medical records 5 times a week for 4 weeks, then twice a week for 4 weeks, and once a week for three months to ensure clinical records are accurate. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. 5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 842	Continued From page 35 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; (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, facility document review, and clinical record review, it was determined that facility staff failed to ensure an accurate clinical record for one of 37 residents in the survey sample, Resident #19. The findings included: Resident #19 was admitted to the facility on 5/22/17 with diagnoses that included but were not limited to type two diabetes mellitus. Resident #19's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/21/19. Resident #19 was coded as moderately impaired	F 842		

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F 842	Continued From page 36 in cognitive function scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #19 was coded in section N (Medications) as receiving insulin injections. Review of Resident #19's November POS (physician order summary) revealed the following order for insulin: "Novolog (1) 100 units/mL (milliliters) Flexpen AC/HS (before meals)/at bedtime) Novolog per sliding scale FBG (fasting blood sugar) less then 90 = 0U (units) 91-120 = 20U 121-130 = 30U 131-180 = 35U 181-220 = 40U 221- 300 = 50U 301 OR> (greater) = 60" Review of Resident #19's November 2019 MAR (Medication Administration Record) revealed that incorrect amount of insulin was documented as administered on 11/13/19, 11/14/19, 11/15/19, 11/18/19, 11/19/19, and 11/20/19. The following was documented: 11/13/19 11:30 AM Bld_Glu: 242; SubQ inj: RLQ (right lower quadrant) (abdomen); Units: 5. (50 was supposed to be given). 11/14/19 11:30 AM Bld_Glu: 237; SubQ inj: LLQ (left lower quadrant) (abdomen); Units: 5. (50 was supposed to be given). 11/15/19 11:30 AM Bld_Glu: 305; SubQ inj: LLQ; Units: 6. (60 was supposed to be given). 11/18/19 11:30 AM Bld_Glu: 369; SubQ inj: LLQ; Units: 6. (60 was supposed to be given). 11/19/19 11:30 AM Bld_Glu: 204; SubQ inj: LLQ; Units: 4. (40 was supposed to be given).	F 842		

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F 842	Continued From page 37 11/20/19 11:30 AM Bld_Glu: 329; SubQ inj: LLQ; Units: 6. (60 was supposed to be given). Further review of Resident #19's November MAR revealed that one nurse Licensed Practical Nurse (LPN) #2 was the nurse who documented all six administrations of the above insulin. On 11/21/19 at 3:22 p.m., an interview was conducted with LPN #2. When asked how to properly administer sliding scale insulin, LPN #2 stated that she would test the resident's blood sugar using the glucometer and then administer insulin per physician's order. When asked if the order should be followed, LPN #2 stated that it should. This writer showed LPN #2 Resident #19's MAR. LPN #2 stated that she left the zero off her number when documenting and charted so fast, she did not catch it. LPN #2 stated that the MAR should have said 60 instead of 6 and 40 instead of 4 etc. On 11/22/19 at 12:26 p.m., ASM #1, the Administrator, ASM #2, the ADON (Assistant Director of Nursing), ASM #3, the Corporate Nurse Consultant, and ASM #4, the Vice President of Operations were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Documentation," documented in part, the following: "Documentation in the medical record will be objective...complete, and accurate."	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	1. CNA #2 has received one on one education regarding infection control practices while feeding residents during mealtime.	01/03/2020

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F 880	Continued From page 38 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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	F 880	Resident #46's physician has been notified that facility staff failed to practice proper infection control practices during the resident's meal on 1 1/20/19. Resident #73.'s physician has been notified that facility staff failed to practice proper infection control practices during the resident's meal on 11/20/19. Resident #57's physician has been notified that facility staff failed to practice proper infection control practices during the treatment observation on 11/20/19. The facility wound care nurse has received one on one education regarding proper treatment procedures with regards to infection control. 2. A review of all staff who assist residents with meals has been completed to identify residents/staff at risk. Negative findings will be addressed upon identification and a one on one in-servicing was completed. 3. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager will conduct an observation of all nursing staff who regularly complete dressing change orders. Negative findings will be addressed upon identification and one on one in-servicing with staff involved will be completed All licensed staff will be inserviced on the facility policy and procedure for proper infection control practices during meals and treatment procedures by the facility's infection preventionist. 4. The Director of Nursing and/or Assistant Director of Nursing will perform 2 random t reatment observations and 2 random meal observations twice a week for 4 weeks, then once a week for 4 weeks, and monthly for 3 months to monitor nursing staff for compliance.	

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F 880	Continued From page 39 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain infection control practices during the dining room observation for two of 37 residents, Resident #46 and #73; and failed to practice infection control measures while performing wound care for one of 37 residents, Resident #57. The findings included: 1. Resident #46 was admitted to the facility on 6/2/19 with diagnoses that included but were not	F 880	5. Data results will be reviewed and analyzed at the facility's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 880	Continued From page 40 limited to dysphagia (difficulty swallowing), and anomaly of jaw size. Resident #46's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/25/19. Resident #46 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #46 was coded in Section G (Functional Status) as requiring extensive assistance with one staff member with meals. 2. Resident #73 was admitted to the facility on 1/18/17 with diagnoses that included but were not limited to dysphagia and left sided paralysis. Resident #73's most recent MDS assessment was a quarterly assessment with an ARD (assessment reference date) of 10/16/19. Resident #73 was coded as being severely impaired in cognitive function scoring 08 out of 15 on the BIMS. Resident #73 was coded in Section G (Functional Status) as requiring limited assistance with one staff member with meals. On 11/20/19 at 12:08 p.m., an observation was made in the restorative dining room. CNA (Certified Nursing Assistant) #2 was observed assisting Resident #46 with her meal. At 12:13 p.m., Resident #73 started coughing and CNA #2 stopped assisting Resident #46 and went over to assist Resident #73. CNA #2 then gave Resident #73 a sip of his drink, and starting to wipe food off the residents clothes with her bare hands. CNA #2 then moved his tray out of they way and wiped his mouth with his clothing protector. CNA #2 was then observed to put on one glove to the right hand and cleaned the rest of the food crumbs off the resident's shirt. CNA #2 then threw the glove away and proceeded to assist Resident #46 with	F 880		

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F 880	Continued From page 41 her meal. CNA #2 did not wash or sanitize her hands prior to assisting Resident #46. On 11/22/19 at 1:00 p.m. a phone interview was attempted with CNA #2. She could not be reached. On 11/22/19 at 1:46 p.m., an interview was conducted with CNA #3, a CNA on Rose unit. When asked if she ever assists residents with meals, CNA #3 stated that she did. When asked how to maintain infection control practices while assisting with meals, CNA #3 stated that staff should wash or sanitize their hands prior to and after assisting a resident with their meal. When asked if hands should be washed or sanitized in-between assisting residents with meals; CNA #3 stated that hands should be washed to prevent the spread of germs. On 11/22/19 at 1:35 p.m., ASM (Administrative Staff Member) #1, the facility administrator was made aware of the above concerns. Facility policy titled, "Assistance with Meals," did not address the above concerns. No further information was presented prior to exit. 3. Resident #57 was originally admitted to the facility on 09/24/14 and readmitted on 10/12/19. Diagnosis for Resident #57 included but not limited to Alzheimer's disease and anxiety disorder. The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 08/03/19 coded the resident with a BIMS summary score of 99 out of a possible score of 15 on the Brief Interview for Mental	F 880		

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F 880	Continued From page 42 Status (BIMS) indicating severe cognitive impairment. C0600-Staff assessment for mental status was conducted because resident was unable to complete the interview coding the resident as having short-term and long-term memory problems. On 11/20/19 at approximately, 9:55 AM wound care observation was made. Initially, the wound care nurse sanitized the resident's bedside table, allowed it to dry, placed a drape on the table, added wound care items etc. After removing the soiled dressings from the Resident's sacrum with a cotton tip applicator and gloved hands. LPN #6 donned gloves without performing hand hygiene and proceeded with cleaning Resident #57's sacrum with clean gauze. After the completion of wound care Licensed Practical Nurse (LPN) #6 removed her scissors and marker from the drape placed on the resident's bedside table then placed the items (scissors and markers) on the uncovered table while discarding the soiled items and drape into the biohazard bag. She disinfected the marker and scissors after she had placed them on the bedside table. She performed hand hygiene and placed Resident #57's water pitcher on his bedside table without disinfecting the table. On 11/20/19 at approximately, 10:43 AM an interview was conducted with LPN #6 concerning the above issues observed during wound care. She stated, "Yes, I would usually clean the table but was a little nervous." "I started off cleaning my hands with the foam disinfectant but it got too sticky and creamy." LPN #6 stated "For infection control measures I should have washed my hands and disinfected the table." The above findings was shared with the	F 880		

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F 880	Continued From page 43 Administrator, the Acting Director of Nursing and the Corporate Nurse Consultant during the pre-exit meeting conducted on 11/22/19 at 12:30 PM. No further information was presented by facility staff.	F 880		